

# Conviction Integrity Conference

Presented by:  
Center on  
Wrongful Convictions  
Bluhm Legal Clinic  
Northwestern Law

October 29, 2014 | 12:30–4:45 p.m. | Thorne Auditorium, Northwestern University School of Law

## CLE MATERIAL AND INFORMATION

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Docket No. 104096.

**IN THE  
SUPREME COURT  
OF  
THE STATE OF ILLINOIS**

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THE PEOPLE OF THE STATE OF ILLINOIS, Appellee, v. ALAN  
BEAMAN, Appellant.

*Opinion filed May 22, 2008.*

JUSTICE KILBRIDE delivered the judgment of the court, with  
opinion.

Chief Justice Thomas and Justices Freeman, Fitzgerald, Garman,  
Karmeier, and Burke concurred in the judgment and opinion.

**OPINION**

The petitioner, Alan Beaman, appeals the dismissal of his postconviction petition. His petition stems from a first degree murder conviction (720 ILCS 5/9-1 (West 1992)), and sentence of 50 years. The appellate court affirmed his conviction on direct appeal. No. 4-95-0396 (1996) (unpublished order under Supreme Court Rule 23). Petitioner then filed his postconviction petition alleging several violations of his constitutional rights. The circuit court of McLean County dismissed the petition following an evidentiary hearing, and the appellate court affirmed the dismissal. 368 Ill. App. 3d 759. We allowed petitioner's petition for leave to appeal. 210 Ill. 2d R. 315(a).

On appeal to this court, petitioner asserts several claims, including that the State violated his constitutional right to due process of law by

failing to disclose information about a viable alternative suspect in the murder. We conclude that the State violated petitioner's right to due process under *Brady v. Maryland*, 373 U.S. 83, 10 L. Ed. 2d 215, 83 S. Ct. 1194 (1963), by failing to disclose material information about the alternative suspect. Accordingly, we reverse the judgments of the circuit and appellate courts and remand this matter to the circuit court for a new trial.

## I. BACKGROUND

Jennifer Lockmiller, an Illinois State University student, was found dead in her apartment in Normal, Illinois, on August 28, 1993. A clock radio electrical cord was wrapped around her neck, and she had been stabbed in the chest with scissors. Her shirt and bra were pushed up around her neck, and her shorts and underwear were pulled down. A box fan was lying across her face.

Seven fingerprints were recovered from the clock radio. Two of the fingerprints were from petitioner, four belonged to Jennifer's boyfriend Michael Swaine, and one was unidentified. Based on the crime scene and Jennifer's class schedule, the State argued that the time of death was shortly after 12 p.m. on Wednesday, August 25, 1993. In a bill of particulars, the State asserted the murder occurred between 12 p.m. and 2 p.m. on that date.

Prior to trial, the State filed a motion *in limine* seeking to exclude evidence of Jennifer's relationships with men other than petitioner and Michael Swaine. The State argued that petitioner should not be allowed to offer alternative-suspect evidence unless he could establish it was not remote or speculative. The prosecutor informed the court that the State did not possess nonspeculative evidence of a third-party suspect. The court reserved ruling on the motion.

Before the jury trial, the prosecutor and defense counsel discussed Jennifer's relationship with a person identified as John Doe. The prosecutor informed the court that Doe had "nothing to do with this case." Petitioner conceded that he did not have any specific evidence showing that another person committed the offense. The trial court then granted the motion *in limine*, ruling that petitioner could not present any evidence of an alternative suspect.

At trial, petitioner testified that he began dating Jennifer in July of 1992. During the following year, petitioner and Jennifer ended and then restarted their relationship a number of times. Petitioner was a student at Illinois Wesleyan University in Bloomington during that time. He often used Jennifer's clock radio to wake up for class. In several letters to Jennifer, petitioner expressed his desire to have a monogamous relationship. The letters indicated that petitioner believed Jennifer was involved with other men.

During the spring semester of the 1993 school year, Jennifer's neighbor heard petitioner pounding on Jennifer's door late at night on several occasions. He also heard petitioner and Jennifer yelling at each other. Petitioner testified that one night in the spring of 1993, Jennifer called and told him that she wanted to end their relationship. He went to Jennifer's apartment to get his compact disc player. When he arrived, he saw John Doe's car in the parking lot. Petitioner pounded on the door to Jennifer's apartment, but she refused to let him inside. Petitioner continued pounding and kicking the door until it broke. After he discovered Jennifer and Doe inside, he took his compact disc player from the apartment and left. Petitioner was yelling while inside the apartment, but he did not touch either Jennifer or Doe.

Additionally, Jennifer and petitioner's roommate, Michael Swaine, began a relationship during the summer of 1993. One night in early July, petitioner suspected that Swaine was at Jennifer's apartment. Petitioner pounded and kicked the door until it broke. He entered the apartment, but could not find Swaine. Petitioner did not touch Jennifer, but confronted her verbally and left after 30 to 45 minutes.

On July 25, 1993, petitioner searched Swaine's room and discovered letters that Jennifer had written to Swaine. Petitioner located Swaine and screamed at him about "seeing" Jennifer. Petitioner then went to Jennifer's apartment, pounded on her door, and when she let him inside, he confronted her by reading the letters. Petitioner emptied a bathroom garbage can on the floor looking for used contraceptives. He left after 15 to 20 minutes. At that point, petitioner considered the relationship to be over.

Petitioner traveled to Cincinnati with a friend that day. While he was in Cincinnati, petitioner talked to Jennifer and Swaine by

telephone. Petitioner returned to Normal on August 4, 1993. He stopped at Jennifer's apartment, had a short conversation with her, and drove her to class before saying goodbye. Petitioner then moved back to his parents' home in Rockford, Illinois.

Jennifer called petitioner at his home in Rockford several times, including a call on August 23, 1993. Petitioner testified that Jennifer asked him if they could get back together when the school year began. Petitioner told her "[n]o, we're through," and hung up the telephone. Petitioner's parents testified that petitioner stated Jennifer wanted him to visit her, but petitioner denied that she invited him.

After Jennifer's body was found in her apartment, police detectives interviewed petitioner several times. Petitioner stated he had not seen Jennifer since August 4. When he was asked to account for his activities between August 23 and August 27, petitioner began with August 25. Petitioner wrote that he went to a church function at 7 p.m., followed by a church music rehearsal, and a party. Petitioner then went to Monday, August 23, and wrote, "Jen called, I hung up, about five minutes." Petitioner then filled out the rest of the week. The date of Jennifer's murder had not been announced publicly at that time. Petitioner denied any involvement in the murder.

Petitioner presented evidence that his car was driven 322 miles between August 24 and August 30. That mileage figure was based on an odometer reading on a receipt from Sears, where petitioner purchased tires on August 24, and a photograph of the odometer taken by petitioner's mother on September 1. Petitioner also presented testimony that he drove 305.6 miles that week in his daily activities in Rockford to show that he could not have driven approximately 140 miles to Normal on August 25. The parties presented conflicting testimony on whether petitioner's odometer had been subject to tampering.

Petitioner also testified that he worked a night shift at his uncle's grocery store, ending at 9 a.m. on August 25. He went home, picked up some cash and a check, and drove to his bank to make a deposit. A bank security videotape showed petitioner leaving the bank at 10:11 a.m. After returning from the bank, petitioner went to sleep in his room until approximately 5 p.m.

Telephone records showed that calls were made from the Beaman residence to their church at 10:37 a.m. and to Mitchell Olson's residence at 10:39 a.m. Olson was the church's director of music and youth ministries. The evidence showed that only petitioner or his mother, Carol Beaman, could have made those calls. Petitioner testified that he did not remember making the calls, but it was "entirely possible" that he made them.

Olson testified that petitioner occasionally played music during church services and they had scheduled a rehearsal for the evening of August 25. Olson did not recall speaking with anyone in petitioner's family that morning, but remembered speaking with Carol Beaman when he called the residence around 2:30 or 3 p.m.

Carol Beaman testified that she did not make the phone calls from her residence at 10:37 and 10:39 a.m. She left home around 7 o'clock that morning. She drove to Independence Village, her mother's assisted-living facility, and took her mother to a clinic for blood tests. They returned to Independence Village at 10 a.m. Carol spent 15 to 20 minutes taking her mother to her room and helping her get settled. She then went to a Wal-Mart store located directly across the street. She checked out at 11:10 a.m., as shown by her receipt. The receipt indicated that she purchased copy paper, poster frames, magazine holders, and blue jeans.

After leaving Wal-Mart, she went to other stores. Her final stop was at a grocery store where she checked out at 2:03 p.m. She went directly home because she had perishable items. She subsequently timed the drive from the grocery store to her residence at 9 to 13 minutes. Accordingly, she testified that she arrived home by 2:16 p.m. However, she previously informed police officers that she arrived home around 3 p.m. When she arrived, petitioner's car was in the driveway and his dog was sitting in front of his bedroom door. She woke petitioner for dinner at approximately 6 p.m.

Normal Police Detective Timothy Freesmeyer testified about drive times and distances relevant to defendant's opportunity to commit the murder. Freesmeyer testified that the distance from petitioner's bank to Jennifer's apartment was 126.7 miles. Freesmeyer's drive time test indicated that petitioner could have arrived at Jennifer's apartment just before noon if he left the bank at 10:11 a.m. and drove 10 miles per hour over the speed limit. The

distance from petitioner's home to Jennifer's apartment was 139.7 miles. Petitioner could have driven from Jennifer's apartment to his residence in Rockford in just under two hours, driving 10 miles per hour over the speed limit.

Freesmeyer further testified that it took him 31 minutes while observing all speed limits to drive the route through downtown Rockford that petitioner "would have taken from Bell Federal Bank to his residence." Freesmeyer testified that driving through downtown Rockford was the "most direct route." Freesmeyer explained that he performed the time trial to "see if it was possible" for petitioner to make the phone call from his residence at 10:37 a.m. Freesmeyer concluded that petitioner would have arrived home at 10:42 a.m. if he left the bank at 10:11 a.m. and made the 31-minute drive. Freesmeyer also testified that it took him 15 minutes to drive from the Beaman residence to the Wal-Mart where Carol shopped on August 25.

On cross-examination, Freesmeyer acknowledged that petitioner never stated he drove through downtown Rockford on August 25. Freesmeyer agreed that the route he tested went "directly through the heart of downtown Rockford" as opposed to "the high speed bypass" around the city.

In terms of other possible suspects, the State presented evidence that Swaine was working at his former high school's bookstore in Elmhurst, Illinois, on August 25. Jennifer's former long-term boyfriend, Stacey Gates, also known as "Bubba," testified that he was employed as a teacher in Peoria, Illinois, and he worked that day.

In closing argument, the State maintained that the evidence clearly established petitioner's motive and opportunity to commit the offense. According to the State, petitioner drove to Normal after he left the bank at 10:11 a.m., arriving at around noon. When he walked into Jennifer's apartment, he saw Swaine's property. At that point, he "snapped" and committed the murder. Petitioner left the apartment by 12:15 p.m. and drove back to Rockford, arriving home around 2:10 p.m. The State argued that petitioner's guilt was also shown by his immediate focus on August 25 when asked to account for his time that week.

The State further argued that petitioner did not make the telephone calls from the Beaman residence at 10:37 and 10:39 a.m.

According to the State, Carol Beaman could have driven home after taking her mother back to Independence Village, placed the calls, and then driven back to Wal-Mart. The State concluded that the circumstantial evidence “weaves around this defendant a web \*\*\* that’s so powerful that you can rest assured that you have the right person here.”

Defense counsel responded that the evidence against petitioner was almost nonexistent, and the State had improperly focused its investigation on him to the exclusion of other potential suspects. Defense counsel explained that petitioner began with the evening of August 25 in accounting for the week because certain events stood out in his memory that day, including a church event, his music rehearsal, and a party. The rest of the week was, for the most part, routine. Counsel argued that the evidence against Swaine was as strong as the evidence presented against petitioner. Counsel concluded that the State failed to prove petitioner guilty beyond a reasonable doubt.

In rebuttal, the prosecutor defended the State’s investigation. He argued, “Alibis, we proved up everybody else’s, but—we just jumped right in there and cleared all these other people, and we just didn’t do the same for him.” The prosecutor further argued, “Did we look at Mr. Swaine? You bet we did. Did we look at Bubba? You bet we did. Did we look at a lot of people and interview a lot of witnesses? You bet we did. And guess who sits in the courtroom \*\*\* with the gap in his alibi still unclosed even after all this?” The prosecutor asserted that the “web of circumstantial evidence unmistakably, undeniably, beyond any doubt” tied petitioner to the murder, and again asked the jury to return a guilty verdict.

The jury found petitioner guilty of first degree murder and the trial court sentenced him to 50 years’ imprisonment. The appellate court affirmed the trial court’s judgment with one justice dissenting. The dissenting justice found the evidence insufficient to prove petitioner guilty beyond a reasonable doubt. No. 4–95–0396 (unpublished order under Supreme Court Rule 23) (Cook, J., dissenting).

Petitioner then filed a postconviction petition with the assistance of counsel. Counsel filed several amendments to the petition. In its final form, petitioner alleged in pertinent part that: (1) his trial

attorneys were ineffective for failing to investigate and present additional evidence establishing that he did not have the opportunity to commit the murder; (2) the State violated his constitutional right to due process of law under *Brady* by failing to disclose material information supporting John Doe's viability as a suspect; and (3) the State violated his right to due process of law by presenting false and misleading testimony from Detective Freesmeyer on the drive time from the bank to petitioner's residence. The trial court denied the State's motion to dismiss the petition and set the matter for an evidentiary hearing.

At the evidentiary hearing, retired Normal Police Lieutenant Tony Daniels testified about the John Doe evidence. Doe and Jennifer had previously been involved in a romantic relationship. He lived in Bloomington, approximately 1½ miles from Jennifer's apartment. Daniels testified that it would take Doe four to six minutes to drive to Jennifer's apartment and back. Doe told police officers that he and Jennifer were about to renew their relationship before her death. Jennifer and Michael Swaine came to his apartment a few days before the murder. Doe stated that he had supplied Jennifer with marijuana and other drugs, and she owed him money.

Daniels interviewed Doe twice in early September 1993 and found him to be "somewhat evasive" and "very nervous." In his first interview, Doe stated that he went out of town on August 24, the day before the murder. In the second interview a few days later, Doe informed Daniels that he did not leave Bloomington until 4 p.m. on August 25. He was in his apartment until 4 p.m. that day. Doe's girlfriend stated that she was with him from just after 1 p.m. until 4 p.m. that day. Doe did not provide any verification of his location before his girlfriend arrived around 1 p.m.

Daniels explained that he asked Doe to take a polygraph examination, but the examiner was unable to start the test because Doe failed to follow his directions. The polygraph examiner testified that the failure to follow the instructions could have been an intentional avoidance tactic. He further testified that Doe was being examined as a suspect in the murder. Daniels asked Doe to try again. Doe initially agreed, but the polygraph examination never occurred due to Doe's lack of cooperation.

Daniels further testified that Doe was charged with domestic battery and possession of marijuana with intent to deliver prior to petitioner's trial. A witness to the domestic battery indicated that Doe had his girlfriend on the floor and was elbowing her in the chest. Doe's girlfriend stated that Doe had physically abused her on numerous previous occasions. Additionally, she stated that Doe was using steroids, causing him to act erratically. Daniels testified that he considered Doe a viable suspect in the murder at the time of petitioner's trial, and he believed that Doe remained a viable suspect.

Petitioner's trial counsel testified that the undisclosed evidence included Doe's polygraph examination, his abuse of his girlfriend, his domestic battery charge, and his steroid use. He testified that he would have surely attempted to present Doe as an alternative suspect if that information had been disclosed.

Petitioner also presented testimony on his opportunity to commit the murder. Petitioner testified at trial that he used the bypass route around downtown Rockford on August 25, when he drove from his residence to the bank. Petitioner's investigator, hired for the postconviction proceedings, testified that he timed the bypass route three times. The drive time was around 22 minutes on each trip driving with the flow of traffic. He also drove two separate routes through downtown Rockford with the flow of traffic, and those trips took him 26 and 27 minutes. Petitioner's investigator also performed three time trials on the route Carol Beaman would have taken from Wal-Mart to her residence. Those trips took 19 or 20 minutes driving with the flow of traffic.

Carol Beaman testified in more detail about her shopping trip to Wal-Mart. First, she picked up paper for her photocopier. She then shopped for poster frames, comparing sizes, weights, and prices. She located plastic binders for her magazines. She also probably checked the prices of spiral notebooks and pocket folders for her thesis project, although she did not buy those items on that trip. In purchasing petitioner's blue jeans, she had to search for his size and his preferred style.

Additionally, Mitchell Olson testified that petitioner was scheduled to perform at church services on August 29, 1993. Olson had scheduled a rehearsal for the evening of August 25. He tried to confirm the rehearsal time earlier that day. Phone records showed a

call from the church to the Beaman residence at 10:22 a.m. Petitioner usually returned Olson's phone calls by calling the church, but petitioner also had Olson's home phone number. Olson testified that he only called the Beaman residence when he needed to reach petitioner. He did not remember ever receiving a phone call from Carol Beaman.

Following the evidentiary hearing, the circuit court concluded that petitioner had failed to establish his constitutional claims. On the ineffective assistance of counsel claim, the court found that trial counsel presented a vigorous defense on petitioner's alibi. His focus on the odometer evidence was a matter of trial strategy. Petitioner's attorney also presented some evidence on the availability of petitioner and his mother to make the telephone calls from their residence on the morning of August 25. Therefore, the circuit court concluded the record did not establish petitioner's claim of ineffective assistance of trial counsel.

The circuit court also denied petitioner's due process claim based on presentation of false or misleading evidence. The court found Detective Freesmeyer's testimony on the drive time from the bank to petitioner's residence was not false or misleading. Rather, the State simply presented factual information and argued for its version of the events.

The circuit court further concluded that petitioner's *Brady* claim failed because the undisclosed information on Doe's polygraph and his domestic battery charge was inadmissible at trial. Additionally, the court found that the evidence pointing to Doe as a viable suspect was remote and speculative. The court found that petitioner had "not provided enough evidence that if presented at the [motion *in limine* hearing], the trial court would have allowed the defense to present John Doe I as a suspect." The circuit court, therefore, denied the petition for postconviction relief.

The appellate court affirmed the circuit court's judgment. 368 Ill. App. 3d 759. The appellate court held that petitioner's due process claim that the State presented false and misleading testimony was forfeited because petitioner did not raise it on direct appeal. Even if it were not forfeited, the claim would fail because the trial court's ruling was not manifestly erroneous. The appellate court also held that the circuit court's decision on the ineffective assistance of

counsel claim was not manifestly erroneous. Counsel's decision to focus on mileage rather than drive times was a strategic choice that was not objectively unreasonable. Finally, the appellate court held that the evidence developed against Doe was too remote and speculative to connect him to the murder. The evidence, therefore, would not have been admissible to establish him as an alternative suspect. The appellate court concluded that petitioner's *Brady* claim failed because he could not establish a reasonable probability that the undisclosed evidence would have affected the outcome of the trial. 368 Ill. App. 3d at 772.

Justice Cook dissented, focusing on the *Brady* claim. 368 Ill. App. 3d at 773 (Cook, J., dissenting). Justice Cook noted that the evidence against petitioner was entirely circumstantial and was similar to that against John Doe. He concluded that petitioner "should have been allowed to present the same type of evidence regarding Doe that the State presented against" him. 368 Ill. App. 3d at 774 (Cook, J., dissenting). Nondisclosure of the additional evidence against Doe was particularly damaging here because the prosecution introduced evidence of three suspects, petitioner, Swaine, and Gates, and argued petitioner was the only one who did not have an alibi. Thus, the prosecutor led the jury to believe that no one else had motive and opportunity to commit the murder. Justice Cook concluded that evidence of Doe as an alternative suspect would have been admitted if the State had disclosed the additional information. Justice Cook also disagreed with the circuit court's determination that the State did not present misleading testimony on the drive time from petitioner's bank to his residence. Accordingly, he concluded that petitioner's conviction should be reversed and the cause remanded for a new trial. 368 Ill. App. 3d at 778 (Cook, J., dissenting).

## II. ANALYSIS

On appeal to this court, petitioner renews his claims that: (1) he was denied due process of law by the State's failure to correct Detective Freesmeyer's testimony that it was not possible for petitioner to arrive home to make the telephone calls on the morning of the murder; (2) his trial attorney was ineffective because he failed to investigate and present available evidence tending to prove that petitioner made the calls from his residence on the morning of the

offense; and (3) his right to due process of law was violated by the State's failure to disclose material information about John Doe, who was a viable alternative suspect.

The Post-Conviction Hearing Act (725 ILCS 5/122-1 *et seq.* (West 2000)) provides a means for a criminal defendant to challenge his conviction or sentence based on a substantial violation of constitutional rights. *People v. Whitfield*, 217 Ill. 2d 177, 183 (2005). A postconviction proceeding is not an appeal from the judgment of conviction, but is a collateral attack on the trial court proceedings. *People v. Johnson*, 191 Ill. 2d 257, 268 (2000). To be entitled to postconviction relief, the petitioner must make a substantial showing of a constitutional violation. *People v. Coleman*, 206 Ill. 2d 261, 277 (2002). Issues decided on direct appeal are barred by *res judicata*; issues that could have been raised, but were not, are forfeited. *People v. Enis*, 194 Ill. 2d 361, 375 (2000).

In noncapital cases, the Act provides a three-stage process for adjudicating postconviction petitions. *People v. Harris*, 224 Ill. 2d 115, 125 (2007). In this case, the petition advanced to a third-stage evidentiary hearing. 725 ILCS 5/122-6 (West 2000). Following an evidentiary hearing where fact-finding and credibility determinations are involved, the trial court's decision will not be reversed unless it is manifestly erroneous. *People v. Pendleton*, 223 Ill. 2d 458, 473 (2006). However, "[i]f no such determinations are necessary at the third stage, *i.e.*, no new evidence is presented and the issues presented are pure questions of law, we will apply a *de novo* standard of review, unless the judge presiding over postconviction proceedings has some 'special expertise or familiarity' with the trial or sentencing of the defendant and that 'familiarity' has some bearing upon disposition of the postconviction petition." *Pendleton*, 223 Ill. 2d at 473, citing *People v. Caballero*, 206 Ill. 2d 65, 87-88 (2002).

We first address petitioner's claim under *Brady v. Maryland*, 373 U.S. 83, 10 L. Ed. 2d 215, 83 S. Ct. 1194 (1963), that the State violated his right to due process by failing to disclose material information on a viable alternative suspect. Petitioner argues that the State's evidence based on his motive and opportunity to commit the offense was entirely circumstantial. He contends there is a reasonable probability that the jury would have acquitted him had it known there was another suspect with motive and opportunity to commit the

murder. The State responds that the withheld evidence was not favorable to petitioner's defense or material to his guilt or punishment. Accordingly, the State argues petitioner's right to due process was not violated by the failure to disclose the evidence.

The circuit court heard testimony on the *Brady* claim at the evidentiary hearing and found that the evidence on Doe as a viable suspect was remote and speculative. In making that determination, the circuit court was required to weigh the evidence. Additionally, the assessment of materiality under *Brady* involves weighing the impact of the undisclosed evidence on the verdict. See *People v. Harris*, 206 Ill. 2d 293, 311 (2002). Accordingly, the *Brady* claim does not present a pure question of law. Rather, it requires applying established law to the facts, including those elicited at the evidentiary hearing. In these circumstances, we review the circuit court's decision for manifest error. See *People v. Morgan*, 212 Ill. 2d 148, 155 (2004). Manifest error is error that is "clearly evident, plain, and indisputable." *Morgan*, 212 Ill. 2d at 155.

In *Brady*, the Supreme Court held that the prosecution violates an accused's constitutional right to due process of law by failing to disclose evidence favorable to the accused and material to guilt or punishment. *Harris*, 206 Ill. 2d at 311, citing *Brady*, 373 U.S. at 87, 10 L. Ed. 2d at 218, 83 S. Ct. at 1196-97. This rule encompasses evidence known to police investigators, but not to the prosecutor. *Kyles v. Whitley*, 514 U.S. 419, 438, 131 L. Ed. 2d 490, 508, 115 S. Ct. 1555, 1568 (1995). To comply with *Brady*, the prosecutor has a duty to learn of favorable evidence known to other government actors, including the police. *Kyles*, 514 U.S. at 437, 131 L. Ed. 2d at 508, 115 S. Ct. at 1567. The Supreme Court has, therefore, noted "the special role played by the American prosecutor in the search for truth in criminal trials." *Strickler v. Greene*, 527 U.S. 263, 281, 144 L. Ed. 2d 286, 301-02, 119 S. Ct. 1936, 1948 (1999). The prosecutor's interest in a criminal prosecution " 'is not that it shall win a case, but that justice shall be done.' " *Strickler*, 527 U.S. at 281, 144 L. Ed. 2d at 302, 119 S. Ct. at 1948, quoting *Berger v. United States*, 295 U.S. 78, 88, 79 L. Ed. 1314, 1321, 55 S. Ct. 629, 633 (1935).

A *Brady* claim requires a showing that: (1) the undisclosed evidence is favorable to the accused because it is either exculpatory or impeaching; (2) the evidence was suppressed by the State either

wilfully or inadvertently; and (3) the accused was prejudiced because the evidence is material to guilt or punishment. *People v. Burt*, 205 Ill. 2d 28, 47 (2001), citing *Strickler*, 527 U.S. at 281-82, 144 L. Ed. 2d at 302, 119 S. Ct. at 1948. Evidence is material if there is a reasonable probability that the result of the proceeding would have been different had the evidence been disclosed. *Harris*, 206 Ill. 2d at 311, citing *Kyles*, 514 U.S. at 434, 131 L. Ed. 2d at 506, 115 S. Ct. at 1566; *United States v. Bagley*, 473 U.S. 667, 682, 87 L. Ed. 2d 481, 494, 105 S. Ct. 3375, 3383 (1985). To establish materiality, an accused must show “ ‘the favorable evidence could reasonably be taken to put the whole case in such a different light as to undermine confidence in the verdict.’ ” *People v. Coleman*, 183 Ill. 2d 366, 393 (1998), quoting *Kyles*, 514 U.S. at 435, 131 L. Ed. 2d at 506, 115 S. Ct. at 1566.

In making the materiality determination, courts must consider the cumulative effect of all the suppressed evidence rather than considering each item of evidence individually. *People v. Hopley*, 182 Ill. 2d 404, 435 (1998), citing *Kyles*, 514 U.S. at 436-41, 131 L. Ed. 2d at 507-10, 115 S. Ct. at 1567-69. After a reviewing court has found a *Brady* violation, the constitutional error cannot be found harmless. *Coleman*, 183 Ill. 2d at 393, quoting *Kyles*, 514 U.S. at 436, 131 L. Ed. 2d at 507, 115 S. Ct. at 1567.

Here, the undisclosed evidence consists of four points: (1) John Doe failed to complete the polygraph examination; (2) Doe was charged with domestic battery and possession of marijuana with intent to deliver prior to petitioner’s trial; (3) Doe had physically abused his girlfriend on numerous prior occasions; and (4) Doe’s use of steroids had caused him to act erratically. Petitioner’s attorney testified at the evidentiary hearing that he did not receive this evidence. In its brief to this court, the State does not dispute that it knew of the evidence and failed to disclose it. In fact, the State refers to the evidence as being “withheld.” Accordingly, petitioner has established that the evidence was suppressed by the State.

The State, however, argues that the evidence was not favorable to petitioner or material to his guilt or punishment. Initially, we note that the circuit court held the State did not violate *Brady* by failing to disclose the polygraph evidence and the domestic battery charge because that evidence would not have been admissible at trial. In

addressing whether the undisclosed evidence was favorable to petitioner, however, we need not decide whether each of the individual items of undisclosed evidence would have been admissible at trial. In this case, petitioner's essential claim is that he could have used the undisclosed evidence, along with the disclosed evidence tending to show Doe's possible involvement in the offense, to present Doe as an alternative suspect. Thus, even if some of the undisclosed evidence would have been inadmissible at trial, it still may have been favorable to petitioner in gaining admission of critical alternative suspect evidence.

In determining whether the undisclosed evidence was favorable to petitioner, therefore, we must consider whether it would have assisted him in presenting Doe as an alternative suspect. An accused in a criminal case may offer evidence tending to show that someone else committed the charged offense. *People v. Kirchner*, 194 Ill. 2d 502, 539 (2000); *People v. Whalen*, 158 Ill. 2d 415, 430-31 (1994). Evidence of an alternative suspect should be excluded as irrelevant, however, if it is too remote or speculative. *Kirchner*, 194 Ill. 2d at 539-40; *Whalen*, 158 Ill. 2d at 431. Generally, evidence is relevant if it tends to make the existence of any fact in consequence more or less probable than it would be without the evidence. *Kirchner*, 194 Ill. 2d at 539.

The undisclosed evidence is clearly favorable to petitioner in establishing Doe as an alternative suspect. First, the circumstances of the polygraph examination indicate that Doe intentionally avoided the test. He did not comply with the polygraph examiner's instructions during the first attempt and failed to cooperate in scheduling a second attempt. Moreover, the polygraph examiner testified that the police had identified Doe as a suspect in the murder. Although the State argues that "the tenor of the police questioning supports the inference that police viewed Doe as a suspect," the State does not contend that the disclosed statements specifically identified him as a suspect. The undisclosed polygraph evidence would have bolstered a claim by petitioner that Doe was a viable suspect not only because the circumstances may be viewed as evasive, but also because the polygraph examiner indicated that Doe was specifically identified as a suspect.

The evidence that Doe was charged with domestic battery and had physically abused his girlfriend on many prior occasions also could have been used by petitioner at a pretrial hearing to establish Doe as a viable suspect. That evidence is relevant to Doe's likelihood to commit a violent act against his girlfriend. The evidence that Doe had physically abused his girlfriend on numerous occasions, together with the evidence that he was in the process of renewing his romantic relationship with Jennifer prior to her death, provided additional support of Doe as a viable suspect. Further, the undisclosed evidence of Doe's steroid abuse may have explained his violent outbursts toward his girlfriend and supported an inference of a tendency to act violently toward others.

Finally, the undisclosed evidence that Doe had been charged with possession of marijuana with intent to deliver could have been used by petitioner as part of Doe's motive to commit the murder. That evidence tends to establish Doe as a drug dealer and, with evidence of Jennifer owing Doe money for drugs, it could have been offered to support a motive to commit the murder.

In analyzing whether the undisclosed evidence is favorable to petitioner, we also note that the Supreme Court recently examined the constitutionality of a rule of evidence restricting a criminal defendant from introducing proof of "third-party guilt" in cases where the prosecution offered forensic evidence that, if believed, strongly supported a guilty verdict. *Holmes v. South Carolina*, 547 U.S. 319, 164 L. Ed. 2d 503, 126 S. Ct. 1727 (2006). In finding the rule of evidence unconstitutional, the Court concluded that "by evaluating the strength of only one party's evidence, no logical conclusion can be reached regarding the strength of contrary evidence offered by the other side to rebut or cast doubt." *Holmes*, 547 U.S. at 331, 164 L. Ed. 2d at 513, 126 S. Ct. at 1735. This observation is applicable to whether the undisclosed evidence here is favorable and material. The impact or strength of the undisclosed evidence can only be determined by also viewing the strength of the evidence presented against petitioner.

Here, the State summarizes its evidence against petitioner as resting "on more than mere opportunity: petitioner's fingerprints were on the murder weapon; petitioner demonstrated knowledge of when Jennifer was murdered; and petitioner had every reason to kill

Jennifer when he arrived at her apartment and saw, for the first time, definitive proof that Jennifer and Swaine had been sleeping together.” In our view, the State’s evidence against petitioner was not particularly strong. The State essentially presented evidence of motive, evidence of opportunity that was strongly disputed by petitioner, inferences from petitioner’s statements to police officers that he knew the date of the murder, and fingerprints on the clock radio that were explained by petitioner’s relationship with Jennifer and made less important by the State’s concession that it would not have been necessary to touch the clock radio in committing the murder. This evidence is tenuous and supports admission by petitioner of the similarly probative alternative suspect evidence on Doe.

We conclude that the evidence withheld by the State is favorable to petitioner because it supports Doe’s viability as an alternative suspect. The combination of the undisclosed evidence with the disclosed evidence tending to establish Doe as a viable alternative suspect cannot be considered remote or speculative, particularly in light of the State’s evidence against petitioner. The undisclosed evidence would have enabled petitioner to present evidence and argument on Doe as an alternative suspect.

Having found that the withheld evidence is favorable to petitioner, we must next determine whether it is material. As noted, evidence is material if there is a reasonable probability that the result would have been different had it been disclosed. *Harris*, 206 Ill. 2d at 311, citing *Kyles*, 514 U.S. at 434, 131 L. Ed. 2d at 506, 115 S. Ct. at 1566; *Bagley*, 473 U.S. at 682, 87 L. Ed. 2d at 494, 105 S. Ct. at 3383. An accused must show “ ‘the favorable evidence could reasonably be taken to put the whole case in such a different light as to undermine confidence in the verdict.’ ” *Coleman*, 183 Ill. 2d at 393, quoting *Kyles*, 514 U.S. at 435, 131 L. Ed. 2d at 506, 115 S. Ct. at 1566. Again, the impact of the alternative-suspect evidence on the verdict cannot be determined without viewing the strength of the evidence presented by petitioner as well as the evidence presented by the State. See *Holmes*, 547 U.S. at 331, 164 L. Ed. 2d at 513, 126 S. Ct. at 1735.

The State’s evidence against petitioner showed that he had a motive to commit the murder based on his jealousy. Additionally, the

State established that petitioner had been violent toward objects, but not people, on several occasions during his involvement with Jennifer. The evidence of petitioner's opportunity to commit the offense was strongly disputed. In closing argument, the State contended that petitioner drove to Normal after leaving the bank at 10:11 a.m. He arrived at around noon. He saw Swaine's property when he walked into Jennifer's apartment. He immediately "snapped," committed the murder, and left the apartment by 12:15 p.m. He then drove back to Rockford, arriving home around 2:10 p.m. The State's timeline depended on petitioner driving 10 miles per hour over the speed limit to Normal and back to Rockford. Additionally, the timeline required petitioner to commit the offense and stage the crime scene in an extremely quick and efficient manner. Petitioner strongly contested the State's opportunity evidence. It is clear that the evidence of petitioner's opportunity to commit the murder is not as strong as that against Doe.

The State's other evidence against petitioner was based on inferences from his statements to police officers and his fingerprints on the clock radio. That evidence, however, was explained by petitioner. Petitioner explained that he began with August 25 in accounting for his time the week of the murder because he had events that day that stood out in his memory. The rest of the week was routine. Petitioner consistently denied any involvement in the murder. Petitioner's fingerprints on the clock radio could have been explained by his prior relationship with Jennifer. Additionally, his fingerprints were not the only ones found on the clock radio. In fact, there was a least one print that was unidentified. Further, the prosecutor conceded in his rebuttal that the murder could have been committed by grabbing the cord and not touching the clock radio. We conclude that petitioner's statements and his fingerprints did not provide particularly strong evidence of his guilt.

We also note that the State's argument relied upon the assertion that all other potential suspects had been eliminated from consideration. The prosecutor informed the jury that the State had "proved up everybody else's" alibi and petitioner was the one "who sits in the courtroom \*\*\* with the gap in his alibi still unclosed." The prosecution presented testimony to establish the alibis of two named suspects, Swaine and Gates. The prosecution's argument that all other

potential suspects had been eliminated from consideration was a key part of the State's case given the tenuous circumstantial evidence of petitioner's guilt.

Based on this record, we conclude that the evidence of Doe as an alternative suspect is material. The evidence presenting Doe as a viable alternative suspect without an alibi would have been critical because it countered the State's argument that all other suspects had established alibis.

Moreover, petitioner could have established Doe as a strong alternative suspect. First, petitioner could have argued that Doe had a motive to commit the murder based on jealousy over his encounter with Jennifer and Swaine at a time when Doe was renewing his romantic relationship with Jennifer. Doe may have also had a motive to commit the offense based on his status as a drug dealer and Jennifer's drug debt. Doe had a clear opportunity to commit the offense. He lived approximately 1½ miles from Jennifer's apartment and did not have any verification of his location before 1 p.m. on the day of the murder.

Further, retired Normal Police Lieutenant Tony Daniels testified that Doe was "somewhat evasive" and "very nervous" during his interviews. The polygraph examiner testified that Doe was viewed by police as a suspect. Doe initially gave a false alibi stating he left town the day before the murder. That false exculpatory statement could be used as probative evidence of consciousness of guilt. See *People v. Milka*, 211 Ill. 2d 150, 181 (2004). Petitioner may have also been able to use some of the other undisclosed evidence to bolster his claim of Doe as an alternative suspect. We need not decide whether that evidence could have been presented, however, because the evidence discussed above is sufficient to establish Doe as a viable alternative suspect.

In this case, the evidence of Doe as an alternative suspect was crucial for petitioner because it countered the State's circumstantial evidence against him and rebutted the State's argument that all other potential suspects had established alibis. We conclude that there is a reasonable probability that the result of the trial would have been different if petitioner had presented the evidence establishing Doe as an alternative suspect. We cannot have confidence in the verdict finding petitioner guilty of this crime given the tenuous nature of the

circumstantial evidence against him, along with the nondisclosure of critical evidence that would have countered the State's argument that all other potential suspects had been eliminated from consideration. Accordingly, we conclude that the State's suppression of the withheld evidence violated petitioner's constitutional right to due process under *Brady*. Based on this record, the circuit court's dismissal of petitioner's *Brady* claim was manifest error.

A *Brady* violation cannot be found harmless. *Coleman*, 183 Ill. 2d at 393, quoting *Kyles*, 514 U.S. at 436, 131 L. Ed. 2d at 507, 115 S. Ct. at 1567. Petitioner's conviction must, therefore, be reversed and the matter remanded for further proceedings. Based on our resolution of the *Brady* claim, it is unnecessary to address petitioner's due process claim that the State failed to correct misleading testimony from Detective Freesmeyer or his claim of ineffective assistance of counsel.

As a final matter, we note that on direct appeal the appellate court held the evidence was sufficient to convict petitioner of this offense. Petitioner does not raise any claim based on the sufficiency of the evidence in this court. Accordingly, there is no double jeopardy impediment to a new trial. See *People v. Wheeler*, 226 Ill. 2d 92, 134 (2007).

### III. CONCLUSION

For the foregoing reasons, we conclude that the State violated petitioner's constitutional right to due process of law. Petitioner's conviction must be reversed based on that constitutional violation. We therefore reverse the judgments of the appellate and circuit courts, vacate petitioner's conviction, and remand to the circuit court for further proceedings.

*Judgments reversed;  
cause remanded.*



the court clearly abused its discretion or applied impermissible legal criteria. *P.J.'s Concrete Pumping Serv. v. Nextel W. Corp.*, 345 Ill. App. 3d 992, 1002 (2d Dist. 2004).

A class action may be maintained where a common question of law or fact predominates over the individual questions that may be involved. *Martin v. Heinold Commodities, Inc.*, 139 Ill. App. 3d 1049 (1st Dist. 1985). However, class certification is not appropriate where there are no questions of law or fact common to the members of the class to be litigated and class action would not result in any increased efficiency to the court or to the litigants in the adjudication of the claims. *McCabe v. Burgess*, 75 Ill. 2d 457 (1979). The test to be applied is that the statutory requisites of commonality are met so long as there are questions of fact or law common to the class and these predominate over questions affecting only individual members of such class. *Smith v. Ill. Cent. R.R. Co.*, 223 Ill. 2d 441, 449 (2006)(quoting *O'Sullivan v. Countrywide Home Loans, Inc.*, 319 F.3d 732, 738 (5th Cir. 2003)); *People v. Weiszmann*, 185 Ill. App. 3d 273 (2d Dist. 1989). A common question of fact or law predominates if successful adjudication of the plaintiff's claim will establish a right to recovery in other class members. *Avery v. State Farm Mut. Auto. Ins. Co.*, 216 Ill. 2d 100, 128 (2005); see also *Society of St. Francis v. Dulman*, 98 Ill. App. 3d 16 (1st Dist. 1981).

### ANALYSIS

#### **I. The Court is unable to circumvent the laws of this State.**

##### **a. Common Questions of Fact or Law Must Predominate**

No court in Illinois has approved class certification in a criminal case arising under the Post-Conviction Hearing Act. Consequently, there is very little precedential guidance in this matter. However, the Illinois Supreme Court addressed an analogous class certification question in the 2006 case of *Smith v. Ill. Cent. R.R. Co.*, 223 Ill. 2d 441 (2006). In a matter of first impression, the plaintiffs requested class certification for mass-tort litigation in which they alleged a multitude of individual injuries as a result of one catastrophic event. The appellant-defendants asked the Supreme Court to decide whether the lower courts had correctly applied the Illinois class action rule under Section 2-801. The parallels between the *Smith* case and this present action are evident upon closer inspection.

In 2003, 21 cars of a freight train derailed in the Southern Illinois town of Tamaroa. Tanker cars containing dangerous chemical mixtures ruptured during the derailment, and some of the cars also caught fire. As a result, more than 1,000 individuals were subjected to a mandatory evacuation. The derailment caused a massive amount of damage.

The Circuit Court granted certification to a class of plaintiffs, finding that because the incident arose from the same nucleus of operative fact—the derailment—the commonality required under Illinois Section 2-801 was sufficient for class certification. After an interlocutory appeal by the Railroad, the Appellate Court agreed that class certification was proper, and noted that federal courts applying Federal Rule 23 (on which our own class certification statute Section 2-801 is based) had found that one “catastrophic incident” could serve as a common element for purposes of establishing commonality for certification of a class of litigants. The Appellate Court found that such cases demonstrated that the commonality requirement can be met despite the other significant differences in individual claims.

The Illinois Supreme Court disagreed with the lower courts. In rejecting the reasoning of those courts, the Supreme Court noted that Federal Rule 23 and Illinois’ Section 2-801 impose different standards for class certification with regards to the element of commonality. The Illinois Section 2-801 requirement of “predominance” is actually a higher standard than Federal Rule 23’s “commonality” requirement. “The purpose of the predominance requirement is to ensure that the proposed class is sufficiently cohesive to warrant adjudication by representation, and it is a far more demanding requirement than the commonality requirement of [Federal] Rule 23(a)(2).” *Smith*, 223 Ill. 2d 441,453, quoting *Bell Atlantic Corp. v. AT&T Corp.*, 339 F.3d 294, 301 (5th Cir. 2003).

The Supreme Court reasoned that the catastrophic event that was common to all claims was not enough to meet the predominance requirements of Section 2-801. The lower courts erred when they ignored the highly individualized nature of each plaintiff’s claim. Specifically, the Appellate Court failed to separate the catastrophic event from the relief sought by the plaintiffs when they “equated liability for the derailment with liability for the alleged health consequences arising from exposure to the chemicals.” *Id.* Predominance was lacking in *Smith* because “[p]roof of proximate causation ... will involve highly individualized

variables....” *Id.* at 454. Further, the Supreme Court noted that the plaintiffs failed to establish a predominance of common questions because individual issues would “consume the great bulk of the time at trial. Consequently, the common issues do not predominate.” *Smith*, 223 Ill. 2d 453-54. Therefore, class certification was improper under Section 2-801’s predominance requirement despite the common catastrophic event at the heart of each individual claim.

Much like the train derailment in Tamaroa, Illinois, Commander Burge’s conduct has caused irreparable harm to many persons. Petitioners assert that Burge’s involvement in their individual cases warrants the certification of the class. It is undeniably true that Petitioners’ claims would not have come about in the absence of Jon Burge. His conduct is the catalyst for Petitioners’ legal claims, just as the train derailment was the catalyst in *Smith*. However, the involvement of Burge, alone, is not sufficient under Section 2-801’s requirement of predominance. Like the plaintiffs in *Smith*, each Petitioner’s legal claim is highly individual.

The unchallenged fact that Burge and those under his command coerced confessions from an unknown number of individuals does not, in and of itself, speak to the merits of an individual Petitioner’s legal claim in this proceeding. Rather, an individual’s legal claim under the Post-Conviction Hearing Act stems from his yet-unproven allegation of police misconduct following his arrest. Any judgment of relief will be based on a specific determination that his confession was coerced and that his coerced confession was used against him at trial and in violation of his constitutional rights. Every such determination is highly individualized and must be made on a case-by-case basis despite the common element of the involvement of Burge. The individual nature of these claims precludes class certification under Section 2-801.

Further, it is clear that predominance is lacking in this action because individual issues will consume the bulk of the litigation. Assume, *arguendo*, that this Court certified the class and each Petitioner received a third stage evidentiary hearing under the Post-Conviction Hearing Act. At each individual third stage hearing a petitioner would endeavor to establish that he was a victim of torture and that his conviction should be vacated in light of *People v. Wrice*, 2012 IL 111860. Obviously, the great majority of time expended in these

proceedings will involve litigating each unique claim. The Supreme Court's holding in *Smith* is clear in this regard: certification is not appropriate in this case under Section 2-801's "predominance" standard.

It is also noteworthy that the successful adjudication of one individual's claims will not establish a right to relief for any other member of the class. In Illinois, a common question of fact or law predominates if successful adjudication of the plaintiff's claim will establish a right to recovery in other class members. *Avery v. State Farm Mut. Auto. Ins. Co.*, 216 Ill. 2d 100, 128 (2005). Assuming one Petitioner's post-conviction action is successful and his conviction is vacated, such a remedy is entirely individual. The successful adjudication of his claim of torture will not establish a right to recovery for any other member of the class.

Petitioners have entirely failed to demonstrate that the questions of fact or law common to the class predominate over any questions affecting only individual members. It is clear that the claims of these Petitioners are each highly individualized and the bulk of time expended in court will involve litigating each individual claim. Further, commonality is also defeated because the successful adjudication of the legal claim of one putative class member will not establish a right to relief for any other class member. Therefore, Petitioners are unable to meet the requirements of Section 2-801 for purposes of demonstrating that that class certification is appropriate.

b. The Post-Conviction Hearing Act

Moreover, the Post-Conviction Hearing Act does not provide a mechanism for summary referral of post-conviction claims to a third stage evidentiary hearing. Rather, the Post-Conviction Hearing Act (Act) establishes a three-step process for adjudicating individual claims of deprivations of constitutional rights during the proceedings. 725 ILCS 5/122-1 *et seq.* Initially, a petition must clearly set forth sufficient facts demonstrating the way in which the petitioner's constitutional rights were violated. 725 ILCS 5/122-2. If the court determines that the petition is frivolous or patently without merit, it must summarily dismiss the petition. 725 ILCS 5/122-2.1(a)(2). If the petition is not dismissed, the State is required at the second stage to answer the petition or file a motion to dismiss. 725 ILCS 5/122-5. If the court does not dismiss the petition on the State's motion then an evidentiary hearing is conducted at the third and final stage of the process.

*People v. Marquez*, 324 Ill. App. 3d 711, 714-715 (1st Dist. 2001). A petitioner must seek leave of court to file a successive petition under the Act, and must demonstrate cause and prejudice. 725 ILCS 5/122-1(f).

The Act establishes a definite procedure for adjudicating an individual's post-conviction claims. There is no statutory mechanism for bypassing the first two stages of review or the restrictions and procedural hurdles involved in filing successive petitions. Petitioners are asking this Court to put aside the law in this case and permit class members to circumvent the parameters of the Post-Conviction Hearing Act. What Petitioners ask is not within the powers of this Court, even for the important issues presented here.

## II. The Unpaid Special Master

That being said, it is of highest importance that these remaining possible Burge-related cases be given resolution. As pointed out during the oral arguments, there is no confidence that the Illinois Torture Relief Inquiry Commission will ever have the funding and resources to achieve its intended purpose and give finality to this painful issue.

Therefore, this Court appoints David N. Yellen, Dean of Loyola University Chicago School of Law to serve as an unpaid "Special Master" to help achieve closure. Dean Yellen has graciously agreed to accept this important undertaking at the request of the Court. He is well respected in the legal community of Chicago. Dean Yellen's major area of academic expertise is criminal law, particularly sentencing and juvenile justice. He has written extensively on the federal sentencing guidelines, served as an advisor to President Clinton's transition team on white collar crime, presently serves on the Illinois Sentencing Policy Advisory Council, and has argued a significant case involving the federal mandatory minimum sentencing statute before the United States Supreme Court. (The *curriculum vitae* of Dean Yellen is attached with this order.) His expertise and talents will be welcomed in this endeavor.

The Special Master is instructed to work with Petitioners' attorneys, who have acknowledged their expertise in this regard (Transcript of December 16, 2013 at p. 81), in attempts to locate the individuals with a "valid claim" of a Burge-related coerced confession who are still languishing in Illinois penitentiaries. Petitioners' attorneys developed the definition of a "valid claim" during the certification hearing. Transcript of December 16, 2013 at p. 89. The elements of a "valid claim" include all of the following:

- 1) The individual was convicted based in part upon a confession;
- 2) The confession was the end result of an interrogation in which Burge or officers under his chain of command or direct supervision participated;
- 3) The individual made an allegation of coercion in the context of his original proceedings, either at a motion to suppress or in some other clear and definitive way, that his confession was the product of physical abuse or torture, and those objections were overruled;
- 4) He remains incarcerated today;
- 5) He has never had the opportunity to present his claim of coerced confession with the benefit of the substantial evidence now available to implicate Burge and those who worked under him.

Once the Special Master has identified individuals meeting these criteria he will forward the names to this Court. This Court will appoint respected attorneys as private *pro bono* counsel to represent each identified litigant. *Pro bono* counsel will then assist the petitioners in preparing and litigating their post-conviction petitions in light of their individual claims and in light of what is now known about the actions of Burge and those under his supervision.

Although he will be unpaid, Dean Yellen is permitted to seek reimbursement to compensate for necessary costs incurred in this pursuit of justice. He will also utilize unpaid law students and other personnel from Loyola University Chicago School of Law to assist him.

When faced with the initial decision in 2001 whether to appoint a Special Prosecutor in Burge-related cases, this Court was aware of the obstacles and difficulties that would be involved in resolving these claims. Nevertheless, this Court strongly felt that the issue of alleged police misconduct under Burge deserved to be fully investigated by a Special Prosecutor. This investigation resulted in a lengthy report by the Special Prosecutor Edward J. Egan which concluded that a pattern of misconduct occurred with Burge and his associates.

At this point in time, it is clear that significant concerns still linger with respect to identifying remaining Burge victims and resolving their legal claims. The adjudication of these claims of torture are particularly ripe in light of the recent Illinois Supreme Court decision in *People v. Wrice*, 2012 IL 111806.

There must be a vehicle to address these painful issues stemming from the Burge-related misconduct. The individuals who are still incarcerated as a result of his wrongdoing deserve resolution. Now, 13 years later, I trust that, with the issuance of this order and appointment of the Special Master, we can finally resolve these matters.

**CONCLUSION**

Therefore, Petitioners' Motion for Class Certification is hereby DENIED. Likewise, Petitioners' Class Action Petition for Relief Under the Post-Conviction Hearing Act is DISMISSED. Dean David N. Yellen is appointed as an unpaid Special Master to identify all incarcerated individuals who have "valid claims" of coerced confessions at the hands of Commander Burge and those under his authority as defined in this Order and to present their names to this Court for the appointment of private *pro bono* counsel to assist them in litigating their individual claims under the Post-Conviction Hearing Act.

ENTERED  
JUDGE PAUL BIEBEL JR-1688  
MAR 12 2014  
DOROTHY BROWN  
CLERK OF THE CIRCUIT COURT  
OF COOK COUNTY, IL  
DEPUTY CLERK

ENTERED:

*Paul P. Biebel Jr.* 1688  
Hon. Paul P. Biebel, Jr.  
Presiding Judge  
Criminal Division

DATED: March 12, 2014

## Former foe having 2nd thoughts

January 22, 2003 | By Steve Mills and Maurice Possley, Tribune staff reporters.

As a young Cook County assistant state's attorney, Thomas Breen had no doubt in 1977 when he sent Michael Evans and Paul Terry off to prison for the murder of 9-year-old Lisa Cabassa.

Now, Breen finds himself in the extraordinary position of not only questioning that case but being the impetus behind the efforts to prove Evans and Terry innocent and win their freedom.

"I would rather [this case] come back 25 years later and find out I'm dead wrong than those guys spend one more day in jail," he said in an interview. "I don't see anything wrong with correcting your errors when the errors are shown.

"If these guys didn't do it--and all the evidence seems to indicate we are dead wrong--then it's devastating."

Breen's doubts emerged slowly as he became a defense attorney and helped clear two men who had been wrongfully convicted--Gary Dotson and Rolando Cruz.

He worked to clear Dotson of rape in what became the nation's first DNA exoneration in 1985.

Then, in 1994, Breen defended Cruz at his third trial for the 1983 rape and murder of 10-year-old Jeanine Nicarico of Naperville. Breen was part of the team that won an acquittal and Cruz's freedom.

Old questions from the Cabassa case began to nag at him. Why had neither Evans nor Terry turned on one another to cut a deal for a shorter prison term? Would three men be involved in such a crime, or was this more likely the act of one person?

The Cruz case provided Breen stunning insight not only into the flaws of the criminal justice system but also challenged many of the ideals upon which he had fashioned his life as a prosecutor.

He had come to believe that the more heinous the crime, the lower the threshold of evidence for a guilty verdict--that prosecutors sometimes used the horror of the crime itself to offset a weak case.

The Cruz case also gave him a different prism to view the Cabassa case, where a single eyewitness to only part of the crime convicted the two men. "Now I'm applying what I've learned in the Cruz case to a case I prosecuted 25 years ago," he said.

The critical moment for Evans and Terry occurred during the preparations for the Cruz trial with fellow defense attorney Lawrence Marshall, now legal director of Northwestern University's Center on Wrongful Convictions.

Working in a 13th-floor office in the Monadnock Building, 53 W. Jackson Blvd., Breen told Marshall about the Cabassa case.

The two were discussing strategy for Cruz's defense in the Nicarico murder, a case not unlike Lisa Cabassa's abduction, rape and murder.

The similarities stirred a conversation about Breen's misgivings about the Cabassa case.

"It started bothering me," Breen said. "I'm beginning to see some of the problems with it."

Breen urged Marshall to seek DNA testing for Evans and Terry to settle his lingering questions about the case.

The case languished, though, for a couple of years as the death penalty issue exploded in Illinois with the release of Anthony Porter in 1999 and Gov. George Ryan's moratorium on executions in January 2000.

Breen again urged Marshall to reopen the long-closed case.

Now, the DNA test findings leave Breen conflicted. He believes he did his job as prosecutor correctly, but the wrong men went to prison.

"Did I try to do it well [in 1977]? I did. The system was different then. I was different," Breen said.

Breen said that in 1977 there was no pressure to take a case to trial if a prosecutor had doubts. His supervisors always told prosecutors to seek justice, not just convictions.

"The word always was to do the right thing," Breen said. "You didn't marry yourself to the case."

Indeed, Breen recalls a defining moment in his career in 1973 when Cook County prosecutors dropped charges against convicted murderer Wilbur McDonald after another man, Lester Harrison, confessed to the crime--a murder in Chicago's Grant Park.

McDonald had been in prison three years before he was released.

"I thought, as a young prosecutor, that was the coolest thing I'd ever seen . . . that the system reacted that way when it had erred," Breen said.

Still, it is rare for prosecutors and defense lawyers to admit mistakes, as Breen is doing.

"Did Tom make a mistake in this case?" Marshall asked. "It certainly appears so now . . . But one way you measure a person's humanity is by how someone remedies mistakes. And by that measure, Tom's actions in this case are heroic."

"It's about as noble a thing," Marshall added, "as I can imagine."

Now, Breen is struggling to reconcile his actions at the 1977 trial with the results of the DNA tests.

"I'm avoiding thinking about this," he said. "When I begin to think that I caused two innocent people--" His voice trailed off as he was unable to finish the sentence. He pressed his hands to his face momentarily, then looked up.

"There are no words to describe what's been done to an innocent person who has been incarcerated," he said. "I want to believe somehow that we were right, but to do that I'd have to be mentally and intellectually dishonest."

"The only thing I can say that I did good was that I brought this up to somebody who could maybe fix it."



**Timothy J. McGinty**  
CUYAHOGA COUNTY PROSECUTOR

TO: All Assistant County Prosecutors and Administrative Personnel  
FROM: Timothy J. McGinty, Cuyahoga County Prosecutor  
DATE: April 17, 2014  
SUBJECT: CCPO Conviction Integrity Unit  
Effective: Immediately

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This Memorandum details the procedure for presenting a post-conviction claim of innocence to the Cuyahoga County Prosecuting Attorney outside of court proceedings. It provides for the careful and expeditious handling of wrongful conviction allegations.

The decision to review and investigate a claim does not infer acceptance of the validity of the alleged innocence claim. Moreover, in consenting to allow DNA testing, the State of Ohio takes no position on the significance (or lack thereof) of any DNA results that may be obtained.

Regional Supervisor Jose A. Torres has been designated as the Conviction Integrity Coordinator. Any questions concerning the procedures described below should be directed to:

Jose A. Torres  
Conviction Integrity Coordinator  
Cuyahoga County Prosecuting Attorney's Office  
1200 Ontario Street, 9th Floor  
Cleveland, OH 44113  
(216) 443-7779  
[itorres@prosecutor.cuyahogacounty.us](mailto:itorres@prosecutor.cuyahogacounty.us)

**OFFICE OF THE PROSECUTING ATTORNEY**  
The Justice Center • Courts Tower • 1200 Ontario Street • Cleveland, Ohio 44113  
(216) 443-7800 • Fax (216) 443-7601

## **CUYAHOGA COUNTY PROSECUTOR'S OFFICE**

### **CONVICTION INTEGRITY UNIT PROTOCOL**

#### **I. OVERVIEW**

The Conviction Integrity Unit (CIU) shall be established for the review of convicted offenders' legitimate extrajudicial post-conviction claims of innocence. The CIU is comprised of a Conviction Integrity Coordinator, an Administrative Assistant, a Conviction Integrity Committee and a Conviction Integrity Policy Advisory Panel.

The Conviction Integrity Coordinator organizes the work of the Committee and leads all re-investigations of any cases that present a meaningful claim of actual innocence.

The Conviction Integrity Committee is comprised of nine senior members of the Cuyahoga County Prosecutor's Office including the Criminal Division Chief, the Appeals Unit Supervisor, the Conviction Integrity Unit Coordinator and six other senior Assistant County Prosecutors.

An Administrative Assistant will be designated to receive all requests, prepare case files for the Conviction Integrity Unit, and track responses and outcomes to all cases.

The Conviction Integrity Policy Advisory Panel is comprised of at least three leading criminal justice experts, including legal scholars and former prosecutors, who advise the Office on national best practices and evolving issues in the area of wrongful convictions.

Notwithstanding other statutory remedies, a criminal defendant may only submit a request for review of a conviction based on a claim of actual innocence to the CIU.

#### **II. CASE INTAKE**

The following types of submissions will be accepted:

##### **A. Non-motion claims of actual innocence**

1. All requests must be submitted in writing. In order for the Conviction Integrity Unit to carry out a preliminary review of a conviction, the following prerequisites must be met:
  - a. The conviction must have been in Cuyahoga County Common Pleas Court,

- b. The convicted offender must be a living person,
  - c. There must be a claim of actual innocence, not a legal issue,
  - d. New and credible evidence of innocence must exist,
  - e. The claim must not be frivolous, and
  - f. The convicted offender waives his or her procedural safeguards and privileges, agrees to cooperate with the Unit, and agrees to provide full disclosure regarding all inquiry requirements of the CIU. (See Waiver).
2. The request must be in writing and shall include the offender's name, case number, evidence of innocence and, if applicable, how the CIU would be able to look further into that evidence.
  3. The CIU does not review non-innocence related claims such as those concerning procedural errors at trial, trial court rulings or ineffective assistance of counsel. Such cases may be screened and summarily dismissed by the CIU.
  4. Priority will be given to those cases in which the convicted defendant is currently incarcerated solely for the crime for which he or she claims actual innocence.
  5. A convicted offender can submit a request on his/her own or by counsel. If the convicted offender is represented by counsel, all communication with the Conviction Integrity Unit must be through the attorney.

#### B. Post-Conviction Motions

All post-conviction relief petitions (R.C. 2953.21), applications for DNA testing (R.C. 2953.72) and new trial motions (Crim. R. 33) will be handled by the Appeals Unit. The Appeals Unit Supervisor may notify the CIU of any of the above motions claiming actual innocence that contain newly discovered evidence bearing on innocence or issues including, but not limited to, one of the following:

1. Misidentification by the victim(s) or witness(es),
2. Recantation by the credible witness,
3. A criminal defendant's meaningful claims of an alibi, and/or

4. Information provided by new witnesses not locatable at the time of trial.

### III. CONVICTION INTEGRITY UNIT REVIEW

#### A. Initial Review

1. After receiving a request, the Conviction Integrity Coordinator will carry out a preliminary review. If the Conviction Integrity Coordinator determines that Section II-A-1 prerequisites were not met, the convicted offender and/or legal representative will be notified that no further action will be taken.
2. If Section II-A-1 prerequisites are met, the Conviction Integrity Coordinator will designate CIU member(s) or another senior Assistant County Prosecutor to review the claim as soon as administratively possible and prepare for the CIU a brief memorandum outlining the merits of the claim of innocence. Particular scrutiny will be given to claims of actual innocence based upon the following grounds: Misidentification, untruthful statements made by informant/CI, alibi, witness recantation and any newly discovered evidence that bears on innocence.
3. The Conviction Integrity Committee shall review the memorandum and determine, by a majority vote, whether there is strong indicium that the convicted offender is actually innocent.
4. If a majority of the CIU Members determines that the request lacks sufficient reasons to further consider the merits, the Conviction Integrity Coordinator will notify the convicted offender and/or legal representative that no further action will be taken. The determination of whether to further review a claim is at the sole discretion of the CIU.
5. Claims made by convicted offenders who plead guilty will have a high standard to meet for review by the CIU. Only in rare and extraordinary circumstances will the CIU initiate an in-depth review of an innocence claim by a convicted offender who has plead guilty.
6. The CIU will not review claims where a convicted offender recants his trial testimony and offers a new theory of innocence.

#### B. In-Depth Review and Re-Investigation

1. The Conviction Integrity Coordinator will supervise the review of those cases that warrant further consideration of the merits.

2. Many post-conviction claims of innocence may be resolved by reviewing the file, appellate briefs, or addressing any open issues with the Assistant Prosecuting Attorney that handled the case. Others may require a more thorough examination. Each case will be sui generis.
3. Once the in-depth review is completed, the designated CIU member(s) or another senior Assistant Prosecuting Attorney conducting the review will submit a final report to the CIU.
4. The Conviction Integrity Committee shall review the additional information received and determine by a majority vote whether a valid claim of innocence is present. The final report, vote and recommendation shall be sent to the Cuyahoga County Prosecutor. Dissenting CIU members will be able to include their position.
5. The final decision is solely that of the Cuyahoga County Prosecutor. This final decision will be communicated in writing to the convicted offender and/or legal representative by the Conviction Integrity Coordinator. There is no timeframe by which the Cuyahoga County Prosecutor must decide on the claim.
6. Each case shall be maintained according to the following procedure:
  - a. The CIU shall create and maintain a tracking system that will record the name of the convicted offender and the ultimate outcome of the claim.
  - b. Completed files will be maintained pursuant to the Cuyahoga County Prosecutor's Office record retention policy
7. If an in-depth review and investigation regarding a claim of factual innocence is granted, the Conviction Integrity Coordinator will notify the victim(s) or survivor(s) in the case, if any. The Conviction Integrity Coordinator will provide the victim(s) or survivor(s) notice that he or she has the right to present his or her views and concerns throughout the investigation.
8. Innocence Claim Investigation Process
  - a. The investigation procedure may be unique to each case and can include:
    - Information from a cooperating defendant,

- A checklist to be completed by the police officers involved in the case,
  - A Brady/Giglio checklist,
  - An identification case checklist.
- b. Detailed records shall be kept by the CIU throughout the investigation.
- c. The case will then be presented to the CIU, which will make a determination as to the merits of the claim of innocence.
9. If at any point during the review of an innocence claim, the case does not meet the criteria set out in the initial request for review, the claim shall be rejected.

#### 10. Extrajudicial Requests for Post-Conviction DNA Testing

- a. All extrajudicial requests for post-conviction DNA testing on behalf of the convicted offender that meet the submission criteria will be forwarded to the CIU. The Conviction Integrity Coordinator will designate the Appellate Unit to review the claim as soon as administratively possible upon receiving the request. Once the review is complete, the Appellate Unit will prepare a brief memorandum outlining the merits. In evaluating the request, the Appellate Unit will do the following:
- Verify the existence of DNA evidence,
  - Verify if evidence is lost or destroyed, and if so, a CIU Committee Member will notify the defendant via letter.
  - If the evidence is located, the CIU will examine the nature of the evidence and its suitability for testing.
  - If the evidence is unsuitable for testing, the CIU will determine whether the evidence has been properly handled and stored and will determine if the storage or handling procedure has reduced the likelihood of meaningful results. If the evidence is unsuitable or testing, the CIU will notify the criminal offender by letter.

- If the evidence is suitable for testing, the CIU will review the evidence depending on its significance in relation to the case.
- b. The CIU will consent to post-conviction DNA testing in any case in which the results will likely settle or be informative as to the issue of guilt or innocence.
  - c. If the CIU does not consent to testing located DNA evidence, the convicted offender can file a motion and request that the Court order the testing.
  - d. DNA testing will be performed by the Office of the Cuyahoga County Medical Examiner or any accredited lab per RC 2901.07(C). Under no circumstances will the CIU consent to DNA testing at an unaccredited lab.
11. In cases where the offender's conviction resulted from a plea of guilty, the CIU will consent to DNA testing where the results would prove actual innocence.
12. The CIU will consent to DNA testing in cases where the convicted offender did not request DNA testing at trial because:
- a. DNA testing was unavailable,
  - b. The existence of the DNA was unknown to the convicted offender, or
  - c. There is reason to believe that the testing conducted at the time of trial is now unreliable.
13. Outcome Determinative DNA Non-Suspect Matches - Upon receipt of DNA test results that indicate a DNA match between evidence that was submitted at the time of the crime and an individual who is not the convicted offender, the CIU will notify the Cuyahoga County Prosecutor of the DNA test results.



Timothy J. McGinty  
Cuyahoga County Prosecutor

**Cuyahoga County Prosecutor's Office  
Conviction Integrity Unit  
Application for Review**

Name: \_\_\_\_\_

Address/Facility: \_\_\_\_\_

Inmate Number: \_\_\_\_\_ Case Number: \_\_\_\_\_

Date: \_\_\_\_\_

In order for the Conviction Integrity Unit (CIU) to carry out a review of a conviction, the following prerequisites must be met:

- a. The conviction must have been in Cuyahoga County Common Pleas Court,
- b. The convicted offender must be a living person,
- c. There must be a claim of actual innocence, not a legal issue,
- d. New and credible evidence of innocence must exist,
- e. The claim must not be frivolous, and
- f. The convicted offender waives his or her procedural safeguards and privileges, agrees to cooperate with the Unit, and agrees to provide full disclosure regarding all inquiry requirements of the CIU. Please complete and sign the Waiver of Procedural Safeguards and Privileges attached to the questionnaire. This form must be notarized.

The CIU does not review non-innocence related claims such as those concerning procedural errors at trial and ineffective assistance of counsel. Such cases may be screened and summarily dismissed by the CIU. Please complete this questionnaire and return to the Conviction Integrity Unit. You may use additional paper if necessary.

**OFFICE OF THE PROSECUTING ATTORNEY**

The Justice Center • Courts Tower • 1200 Ontario Street • Cleveland, Ohio 44113  
(216) 443-7800 • Fax (216) 443-7601

1. What is the crime for which you were convicted and you are claiming innocence?

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2. Where did the crime take place?

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3. Explain why you are innocent.

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4. What evidence or testimony supports your claim that you are innocent?

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Please return this application and all other relevant documents to the following address:

Conviction Integrity Unit  
Cuyahoga County Prosecutor's Office  
1200 Ontario Street, 9th Floor  
Cleveland, Ohio 44113

**NOTE: The CCPO Conviction Integrity Unit (including all other assisting units and individuals) reviews cases for the sole purpose of investigating claims of actual innocence. The decision to review and further investigate a claim cannot be inferred as an acceptance of the validity of the alleged innocence claim. Moreover, in consenting to allow DNA testing, the State of Ohio does not concede and takes no position on the significance (or lack thereof) of any DNA results which may be obtained in the course of the testing. Moreover, the Unit does not act as legal counsel to any person whose case is being investigated.**

Cuyahoga County Prosecutor's Office Conviction Integrity Unit  
**WAIVER AND CONSENT**

<b>STATE OF OHIO</b>		▶ Case No. _____
Cuyahoga County		Common Pleas Court
<b>STATE OF OHIO</b> vs.		
Name of Convicted Offender:		
DOB:	Age	Highest Level of Education Completed
Convicted Offense(s):		
Alleged Date of Offense:		Date of Conviction
<p>The convicted offender must review the completed waiver and consent form before signing. This form must also be notarized.</p> <p>The convicted offender must place his/her initials to the right of each statement if he/she agrees with the statement and agrees to comply with any terms therein.</p> <p>The Conviction Integrity Unit of the Cuyahoga County Prosecutor's Office shall be referred to as "Conviction Integrity Unit" throughout this document.</p>		
<b>WAIVER OF PROCEDURAL SAFEGUARDS AND PRIVILEGES AND CONSENT TO INQUIRY</b>		<b>Initials of Convicted Offender</b>
1. I acknowledge that I have been convicted of the offense(s) noted above by the State of Ohio.		(1) _____
2. I believe that new and credible evidence of innocence must exist.		(2) _____
3. I am requesting that the Unit review my claim of complete factual innocence.		(3) _____
4. I consent to a formal inquiry of my case by the Conviction Integrity Unit.		(4) _____
5. I agree to cooperate fully with the Conviction Integrity Unit review.		(5) _____
6. I agree to provide full disclosure regarding all inquiry requirements of the Conviction Integrity Unit review.		(6) _____
7. I understand that if I refuse to cooperate in any way or become uncooperative with the Conviction Integrity Unit, the inquiry may be discontinued.		(7) _____

8. I understand that the Conviction Integrity Unit may determine that my case does not meet their criteria and at any point reject my claim.	(8) _____
9. I understand that I have no right to appeal a rejection of my claim by the Conviction Integrity Unit.	(9) _____
10. (a) I understand that I am waiving all of my procedural safeguards and privileges with regard to my claim of innocence.	(10a) _____
(b) I understand that this includes a waiver of my right against self-incrimination pursuant to the Fifth Amendment of the United States Constitution and Article I, Section 10 of the Ohio Constitution.	(10b) _____
(c) I understand that this includes a waiver of any privileges to prevent testimony of others including but not limited to: spousal, clergy, and medical privilege.	(10c) _____
11. I understand that the Conviction Integrity Unit may provide disclosure to the appropriate authorities of the following:	
(a) Evidence uncovered by the Conviction Integrity Unit that supports my guilt.	(11a) _____
(b) Evidence uncovered by the Conviction Integrity Unit that tends to show I may have committed unrelated felonies.	(11b) _____
(c) Evidence uncovered by the Conviction Integrity Unit that tends to show I may be guilty of a higher level crime than the one for which I was charged or convicted.	(11c) _____
(d) Evidence uncovered by the Conviction Integrity Unit that tends to show that other people may have been involved in the commission of the crime for which I was convicted.	(11d) _____
(e) Evidence of criminal acts, professional misconduct, and other wrongdoings of others will be referred to the appropriate authorities.	(11e) _____
12. I also understand that evidence uncovered by the Conviction Integrity Unit that is favorable to me shall be disclosed to me regardless of the outcome of the review.	(12) _____

**ACKNOWLEDGEMENT BY CONVICTED OFFENDER**

I have read and understand all of the above statements. By initialing the statements and signing below, I understand and agree to comply with any terms herein. No one has told me to agree to anything that I oppose or do not understand. My agreements are of my own free will and are given voluntarily.

Date:

Signature of Convicted Offender:

Name of Convicted Offender (Type or Print):

**CERTIFICATION BY ATTORNEY FOR CONVICTED PERSON (if represented by counsel)**

I hereby certify that I have fully explained to the convicted Offender each statement and that his/her signature is a result of an independent and informed decision made by him/her. I further certify that I was with the convicted Offender as he/she provided initials and signature to this document and that the signature above is indeed that of the convicted person.

Date:

Signature of the Lawyer for Convicted Offender:

Name of Lawyer for Convicted Offender (Type or Print):

**SWORN AND SUBSCRIBED BEFORE ME**

Date:

Signature of Notary:

Name of Notary:

Notary Commission Expires:

**The original copy of this form must be delivered to the Conviction Integrity Unit. Please retain a copy for your records.**



## A look at conviction-review initiatives nationwide

Posted: Jun 19, 2014 3:55 PM CST  
Updated: Jun 19, 2014 3:55 PM CST

By JENNIFER PELTZ  
Associated Press

NEW YORK (AP) - Prosecutors around the country have set up systems to assess claims of wrongful conviction in recent years, and they have reviewed thousands of cases and dismissed dozens of convictions so far. A look at some of the initiatives:

**Baltimore City state's attorney's office:** Created in 2012, an in-house conviction review unit has reversed the conviction of at least one person.

**Brooklyn district attorney's office (New York City):** Formed in 2011 and expanded under a new administration this year, the conviction review process has prompted the dismissals of at least 10 cases, seven of them this year. A 10-prosecutor internal unit and an outside panel of defense lawyers are now looking at about 90 cases.

**Cook County state's attorney's office (Chicago):** An in-house review unit has disavowed at least six convictions since its 2012 formation.

**Colorado attorney general/Denver district attorney's offices:** Setting out to determine whether new DNA testing might cast doubt on violent crime convictions, prosecutors and investigators reviewed more than 1,700 cases from 2010 to 2014. They ultimately concluded that only one case presented enough of an identity question to merit new testing; that defendant was exonerated. The work is to continue.

**Cuyahoga County prosecutor's office (Cleveland):** It announced a new nine-person unit this April to review "legitimate claims of innocence."

**Dallas County district attorney's office (Dallas):** Formed in 2007, this two-prosecutor, one-investigator unit has reviewed more than 400 cases and cleared 33 people.

**Lake County state's attorney's office (Waukegan, Illinois):** A year-old panel of retired judges, retired prosecutors and defense lawyers - all from outside the county - has screened more than 15 cases and is looking further at three or four so far.

**Oneida County district attorney's office (Utica, New York):** Created in 2013, a panel of prosecutors, police investigators and a community representative (a court interpreter) is reviewing three cases so far.

**Manhattan district attorney's office (New York City):** A senior prosecutor has led more than 150 case reviews, at least 12 reinvestigations and four conviction reversals since March 2010.

**Milwaukee County district attorney's office (Milwaukee):** Flaws in DNA collection spurred prosecutors in 2010 to revisit every homicide case dating to 1992; after screening 2,100 and reviewing files on 486 of them, the DA ultimately stood behind all the convictions except one that had come under question shortly before the process started.

**Philadelphia district attorney's office:** It announced this April that a new conviction review unit will assess claims of innocence and new evidence. It's in addition to a unit that reviews requests for various forms of post-conviction relief and grants about three or four a year.

**Santa Clara County district attorney's office (San Jose, California):** Launched as an experiment in the early 2000s, later disbanded and revived by a new administration in March 2011, the in-house program has reviewed over 100 cases and exonerated at least five people.

**Wayne County prosecutor's office (Detroit):** Amid concern about how a police lab had interpreted gun evidence, prosecutors reviewed thousands of cases and retested evidence from more than 400 cases from 2010 to 2013. Six convictions were overturned, but all six defendants later pleaded guilty or were convicted at retrials.

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The Post's View

# New U.S. attorney's office unit will review cases of possible wrongful conviction



By Editorial Board September 24 at 7:41 PM

Advertisement

**FIVE TIMES** in the last five years, the U.S. Attorney's Office in Washington has admitted to mistakes that resulted in wrongful convictions. Prosecutors can't give back to these five men the years of their lives spent in prison for crimes they didn't commit; that injustice is irrevocable.

But prosecutors can learn from these mistakes. So it is a promising development that a special unit is being established to determine whether others have been similarly wronged. Equally important is the unit's mission to come up with recommendations to fix the problems that cause wrongful convictions so as to prevent future miscarriages of justice.

U.S. Attorney Ronald C. Machen Jr. announced Sept. 11 the creation of a conviction integrity unit within his office that will identify and investigate cases in which there may have been wrongful convictions and recommend practices for police and prosecutors to avoid future errors. The unit, the first for a U.S. attorney's office, is intended not to replace the scrutiny of convictions through traditional litigation in the courts but rather to create a structure in which there is collaboration between defense and prosecutors. The advantage of such cooperation is that it concentrates

New U.S. attorney's office unit will review cases of possible wrongf... <http://www.washingtonpost.com/opinions/new-us-attorneys-office-un...>  
resources and brings together specialists, helping to speed the review process and avert the lengthy delays that occur in litigation.

Several cities, including Dallas and New York, have established similar units. Success, according to experts, depends on setting up rules that allow for the useful exchange of information and clear protocols on how cases will be reviewed and evidence evaluated. Also important are protections against prosecutors interpreting evidence with preconceptions that arise, however unintentionally, from their traditional roles. Mr. Machen told us that all the details haven't been worked out and that, as a federal agency, his unit may operate under some constraints. But it is encouraging that his office consulted with nationally recognized experts, has conducted training to guard against the cognitive bias and plans to have the unit's work reviewed by a committee that will include defense attorneys. The willingness of Mr. Machen's office to be collaborative, not adversarial, was apparent in how it worked with the Mid-Atlantic Innocence Project to overturn the conviction of Kevin Martin in the rape and murder of a young woman in 1982.

Mr. Machen says he is setting up a unit that is intended to make a difference and not just offer the illusion of something being done. As he said in announcing his new unit, "As prosecutors, our goal is not to win convictions but to do justice."

**Read more about this topic:**

**[The Post's View: The flaws of the judicial system](#)**

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# First federal unit set up to correct wrongful convictions

BY Carey Reed *September 14, 2014 at 2:31 PM EDT*

The U.S. Attorney's Office in Washington has set up the first federal unit to identify and investigate cases that ended in wrongful convictions, Reuters reports.

"This new unit will work to uncover historical injustices and to make sure that we are doing everything in our power to prevent such tragedies in the future," U.S. Attorney Ronald C. Machen Jr. told The Washington Post before the formal announcement on Friday.

The creation of the Conviction Integrity Unit came after the U.S. Attorney's Office spent four years reviewing more than 2,000 cases involving FBI analysis of fiber and hair evidence. The review has already garnered a handful of exonerations for individuals convicted of crimes committed in the 1980s.

Last week, Henry Lee McCollum, 50, and Leon Brown, 46, were declared innocent after serving thirty years for the 1983 rape and murder of an 11-year-old girl in North Carolina. McCollum, who was on death row, and Brown, who was serving a life sentence, were freed after DNA evidence linked another man to the crime, the New York Times reports.

In July, Kevin Martin, 50, who was convicted of the 1982 killing of a woman in Washington D.C. was exonerated based on DNA evidence. The U.S. Attorney's Office challenged original forensic evidence of hair that linked Martin to the crime, according to the Washington Post.

The first of the exonerations from the U.S. Attorney's reevaluation and new DNA evidence came in 2009 for Donald Gates. Gates was convicted of the 1981 rape and murder of a Georgetown University student based in part on hair evidence.

The results of the U.S. Attorney's Office review are being shared with the Mid-Atlantic Innocence Project, a nonprofit dedicated to correcting and preventing wrongful convictions in D.C., Maryland and Virginia. The organization is located at George Washington University Law School in Washington, D.C.

All four men had served well beyond the average sentence typical of DNA exonerees, according to the Mid-Atlantic Innocence Project, which notes the average sentence served is 13.6 years.

One of the most publicized cases of wrongful conviction and exoneration in recent years is the case of Antron McCray, Kevin Richardson, Yusef Salaam, Raymond Santana Jr. and Kharey Wise, otherwise known as the Central Park Five, in 2002. The five black and Latino men were convicted as youths of the beating and raping of a female jogger in Central Park in 1989.

On Sept. 5, the men were awarded \$41 million in a settlement, roughly \$1 million for each year of their imprisonment.

The federal government, 29 states and the District of Columbia have enacted laws to award monetary compensation to people who have been exonerated, according to Mid-Atlantic Innocence Project.

[courant.com/news/opinion/op\\_ed/hc-op-cameron-wrongful-conviction-integrity-unit-c-20140701,0,2995607.story](http://courant.com/news/opinion/op_ed/hc-op-cameron-wrongful-conviction-integrity-unit-c-20140701,0,2995607.story)

# Courant.com

OP-ED

## Wrongful Convictions Require State Vigilance

By DAVID R. CAMERON | OP-ED

The Hartford Courant

7:32 PM EDT, July 1, 2014

In recent years, as they have become increasingly aware of the frequency and various causes of wrongful convictions, prosecutors in a number of large cities and counties across the country created conviction integrity units. These units re-examine the evidence in cases in which there's good reason to believe a wrongful conviction occurred because of mistakes in the initial investigation, eyewitness misidentifications, perjury of witnesses and/or official misconduct.

Rather than continuing to rely exclusively on a process that is overloaded with frivolous petitions and drags out appeals for decades, Connecticut should follow the lead of those cities and counties and create a statewide conviction integrity unit.

Since 2007, such units have been created in more than a dozen cities and counties — first in Dallas, then in Chicago and Cook County, San Jose and Santa Clara County, Manhattan and Brooklyn in New York, Detroit and Wayne County, Denver and, most recently, Philadelphia and Cleveland. In most of the cases reviewed, the convictions have remained in place. Nevertheless, the re-examinations have resulted in the dismissal of 33 convictions in Dallas, four in Manhattan and seven in Brooklyn.

There are instances in which the evidence of actual innocence — most notably, DNA evidence — surfaces after a conviction that is so conclusive that prosecutors will ask a court to throw out a conviction. The New York-based Innocence Project reports that, since 1989, 316 wrongful convictions have been thrown out because of DNA evidence that conclusively tied someone other than the person convicted to the crime. In Connecticut, three such exonerations have occurred over the past eight years.

But it is important to realize that the absence of conclusive DNA evidence of actual innocence does not constitute proof that an individual was rightfully convicted of the crime for which he or she is incarcerated. There are cases in which, although it doesn't constitute proof of actual innocence, there is DNA evidence that points to someone else as the perpetrator. And there are, of course, many cases in which there is no DNA evidence.

Statistics on how many people have been convicted of a serious felony in the U.S. over the 25 years since 1989 are hard to find, let alone how many of those were wrongfully convicted. But given that more than 2 million people are now incarcerated, surely the number of wrongful convictions over the past 25 years far exceeds the

316 for which there was an exoneration on the basis of DNA evidence.

Even among the known wrongful convictions, the exonerations resulting from DNA evidence represent only a small portion of all wrongful convictions and exonerations. The National Registry of Exonerations, a cooperative project of the University of Michigan Law School and the Center on Wrongful Convictions at the Northwestern University School of Law, reports there have been 1,385 exonerations, meaning that DNA-based exonerations constitute less than one-quarter of all exonerations.

Unfortunately, for those convicted of a serious felony for which there is no conclusive DNA evidence of innocence, there is no proactive state effort to consider whether a wrongful conviction occurred. There is only the drawn-out habeas process with its years, even decades, of appeals, a process in which the scales of justice seem to be tipped heavily in favor of the state and in which prosecutors seem to be concerned only with defending the original conviction.

In recent years, Connecticut enacted important legislation designed to prevent wrongful convictions. It has required that confessions to serious crimes be videotaped to prevent false confessions. And in 2012, it mandated the blind or double-blind administration and sequential presentation of a suspect and fillers in a lineup or photo array in order to minimize eyewitness misidentifications — the single most frequent cause, by far, of wrongful convictions.

The state now leads the country in preventing wrongful convictions. There is no reason it should not also lead the country in correcting any wrongful convictions that occurred in the past. One way to do that is to create a statewide conviction integrity unit in the office of the chief state's attorney.

*David R. Cameron is a professor of political science at Yale and a member of the state's Eyewitness Identification Task Force.*

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# THE CRIME REPORT

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## Inside Criminal Justice

SPECIAL REPORT

### Wrongful Convictions: Can Prosecutors Reform Themselves?

March 27, 2014 08:08:40 am

By Hella Winston

In October 2003, a star college football player named Mark Fisher was found [shot dead](#) ([http://en.wikipedia.org/wiki/John\\_Giuca](http://en.wikipedia.org/wiki/John_Giuca)) on a leafy, residential Brooklyn, NY street. The crime attracted intense media coverage and stymied investigators for months.



Brooklyn District Attorney Kenneth Thompson, who has pledged to review questionable convictions. (Image via Wikipedia)

Indeed, according to a 2005 *New York Daily News* article, it wasn't until an "elite team" was set up to investigate the killing, headed by then Brooklyn district attorney Charles Hynes' controversial top deputy, Michael Vecchione— that prosecutors were able to break what was termed the "wall of silence" and solve the case.

Ultimately, 22-year-old John Giuca and 19-year-old Antonio Russo were arrested and charged with Fisher's murder. At trial, both Giuca and Russo were found guilty and sentenced to 25 years to life.

At the time, the convictions represented an important victory for both Hynes (who was then running for reelection in a hotly contested race) and the lead prosecutor, Anna-Sigga Nicolazzi, who in its wake appeared on at least two TV specials about the case and has since made a name for herself appearing as a legal commentator on Fox News and *Imus in the Morning*.

From the beginning, however, Giuca maintained his innocence.

After he was convicted, his mother, Doreen [Giuliano](#) ([http://www.vanityfair.com/magazine/2009/01/brooklyn\\_sing200901](http://www.vanityfair.com/magazine/2009/01/brooklyn_sing200901)), befriended a man who had been a juror in her son's trial, and then documented, in secretly recorded conversations, that the juror had undisclosed connections to the case and a bias against her son that should have disqualified him from serving on the jury.

These discoveries became the basis of several appeals in which Giuca argued that, because the juror failed to disclose his connections to people involved in the case, he did not receive a fair trial.

All of these appeals failed, however, and until recently it looked as if Giuca would likely serve out his sentence.

#### Prosecutorial Misconduct?

But over the past year, Giuca's new lawyer, Mark Bederow, with assistance from Jay Salpeter, an ex-cop-turned-private investigator with a specialty in wrongful convictions, has uncovered what Bederow alleges is compelling evidence of improper conduct by Nicolazzi, the prosecutor.

The alleged misconduct included a failure to disclose—as required by law—any benefit or expectation of a benefit given to a [witness](#) (<http://thecrimereport.s3.amazonaws.com/2/39/f>)

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The Shrinking Youth Incarceration System

[\(2393/link\\_1a\\_avito\\_trial\\_testimony.pdf\)](#) , as well as vouching for that same witness's perjured testimony.

NEW & NOTABLE APRIL 2, 2014

A series of studies by the National Council on Crime and Delinquency highlights efforts to reduce the rate of juvenile incarceration

Bederow and Salpeter have also obtained sworn recantations from three prosecution witnesses, two of whom say they were pressured by police and Nicolazzi into making false statements at trial.

Two other witnesses appear to have withheld information from investigators and/or changed their stories multiple times, and both have troubling connections to Hynes: one is the son of a woman who was a member of the executive committee of the Brooklyn GOP, who crossed party lines in 2005 to endorse Hynes for DA (and who allegedly gave her son a false alibi to the press and told a neighbor to stonewall cops by avoiding mentioning her son).

The other is the daughter of a Hynes donor (<http://www.villagevoice.com/2013-08-12/news/charles-hynes-murder-witness/>) who, since 2012, has been working as an Assistant District Attorney in the Brooklyn DA's office.

Bederow submitted a petition ([http://thecrimereport.s3.amazonaws.com/2/92/a/2394/link\\_2\\_giwa\\_brooklyn\\_da\\_civ\\_submission\\_final.pdf](http://thecrimereport.s3.amazonaws.com/2/92/a/2394/link_2_giwa_brooklyn_da_civ_submission_final.pdf)) to the Conviction Review Unit (CRU) of the office of the newly elected Brooklyn DA, Ken Thompson, who made [the issue of wrongful convictions](#) (<http://www.nydailynews.com/new-york/brooklyn/new-bklyn-da-ken-thompson-asks-article-1.1472079>) one of the centerpieces of his successful campaign last Fall.

Conviction Review Units (also known as Conviction Integrity Units or Post-Conviction Review Sections) are a relatively new phenomenon. The first ones were established by DA Craig Watkins in Dallas in 2007 and by former Harris County, Texas DA Pat Lykos in 2008.

They have begun to crop up in DA's offices in other parts of the country as well, including: Cook County, IL; Santa Clara, CA; Wayne, MI; and Brooklyn and Manhattan in New York City.

In general, they involve the implementation of what are known as both "front-end" and "back-end" reforms —measures to reduce the risk of wrongful convictions before a case goes to trial and a process to investigate claims of actual innocence after a conviction, respectively.

(Thompson's office declined to comment on the substance of Bederow's petition, citing the pending review, but did tell the *Daily News* that "Anna-Sigga Nicolazzi is a respected and outstanding prosecutor who has an exemplary trial record.")

## Investigating 'Gross Violations'

While many of the details about how Thompson's CRU will operate have not yet been made public, a [February press release](#) ([http://thecrimereport.s3.amazonaws.com/2/cc/8/2395/link\\_3\\_thompson\\_press\\_release.pdf](http://thecrimereport.s3.amazonaws.com/2/cc/8/2395/link_3_thompson_press_release.pdf)) from the office notes that it will consist of "experienced prosecutors, investigators and support staff tasked with the responsibility of conducting a thorough re-investigation of cases identified as having a colorable claim of actual innocence or gross violations of a defendant's constitutional rights."

Thompson also appointed an outside panel of three lawyers to "advise on a range of issues, including whether a conviction should stand, needs additional review or should possibly be overturned."

Drawing on comments Thompson made during his campaign, Bederow told *The Crime Report* that, considering Thompson's pledge to make the review of questionable convictions obtained under the prior administration a priority, "we believe it is in everyone's interest, including Mr. Giuca's, to work with the new DA and allow his staff to conduct a careful and thorough review of the investigation and trial, including the evidence we have uncovered, before resorting to adversarial proceedings."

But is it?

While Conviction Integrity Units can play an important role in implementing much needed "front-end" reforms—including enhanced training, better discovery-related policies and procedures, the use of videotaped confessions and improved practices related to eyewitness identification—their value in evaluating post-conviction claims of innocence is much more questionable, particularly in cases that don't involve DNA.

Indeed, lawyers with experience working with CIUs point not only to their criteria for re-evaluating a case, but also to their structure and staffing, as major obstacles to their ability to function effectively.

Although these various units are all involved in reviewing possible wrongful convictions emanating from their own offices, they differ in terms of their criteria for post-conviction review.

### Standards for Review

While Dallas, Manhattan and Santa Clara all hold as their standard of review whether there is clear and convincing evidence for a plausible claim of actual innocence, the Dallas CIU has noted that it would relax this standard if a post-conviction investigation uncovered "glaring constitutional errors" at trial, even if those errors did not clearly relate to guilt or innocence—a standard that seems consistent with Thompson's proposed plan to look at "gross violations" of a defendant's constitutional rights.

Moreover, unlike Dallas, Manhattan will not reinvestigate a case if a defendant knew or should have known at trial the basis for his current claim—a standard that can, in effect, punish the defense for what is often the failure of prosecutors to turn over certain material to them, or for ineffective assistance of counsel.

Some CIUs will not look at cases in which a defendant pleads guilty, regardless of research that shows that coerced or false confessions are a common cause of wrongful convictions.

Perhaps even more important, there is no uniformity in how these units are structured and operate. For example, while the Dallas CIU—which is headed by a highly regarded former defense attorney—works in collaboration with defense attorneys, local innocence projects and law students, the Manhattan CIU, with a prosecutor at its helm, conducts all of its post-conviction reviews internally.

To veteran defense attorney Ron Kuby, who has worked with DA Conviction Integrity Units in Manhattan, Brooklyn and Nassau County, the Dallas model is far superior.

"Number one, [in Dallas there is] complete transparency," Kuby told *The Crime Report*.

"Both sides share all of their information. We get everything in their file, they get everything in our file, except certain privileged communications. And second, the investigation is undertaken in a collaborative way.

"We sit down together and we discuss witnesses. And we discuss...what would be the best side to approach this witness. Should we do it together? Should the defense pursue this witness because frequently the defense is able to win trust where the police don't, or should the police pursue this particular witness?"

### Going to Court

After representing witnesses in a case that was brought to the Manhattan CIU, Kuby decided that he would never bring a case to that office again. In fact, he has concluded that, whenever possible, going to court is the preferable route because in that arena, armed with subpoena power, "it's easier [for the defense] to convince a judge that a result would have been different at trial than to convince a prosecutor."

According to Kuby, "[Prosecutors] look for evidence to support the conviction. And defense lawyers who are foolish enough to cooperate with them end up serving up their witnesses, and [then the DA goes out and collects impeachment information] on [those] witnesses.

"The truth is, the hallmark of great lawyering is making a totally truthful person look like a liar."

Louise Scurry, a public relations expert who has worked on numerous wrongful conviction cases, including those of Martin Tankleff, The West Memphis Three, Jesse Friedman and Jon-Adrian Velazquez, agrees.

"There's an underlying hope that prosecutors, when exposed to what you believe is strong evidence will say 'ah ha, this is really compelling.'"

But, according to Scurry, this has not been the reaction in the cases he has worked on.

In the case of Velazquez (<http://www.freesjonadrianvelazquez.org/>), whose murder conviction was recently reviewed and upheld ([http://thecrimereport.s3.amazonaws.com/2/31/7/2388/link\\_4\\_velazquez.pdf](http://thecrimereport.s3.amazonaws.com/2/31/7/2388/link_4_velazquez.pdf)) by the Manhattan DA's CIU, Scurry noted that "[the process] was adversarial."

"[Defense attorney] Bob Gottlieb turned over witnesses to whom the real killer confessed," Scurry continued. "They exposed themselves, those witnesses came to New York, and they were treated horribly, like defendants. These were witnesses who had a lot to lose. They know the murderer." Gottlieb has since filed a [440-10](#)

motion ([http://thecrimereport.s3.amazonaws.com/2/07/e/2397/link\\_6\\_april\\_2\\_2013\\_letter\\_redacted1.pdf](http://thecrimereport.s3.amazonaws.com/2/07/e/2397/link_6_april_2_2013_letter_redacted1.pdf)) , or a motion to vacate the conviction based on newly discovered evidence.)

Gettleb, who was appointed in 2008 to the New York State Bar Association's Task Force on Wrongful Convictions, concedes that the concept of a DA remedying wrongful convictions is "noble"—but he adds there is an "inherent conflict in having an integrity unit in a DA's office and staffed by prosecutors who are involved in other investigations, in cases, other than examining prior convictions."

In the Velazquez case, where there was no DNA or physical evidence that could be re-examined, Gettleb was, he believed, at a significant disadvantage with the CIU. (At least until now: according to Gettleb, recent scientific advances suggest that some evidence in the case can be tested, something he is now pursuing),

## Eyewitness ID

This "conviction was based solely, one hundred percent, on faulty eyewitness (identification) and it has been established by scientific studies that eyewitness ID is inherently suspect, and that conviction is as inherently invalid as the convictions that were based on faulty evaluations of DNA," Gettleb told *The Crime Report*.

However, he continued, "the reality is that it is...impossible to prevail in those cases where the claim is that a person is wrongly convicted based on eyewitness ID, a faulty line-up, (or) perjured testimony, because there is an institutional bias that exists under the present structure, and cannot be overcome, to protect and defend prior convictions."

To be sure, these units have been instrumental in righting some very serious wrongs.

A recent report found that close to 40 percent of exonerations in 2013 were initiated either by law enforcement or included police and prosecutors' cooperation. To date, Watkins' CIU in Dallas has been involved in 33 exonerations. The current Santa Clara, CIU has investigated and exonerated five people, including a man who was serving a life sentence; and another who had served 8 years in prison for a rape he did not commit.

The Manhattan DA's office has reviewed approximately 140 cases since its formation in 2010, reinvestigated at least 12 of the cases and consented to vacate convictions in three of those cases.

And last year, an investigation by Hynes' CRU in Brooklyn led to the release of a man named David Ranta, who had served 23 years for a murder that he most likely did not commit.

(Hynes' office stopped short of declaring Ranta factually innocent, but said instead (<http://www.nytimes.com/2013/03/20/investigation-brooklyn-prosecutor-to-seek-freedom-of-man-convicted-in-1980-killing-of-rabbi.html?pagewanted=all>) that the evidence against him had eroded significantly, blaming a retired, "rogue" detective for much of that "erosion.")

But even the most committed district attorney still has to contend with the fact that the cases that come to his or her office's CIU or CRU may well involve people who are still employed by the office, or police officers and even judges with whom the office has important relationships it needs to maintain.

For example, in the Giuca case, Thompson will be in the difficult position of investigating allegations against a highly regarded prosecutor (albeit one who was hired by the previous administration) currently working in his office. And he will also have the unenviable task of re-interviewing another current employee who is a factual witness in the case and who, records show, was uncooperative with the initial investigation.

## Independent Review

Indeed, in a *Huffington Post* article ([http://www.huffingtonpost.com/kenneththompson/brooklyn-da-hynes-wrongful-convictions\\_b\\_2683461.html](http://www.huffingtonpost.com/kenneththompson/brooklyn-da-hynes-wrongful-convictions_b_2683461.html)) he wrote during the campaign, Thompson himself noted that "internal conviction integrity units are best used to correct mistakes such as eyewitness misidentifications and false confessions. But...wrongful conviction cases premised on serious allegations of police and prosecutorial misconduct require independent review."

As Kuby notes, "Prosecutors have friends, colleagues" and "even if they have the utmost integrity," this cannot help but play a role in these reviews.

"If a DA is really serious and committed to having a CIU," said Gettleb, "then (the CIU) must be staffed with an inspector general-type prosecutor who has no connection to the past procedures and trials that are the subject

of the conviction review.

"That person must be totally separate and apart, with his or her own staff and offices. Members of the CIU (also) cannot include the chief assistant DA or any of the executive staff of the DA's office. It must truly be an independent entity.

"If you're not prepared to do that, then you really can't claim that you have an independent unit to evaluate past convictions."

Kuby believes there is an even bigger problem with a DA evaluating wrongful convictions emanating from his office: overturning too many convictions, even if the evidence requires it, can also raise serious issues not only for prosecutors, but for the system as a whole.

"Outside of incapacitating highly dangerous people, the criminal justice system seeks to create a sense of legitimacy in the minds of the public and to provide deterrence to wrongdoers," Kuby said.

"It doesn't much matter if people are guilty or innocent, if people think they are guilty. But whenever you expose a wrongdoing, you undermine the legitimacy of the system."

That's why people like Scury believe that the task of reviewing wrongful convictions should not be left to prosecutors, but given to an independent and independently funded entity set up for the purpose.

"We have had far too many wrongful convictions in New York City," says Scury. "(We) need a [truly independent] official body that can present solutions as well as have investigative responsibilities and subpoena power to review cases where credible evidence exists of a wrongful conviction and prosecutor and/or police complicity."

But Scury goes a step further, suggesting that the best way to address the problem of wrongful convictions is to "hold public officials who engage in these activities legally responsible: criminally and civilly"—something that almost never happens, because prosecutors and police have close to global immunity for actions undertaken in their law enforcement roles.

As Scury notes, "Prosecutors are virtually omnipotent and protected from any consequences of their actions."

**Editors Note:** For additional reporting on wrongful convictions, please see David Krajicek, "*When 'Mob Journalism' Helps Convict the Innocent*", published in TGR (<http://www.thecrimereport.org/news/inside-criminal-justice/2014-02-when-mob-journalism-helps-convict-the-innocent>) Feb 18, 2014.

.. *Hella Winston has a Ph.D. in sociology and works as a freelance investigative journalist. She is currently a postdoctoral fellow at Johns Hopkins and a Senior Fellow at the Schuster Institute for Investigative Journalism. She welcomes comments from readers.*

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## Where Brooklyn ranks in conviction review initiatives



Ken Thompson has been progressive in looking into wrongful convictions. Eagle file photo

By Jennifer Peltz  
Associated Press

Last week Brooklyn's District Attorney moved to vacate murder charges against Roger Logan, convicted in the 1997 shooting death of Sherwin Gibbons. The decision followed a thorough review of the case by the Brooklyn's Conviction Review Unit (CRU). Created in 2011, the CRU's efforts have revealed 7 Brooklyn defendants who have been wrongfully convicted--each of which served at least 10 years behind bars.

Prosecutors around the country have set up systems to assess claims of wrongful conviction in recent years, and they have reviewed thousands of cases and dismissed dozens of convictions so far. A look at some of the initiatives:

- Baltimore City state's attorney's office: Created in 2012, an in-house conviction review unit has reversed the conviction of at least one person.
- Brooklyn district attorney's office (New York City): Formed in 2011 and expanded under a new administration this year, the conviction review process has prompted the dismissals of at least 10 cases, seven of them this year. A 10-prosecutor internal unit and an outside panel of defense lawyers are now looking at about 90 cases.
- Cook County state's attorney's office (Chicago): An in-house review unit has disavowed at least six convictions since its 2012 formation.
- Colorado attorney general/Denver district attorney's offices: Setting out to determine whether new DNA testing might cast doubt on violent crime convictions, prosecutors and investigators reviewed more than 1,700 cases from 2010 to 2014. They ultimately concluded that only one case presented enough of an identity question to merit new testing; that defendant was exonerated. The work is to continue.
- Cuyahoga County prosecutor's office (Cleveland): It announced a new nine-person unit this April to review "legitimate claims of innocence."
- Dallas County district attorney's office (Dallas): Formed in 2007, this two-prosecutor, one-investigator unit has reviewed more than 400 cases and cleared 33 people.
- Lake County state's attorney's office (Waukegan, Illinois): A year-old panel of retired judges, retired prosecutors and defense lawyers — all from outside the county — has screened more than 15 cases and is looking further at three or four so far.
- Oneida County district attorney's office (Utica, New York): Created in 2013, a panel of prosecutors, police investigators and a community representative (a court interpreter) is reviewing three cases so far.
- Manhattan district attorney's office (New York City): A senior prosecutor has led more than 150 case reviews, at least 12 reinvestigations and four conviction reversals since March 2010.
- Milwaukee County district attorney's office (Milwaukee): Flaws in DNA collection spurred prosecutors in 2010 to revisit every homicide case dating to 1992; after screening 2,100 and reviewing files on 486 of them, the DA ultimately stood behind all the convictions except one that had come under question shortly before the process started.
- Philadelphia district attorney's office: It announced this April that a new conviction review unit will assess claims of innocence and new evidence. It's in addition to a unit that reviews requests for various forms of post-conviction relief and grants about three or four a year.
- Santa Clara County district attorney's office (San Jose, California): Launched as an experiment in the early 2000s, later disbanded and revived by a new administration in March 2011, the in-house program has reviewed over 100 cases and

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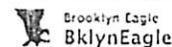
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Charisma L. Miller, Esq., Brooklyn Daily Eagle contributing.

June 10, 2014 · 11:30am

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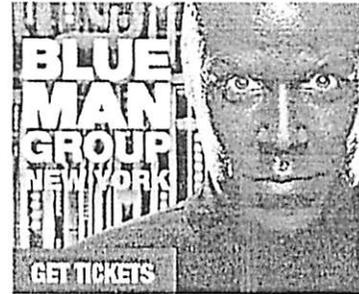
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## Dallas targets wrongful convictions, and revolution starts to spread

The Conviction Integrity Unit formed in Dallas to correct wrongful convictions has become a national model that is slowly changing prosecutors' willingness to reopen the books nationwide.



District Attorney Craig Watkins (r.) greeted Richard Miles at state district court in Dallas in February 2012. Mr. Miles was exonerated of a murder he did not commit.

(LM OTERO/AP)

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By Elizabeth Barber, Staff writer / May 25, 2014 at 1:07 pm EDT

Dallas

It wasn't until 2006, more than 10 years after he had been sent to prison, that things started going right for Richard Miles.

At 3:15 a.m. on May 16, 1994, Mr. Miles had been at the wrong place at the wrong time – a liquor store six miles from the South Dallas Texaco gas station where two men had been shot, one fatally. Miles, age 19, had left home the year before, tired of life as a preacher's kid. "I felt like I'd been deprived of the whole world," he says. So he had gone out to see that world.

First, he saw a police helicopter's spotlight float over the street and settle on him. Then he saw the inside of a police car.

He'd just been using the liquor store's pay phone to ask a friend who lived around the corner to let him in, he told police. But at his 1995 trial, it all went

**wrong.**

**A witness pointed out Miles as the gunman. A ballistics expert said Miles's hands had tested positive for gunshot residue. Prosecutors pointed out that Miles had done time for drug possession and could be mixed up in the kind of bad business that ends with smoking guns in parking lots at odd hours. Police said they had no other suspects.**

**Miles was sentenced to 40 years in prison for murder and 20 years for attempted murder.**

**Today, Miles is free, exonerated of the crimes he did not commit by a Dallas district attorney who decided it was his job to find, and fix, the wrongful convictions his predecessors had won. The Conviction Integrity (CI) Unit that Craig Watkins began in 2006 has become a national model and has since spread to a handful of other counties around the United States.**

**Some of these units are window dressing created mostly for public relations, critics say. But the Dallas CI Unit has had a profound impact in the city and has come at a time when concerns about wrongful convictions are rippling through the American justice system.**

**Indeed, as exonerations nationwide force prosecutors to reconsider their role in public safety, Mr. Watkins has cast himself as a leading reformer, taking on the insular culture within district attorneys' offices and challenging the credo that the most effective district attorney is the one who wins the most convictions.**

**"One overriding truth is that the prosecutor is by far the most important and powerful actor in the criminal justice system," says Samuel Gross, editor of the National Registry of Exonerations.**

**In that way, the Dallas CI Unit is about much more than just the innocence of Miles and the 32 others it has freed, some say. "In 10 years we'll look back and say we began a process in Texas that fundamentally changed attitudes about the whole meaning of justice in this country," says Jeff Blackburn, founder of the Innocence Project of Texas, one of a patchwork of innocence projects across the country.**

## **Miles's big break**

**For Miles, things began to change the moment his letter landed on the desk of a volunteer at Centurion Ministries, a nonprofit group that works to free the wrongfully convicted. The organization gets 1,000 letters a year from inmates asking for help. Most get polite refusals.**

**But Miles's letter was different. Too much of the case looked wrong. Miles is light-skinned, 5-foot-9, and 190 pounds, but witnesses said the shooter was dark-skinned and 6-foot-2 to 6-foot-4. When a caseworker got a copy of the**

Dallas Police Department's file on Miles, it included a report of a call from a woman who said her ex-boyfriend – a 6-foot-6, dark-skinned drug dealer – was the killer. Yet the report hadn't been mentioned at trial – although it had been written three months before the trial began.

In May 2009, Jim McCloskey, founder of Centurion Ministries, requested a meeting with a prosecutor in the Dallas County District Attorney's Office. The expectation was that the department would stall or argue or refuse point blank.

But he had reached the Dallas CI Unit. Not only did a prosecutor agree to see Mr. McCloskey, she told him she agreed Miles could be innocent. "That kind of cooperation was almost unheard of," adds McCloskey.

Between 1989 and 2013, some 1,304 people were exonerated nationwide, according to the National Registry of Exonerations. The group says that number only hints at the true figure.

But it is a number many district attorneys' offices still see as an indictment of their efforts. The pressures on prosecutors to both secure convictions and then fight to maintain them are considerable. District attorneys, who are elected, often see their success measured by their conviction rate. In high-crime cities like Dallas, district attorneys can feel that their best bet for wooing the public is to put people behind bars and keep them there.

Moreover, district attorneys who start rifling through their own books, pointing out where mistakes could have been made, risk ruffling fellow prosecutors who say the office should protect its own. In the early 2000s, the Dallas County District Attorney's Office was no different, says Heath Harris, who joined in 1995.

"You would get big accolades for big sentences, and everyone wants to be promoted," says Mr. Harris, who is now the top assistant district attorney in the Dallas office.

The office is on the top floor of a bland, putty-colored municipal complex separated from downtown by a freeway and some baked-looking parking lots that want for trees but might settle for some shrubs. The building has 10 almost identical floors – industrial off-whites, heel-clicking floors – as if the building were mimicking the legal labyrinth that some of its handcuffed visitors will end up navigating.

When he was elected in 2006, Watkins sought to change that office fundamentally. A former public defender who had never prosecuted a case – and who had lost his first district attorney election in 2002 – Watkins was Dallas's first African-American district attorney.

That would not be his last "first." Within a year, Watkins started his first-of-its-kind CI Unit, staffed with two prosecutors, an investigator, and an assistant. Their jobs were to do nothing but correct wrongful convictions.

**"This is the natural function of a prosecutor's office," says Watkins.**

**Many begged to differ.**

**"There was an unspoken desire for us to fail," says Mike Ware, the unit's first head and now a private defense lawyer in Fort Worth, Texas. "What we were doing was contrary to conventional thinking, and we knew it was going to make traditional allies upset with us."**

## **Watkins's revolution**

**Seven of 234 assistant district attorneys quit. Some of them might just not have liked Watkins, a tall man with a reputation for temper tantrums and diva arrogance. But Watkins says those prosecutors just didn't like the new way of doing things.**

**He didn't mind, he says. Watkins fired a few prosecutors, too, including the prosecutor on Miles's case, Tom D'Amore. It gave him a chance to bring in new people.**

**Watkins also introduced several reforms to change the convictions-at-all-costs culture. One change included playing down the adversarial relationship between the defense and the prosecution, says Watkins.**

**"Things have changed dramatically," says Lynn Pride Richardson, head of the Dallas Public Defender's Office, during an elevator ride down from Watkins's office. "Since Watkins, our relationship has gotten a lot better."**

**Watkins's most visible effort, though, was to get innocent people out. The office began an internal audit of more than 400 cases in which an inmate's request for a DNA evidence test had been turned down. Prior prosecutors had been "fighting those requests tooth and nail," says Harris.**

**At least three of those initial cases resulted in convictions being set aside, says Mr. Ware. It also turned out to be just the beginning.**

**To date, the office has freed 33 innocent people, according to office data. Critics note that Watkins's office has not exonerated anyone whom his own office has prosecuted, leading critics to suggest that he is more interested in righting predecessors' wrongs than in exposing his own. But the office is still going strong. As of March, it was investigating 30 cases and had a backlog of 200 cases that have come from internal reviews, local innocence projects, and defense lawyers.**

**"There was this bias that once the judge closes the book, the book should stay closed," says Mr. Blackburn of the Innocence Project of Texas, who is also a private defense lawyer.**

**When the Dallas CI Unit began to reopen Miles's book, it found a story that spoke to the myriad ways that the rush to convict can warp the justice system.**

In January 2010, the unit reinterviewed the witness who had pointed out Miles in court. The witness confessed in an affidavit that just before testifying he told the prosecutor, Mr. D'Amore, that he "did not recognize Miles."

But D'Amore told him to "just point out the man sitting at the table with the defense lawyer," according to the affidavit.

Then, in another blow, the ballistics expert told the Dallas CI Unit in July 2010 that she would call the test for gunpowder residue negative if she could do it over again. The residue could have come from a cigarette, and Miles had been smoking that night.

One prosecutor's office had sent Miles to prison. Now, the same office was getting him out. "Richard Miles would not be free," says McCloskey, "were it not for the Dallas district attorney's Conviction Integrity Unit."

## **An idea spreads**

Gradually, some district attorneys across the country noticed what was happening in Texas and knew that, before Watkins arrived, Dallas had been just like any other county. "Nothing was going on in Texas that wasn't going on anywhere else in the country," says Gary Udashen, a private defense lawyer in Dallas and president of the Innocence Project of Texas. "Every county should do what Dallas has done."

More counties are trying. At least 11 CI Units are housed in some of the biggest district attorneys' offices across the US, including the Brooklyn borough of New York City and Michigan's Wayne County (Detroit). In April, district attorneys' offices in Philadelphia and Ohio's Cuyahoga County (Cleveland) founded units.

CI Units' effects are felt even in district attorneys' offices that don't have them, says Mr. Gross of the National Registry of Exonerations.

"The publicity the units receive has helped generate an atmosphere in which the issue of exonerations is more important to prosecutors," he says. "It's something you get political points for."

For example, this week, Brooklyn District Attorney Kenneth Thompson announced that his CI Unit would examine 90 mostly homicide cases from the 1980s and 1990s.

Last year, 38 percent of the 87 exonerations in the US – a record number – were achieved either at the behest or with the cooperation of law enforcement, according to the National Registry of Exonerations.

Still, it's difficult to gauge the motives behind prosecutors' interest in overturning wrongful convictions. It's possible that some prosecutors become aware that an innocence project's work has made an exoneration imminent and seek to quell a possible public firestorm, says Rob Warden, executive director

of the Center on Wrongful Convictions at Northwestern University Law School.

**“Most of these CI Units remind me of [George] Orwell’s Ministry of Truth” in “1984,” he says. They’re “window dressing.”**

**It’s also hard to judge the worthiness of CI Units. No CI Unit has a success rate equal to that of the Dallas unit, and some are beleaguered by questions about how committed prosecutors are to the process.**

**For instance, the CI Unit in Manhattan has reviewed 140 cases and overturned three convictions, according to The Crime Report, a criminal justice news website. The unit was also criticized when, after an internal 18-month investigation, it decided not to overturn the murder conviction of Jon-Adrian Velazquez despite media reports casting doubts on the verdict.**

**In other instances, the evidence to overturn convictions is harder to come by. When Texas’s Harris County founded a CI Unit, it realized that most of its post-conviction DNA evidence had been destroyed. In contrast, when Watkins was elected, his office was sitting on mountains of untested DNA evidence, in part thanks to his predecessors’ failures to test it, and in part thanks to the local crime lab, which had stored all biological evidence post-conviction.**

## **Changing the way we look at justice**

**DNA evidence played no role in Miles’s case, which ended when he was exonerated on Feb. 15, 2012 – two years after his release from prison. D’Amore, who prosecuted Miles’s case, says he never knew about the police report filed before the trial. He says the police did not tell the district attorney’s office anything new had come in. He also denies the allegations of coaching the witness.**

**“I didn’t do it,” says D’Amore, now a private defense attorney in Dallas. “It’s a horrible thing when someone is convicted of a crime they didn’t do, but I presented to the jury the information I had, and nothing more, nothing less.”**

**Miles filed a formal grievance against D’Amore with the State Bar of Texas in 2012; it was dismissed in April. The witness who said that D’Amore encouraged him to lie told the Monitor he did not remember if D’Amore had done so, or if someone else had done so, and he declined to say what he told the state bar.**

**Miles did not have high hopes. During the past four decades, prosecutors nationwide have been disciplined for misconduct in less than 2 percent of the 3,625 cases in which it happened, according to the Center for Prosecutor Integrity.**

**Miles says nothing can give him back the lost years. But his experience can have an impact.**

**“All I can do now is change the way we look at the criminal justice system,” he says. “We’ll never change our justice system if the people in it right now aren’t held accountable.”**

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NATIONAL INSTITUTE OF JUSTICE

# ***MENDING JUSTICE:*** Sentinel Event Reviews

**NIJ**

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The findings and conclusions in this publication are those of the authors and do not necessarily reflect the official position or policies of the U.S. Department of Justice.

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NCJ 247141



Office of the Attorney General  
Washington, D. C. 20530

MESSAGE FROM THE ATTORNEY GENERAL

The effectiveness and legitimacy of our justice system depend as much on the way it handles its mistakes as it does on how it carries out its core enforcement, prosecutorial, and correctional functions. Because ours is an institution set up to discover the truth, tolerance for mistakes is exceptionally low. But as justice system professionals, we are deceiving ourselves if we think our decisions and actions are infallible. The hundreds of DNA-enabled exonerations are testimony to the vulnerabilities of a fact-finding process that relies on human agency and judgment.

Practitioners in an adversarial system that probes, refutes, and defends do not, in general, concede fault readily. Yet we are missing a chance to improve outcomes if we ignore the opportunity for growth that an honest assessment of error presents. Some errors are the result of careless omission or even willful commission by a single individual or group. In those cases, the ones responsible should be held accountable. But other mistakes stem from decisions that were well-intentioned, were consistent with customary practice, and seemed sound at the time. The problems that arise could have been avoided had the system been better equipped with safeguards.

Criminal justice errors – whether they are wrongful convictions, premature prisoner releases, long-unsolved cold cases, or other serious oversights – are rarely the fault of a single actor. Perhaps there are better ways to deal with these mistakes, taking a page from other professions such as medicine and aviation, which have institutionalized processes for diagnosing and correcting mistakes. Our National Institute of Justice has begun to explore whether sentinel events reviews – so named because like sentries, these problems signal greater dangers ahead – have a place in the future of our field. The primary essay in this collection is by James Doyle, a former National Institute of Justice visiting fellow, who describes the genesis of this innovative process and its core components. The short commentaries that follow continue the conversation by describing the advantages that could accrue from employing sentinel events reviews and by outlining the challenges that must be met in order to make them part of our arsenal of problem-solving tools.

With few exceptions, justice system professionals hold themselves to high standards of integrity and are thorough and exacting in their quest for answers. If we truly hope to get to the bottom of errors and reduce the chances of repeating them, then it is time we explore a new, system-wide, way of responding, not by pointing fingers, but by forthrightly assessing our processes, looking for weaknesses in our methods, and redesigning our approach so that the truth will be more attainable. I hope that these essays will launch this important and timely exploration and stimulate new ideas about ways we can ensure a fairer and more effective system of justice.

A handwritten signature in black ink, appearing to read "Eric H. Holder, Jr.", written in a cursive style.

Eric H. Holder, Jr.  
Attorney General

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## Introduction

Confidence in our nation’s criminal justice system rests on several core beliefs: First, that most justice work is routine, following a fairly prescribed path that renders error a rarity. Second, that in the rare instance when a mistake does occur, it is typically a clear case of negligence or misconduct, and “the system” readily detects and fixes it through its many separate (and characteristically adversarial) components, which “backstop” each other. Finally, when an error occurs, we believe that there are processes in place to make sure that type of error will never happen again.

The problem is that these beliefs may be largely unfounded.

Errors — such as a wrongful arrest, the wrongful release from prison of a dangerous offender who harms another victim, the conviction of an innocent person, a wrongful police shooting — not only occur in our criminal justice system, but they can occur in seemingly routine cases. Errors often go undetected and, when they are detected, the detection frequently seems to be the result of extraordinary luck or perseverance after many years.

Certainly, most criminal justice agencies have error-detecting processes in place: consider, for example, police internal affairs reviews and prosecutors’ professional ethics boards. Too often, however, these become a “gotcha” process that assigns blame, which can drive errors underground, making them harder to detect and correct. In other words, the criminal justice system lacks what medicine, aviation, and other high-risk enterprises have found essential to detecting and addressing organizational errors: a nonblaming, all-stakeholder, forward-leaning mechanism through which we can learn from error and make systemwide improvements that go beyond disciplining rulebreakers and render similar errors less likely in the future.

In this publication, the National Institute of Justice (NIJ) explores the feasibility of mobilizing an “organizational accident,” learning-from-error approach in the criminal justice system. We introduce the notion of the “sentinel event”: a bad outcome that no one wants repeated and

that signals the existence of underlying weaknesses in the system.

“Sentinels stand watch,” says James Doyle. “They detect the first signs of a looming threat and sound a warning that should not be ignored.” Beginning on page 3, Mr. Doyle — who served as a Visiting Fellow at NIJ for two years — discusses how the medical field first heard sentinel event warnings with the rise of unexpected infections acquired in hospitals and when “wrong patient” surgeries occurred. In aviation, sentinel event warnings are sounded each time an airplane crashes or a near miss occurs.

In criminal justice, a sentinel event could be similarly easy to recognize: the exoneration of an innocent person; the release from prison of a dangerous person; or even a near miss in which an innocent suspect was arrested, processed, and held until the error was finally discovered and greater harm was avoided. Could these sentinel events signal underlying weaknesses in the justice system? Could an all-stakeholder, nonblaming, forward-looking review of such events lead to greater system strength and effectiveness?

Mr. Doyle explains that, when bad outcomes occur in a complex social system — like our justice system — they are rarely the result of one individual’s mistake. Rather, multiple small errors combine and are exacerbated by underlying system weaknesses. After the exoneration of an innocent person, for example, the answer to the question, “Who is responsible for this wrongful conviction?” is, almost invariably, “Everyone involved, to one degree or another . . . if not by making a mistake, then by failing to catch one.” And “everyone” can include not only those who operate at the sharp end of the system, like the police, but also, Doyle writes, “the distant actors who set their budgets, assign their caseloads and define their legal authority.”

We also present a collection of commentaries from highly respected “early adopters” who offer their unique perspectives regarding the innovative notion of a sentinel event review process in the justice system.

Milwaukee District Attorney John Chisholm reflects on his experience as a young Army officer when “after-action reviews” were instituted in an effort to improve system performance. “The goal was to encourage leaders to honestly acknowledge and learn from mistakes,” he writes. “It also encouraged nonlinear thinking and initiative by junior leaders (like me), by elevating the status of all participants and treating them as equals.”

Madeline deLone, executive director of the Innocence Project, endorses the idea of a sentinel events approach and builds on lessons she learned as a prison health care administrator on Rikers Island. Dr. Barney Melekian, former director of the Office of Community Oriented Policing Services (COPS), writes that all-stakeholder, nonblaming reviews would push beyond whether a police officer, for example, “utilized a ‘workaround’— whether he or she zigged instead of zagged — but would address why and how the system put him or her in a position where that seemed like the best or least bad choice available.” And Greg Matheson, former director of the Los Angeles Police Department laboratory, writes that developing a sentinel event process, aimed at continuous systemwide quality improvement, “is an opportunity we cannot afford to lose.”

Several commentaries look at the important element of *nonblaming* in a sentinel event review process. Jennifer Thompson — whose erroneous identification of the man who raped her played a role in sending an innocent man to prison for more than 10 years — speaks truth to power about “the blame game” that can prevent us from learning from error.

At first glance, these individual commentaries may seem to speak only to the separate components, or “silos,” of the criminal justice system — the police or victims, prosecutors or crime labs, defense counsel or academics or judges. But, as you read them, we invite you to remember that each silo operates within a much larger system. And it is the *interdependence* of these separate silos that lies at the heart of NIJ’s Sentinel Events Initiative. Indeed, it is the great “gravitational pull” generated by cultures within each silo that argues for the creation of an opposing force: a true systemwide analysis of errors *across* the entire criminal justice system.

### Building the Science

Every error that occurs in our criminal justice system — every episode of failed justice — inflicts specific harms: An individual is wrongfully convicted, a criminal goes free, a victim is deprived of justice, a community is ill-served, and the agencies of justice emerge more tarnished and less trusted than before. Although it is imperative to address these specific harms, that alone is not enough. Errors must be recognized as potential sentinel events that could signal more complex flaws that threaten the integrity of the system as a whole.

As the science agency of the Department of Justice, NIJ is focused on answering key research questions about the sentinel events approach of learning from error:

- Can the many parts of the justice system participate fully in a nonblaming review of an error that moves beyond ascribing blame toward future, “preventive” accountability?
- Does such an approach provide a means to achieve desired outcomes, such as increased effectiveness and fewer errors, and other public safety dividends, such as greater public perception of integrity of the nation’s justice system?
- Can a sentinel events approach be sustained over time and incorporated into the routine activities of state and local justice processes?

The successes of sentinel event reviews in other professions inspire us to imagine a justice system that is constantly working to understand itself and its errors and is strengthening its processes by embracing a forward-leaning approach where shared responsibility prevails over finger-pointing and blaming. Yet we do not take this inspiration as an article of blind faith: NIJ’s commitment to testing, analyzing and objective evaluation remains uncompromised. The evidence may show that efforts to adopt a sentinel events approach in criminal justice are not feasible or effective, or it may reveal that these are indeed the first formative steps in a revolution that ensures a system that is fair, unbiased and worthy of our highest ideals.

## Learning From Error in the Criminal Justice System: Sentinel Event Reviews

By James M. Doyle

**D**NA exonerations of wrongfully convicted defendants have thrown new light on the problem of error in criminal justice, revealing a gap in our system's design. The U.S. criminal justice system lacks a feature that medicine, aviation and other high-risk enterprises see as critical: a way to account for unintended tragic outcomes, to learn lessons from our errors, and to use these lessons to reduce future risks.

Many fields facing high-risk incidents have responded to the dangers exposed by known errors by developing —

- The consistent practice of an all-stakeholder, nonblaming, forward-looking examination of known errors and other sentinel events, and
- The means for mobilizing and sharing the lessons of sentinel events in an ongoing conversation among practitioners, researchers and policymakers.

Sentinels stand watch. They are the first to see threats, and they sound a warning before those threats can do harm. A sentinel event in the criminal justice system warns us of threats to justice, and it calls us to act. It is a significant, unexpected negative outcome that signals a possible weakness in the system or process. Sentinel events are likely the result of compounded errors and — if properly analyzed and addressed — may provide important keys to strengthening the system and preventing future adverse events or outcomes.

Medical professionals use sentinel event reviews to examine unexpected patient deaths, medication errors, wrong-patient surgeries, “near misses” and similar incidents to account for their root causes. These reviews focus on reducing future risk, not on fixing blame for past mistakes. They look over the horizon to intercept preventable harms.

Can our criminal justice system develop this capacity for forward-looking accountability?<sup>1</sup> Can we enhance professionalism by accepting error as an inevitable

element of the human condition and studying known errors in a disciplined and consistent way? Can we focus on addressing future risk instead of fixing blame for past events? Can we share lessons learned to prevent future errors?

During my two years as a Visiting Fellow at the National Institute of Justice, I began a reconnaissance: a preliminary exploration of the potential for mobilizing in our criminal justice system the lessons that industry, aviation and medical safety reformers learned as they used sentinel events to develop “cultures of safety.”

### Lessons Learned From the Medical Field

One way to see the learning opportunities presented by criminal justice sentinel events is to consider contemporary medicine's encounter with its own version of the problem: “iatrogenic” injuries to patients or harms caused by medical treatment.

Just as the criminal justice system is haunted by the fact that it sometimes convicts the wrong person, medicine is haunted by the fact that it sometimes operates on the wrong patient.<sup>2</sup> When modern medical researchers began to look carefully into wrong-patient events, they uncovered surprising insights. For example, one intensive examination of a wrong-patient surgery discovered at least 17 errors — among them, that the patient's face was draped so that the physicians could not see it; a resident left, assuming the attending physician had ordered the invasive surgery without telling him; conflicting charts were overlooked; and contradictory patient stickers were ignored. The researchers' analysis showed not only mistakes made by individual doctors and nurses but also latent systemic problems. Communications between staff members were terrible, and computer systems did not share information. When teams failed to function, no one was concerned because of a culture of low expectations that “led [staff] to conclude that these red flags signified not unusual, worrisome harbingers but rather mundane repetitions of the poor communication to which they become inured.”<sup>3</sup>

### What is a Criminal Justice Sentinel Event?

What would constitute a sentinel event in criminal justice? Wrongful convictions, certainly, but also “near miss” acquittals and dismissals of cases that at earlier points seemed solid; cold cases that stayed cold too long; “wrongful releases” of dangerous or factually guilty criminals or of vulnerable mentally handicapped arrestees; and failures to prevent domestic violence within at-risk families.

Sentinel events can include episodes that are “within policy” but disastrous in terms of community relations (such as the arrest of Harvard professor Henry Louis Gates), whether or not everyone agrees that the event should be classified as an “error.” Even the lengthy and expensive incarceration of a harmless geriatric prisoner, where the excessive cost constitutes the harm, could be examined as a sentinel event.

In fact, anything that stakeholders can agree should not happen again could be considered a sentinel event.

Deviations from good practice had become normal — and a tragedy resulted.

The crucial point for the researchers, however, was that no single one of the 17 errors could have caused the wrong-patient surgery by itself.<sup>3</sup>

The bottom line: Researchers in the medical field determined that many avoidable harms, including wrong-patient surgeries, were the result of an “organizational accident.”

### Criminal Justice Errors as Organizational Accidents

No single error can cause an organizational accident independently; the errors of many individuals (“active errors”) converge and interact with system weaknesses (“latent conditions”), increasing the likelihood that individual errors will do harm. The practitioners and organizations involved in these tragedies do not *choose* to make errors. These events involved normal people, doing normal work, in normal organizations,<sup>4</sup> and they suffer, in Charles Perrow’s memorable phrase, “normal accidents.”<sup>5</sup> Like the Challenger launch decision, the outcomes reflect “mistake[s] embedded in the banality of organizational life.”<sup>6</sup>

Consider our traditional wrongful conviction narrative: The witness picks the wrong man, the cops and district attorney believe the witness, and so does the jury. The inadequacies of this narrative emerge as soon as we apply the organizational accident concept.

A wrongful conviction is not the result of a single error, nor is it the fault of one operator or one investigative technique. As in a wrong-patient surgery, many things have to go wrong before the wrong person is convicted. Yes, the eyewitness does have to choose the wrong man from the photo array, but before that, law enforcement officers have to decide to put him into the array, design the format of the array and choreograph its display. Forensic evidence at the crime scene could have been overlooked or — even if properly collected and then tested in the lab — distorted during the courtroom presentation. Cell phone, mass transit card data or other alibi information could have been ignored. Tunnel vision — augmented by clearance rate and caseload pressures from above — may have overwhelmed the investigators and the prosecutors.<sup>7</sup> Poorly funded or untrained defense counsel may have failed to investigate alternative explanations or to execute effective cross-examination. The witness erred; the police erred; the technicians erred; the prosecutors erred; the defense erred; the judge and the jury erred; and the appellate court erred, too.

No single error would have been enough. The errors combined and cascaded — *then* there was a tragedy.

In an organizational accident, the correct answer to the question, “Who is responsible?” is almost invariably, “Everyone involved, to one degree or another,” if not for making a mistake, then by failing to catch someone else’s. In the instance of a wrongful conviction, “everyone” may include not only witnesses, police, forensic scientists and lawyers at the sharp end of the

system, but also legislators, policymakers, funders and appellate judges who were far from the scene of the event but who helped design the system and dictated the conditions under which the sharp-end operators work.

### The Problem With Single-Cause Approaches to Understanding Error

When we apply the organizational accident concept to a criminal justice sentinel event, it illuminates the limitations of two conceptions of error that criminal justice reformers, horrified by miscarriages of justice, have adopted almost by reflex:

- **Bad apples:** This conception of error focuses on punishing individual actors to guarantee overall system reliability.
- **Swiss cheese:** This conception of error focuses on performing a sequence of independent protective “screens” that culminates in an end-of-process adversary inspection to ensure quality control. It inspires efforts to repair the component screens individually — the police reform investigation practices, the district attorneys reform prosecutorial practices, and so on.

Safety experts see these approaches as inadequate. In fact, they see them as dangerous traps.<sup>8</sup>

#### Bad apples: Why this approach is not enough

In criminal justice, we traditionally take an approach to error that assumes a “bad apple” operator is responsible. Someone must be to blame for the error, so the impulse is to find and discipline that person. This is what people typically mean when they call for “accountability” in the aftermath of the exoneration of an innocent person.<sup>9</sup> The bad-apple orientation, however, is inadequate to describe how things go wrong, and it has a crippling impact on efforts to prevent future errors.

Traditionally, medicine was governed by a similar assumption. As Dr. Lucian Leape, a professor at the Harvard University School of Public Health and a pioneer in the patient safety movement, wrote in his seminal essay, “Error in Medicine”:<sup>10</sup>

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?

Medicine often convened its “morbidity and mortality” reviews following adverse events in this spirit, and in the eyes of the front-line practitioners, they became exercises in “blaming and shaming.”<sup>11</sup>

Medical culture’s “good man, good result” attitude translates seamlessly to criminal justice. In the “bad apple” approach to error analysis, the error occurred because some doctor (or police officer), nurse (or forensic scientist), or x-ray technician (or lawyer) was lazy, ill-trained, venal or careless. In the bad apple approach, the task of conscientious professionals is to act as the custodians of a presumptively safe system and to protect it from incompetent and destructive individuals.<sup>4</sup>

It may be human nature to think that a big tragedy must have a big cause and that a tragic event requires that tragic punitive consequences fall on somebody. Besides, no field can function without employing disciplinary tools. A sentinel events approach to reviewing mistakes does not eliminate disciplinary consequences for consciously unethical behavior or knowing violations of settled rules.<sup>12</sup> But it does see punishment of the lone bad apple as the wrong place to stop. We cannot discipline our way to safety, and equating “accountability” exclusively with blame and punishment has potentially crippling consequences.

By focusing exclusively on ascribing blame, we drive many valuable reports of errors underground and leave latent system weaknesses unaddressed. Practitioners do not want to be blamed, and they do not want to become entangled in the unpredictable machinery of blaming colleagues. Inevitably, in a blame-oriented system, less and less gets reported and less and less is learned.

This dynamic applies at the agency as well as the individual level. When a notorious sentinel event cannot be buried completely, the impulse to keep it “in house” or to try to shift the blame to someone else’s “house” intensifies. But because no individual house can ever fully explain an organizational accident, this approach allows overlapping weaknesses that might be studied and understood to remain latent in the system. Searching for a single cause prevents us from understanding how complex systems fail through the confluent, cascading errors — active and passive — of multiple contributors from many houses.<sup>13</sup>

Even where we can identify a bad apple — a corrupt or incompetent forensic scientist, for example, or a prosecutor who buries plainly exculpatory evidence — the lone villain approach is incomplete. Surrounding the bad apple are the people who hired him, created his work environment and failed to catch his mistakes. They, and the vulnerabilities they contribute, will still be with us after the bad apple is removed. We never ask the critical question, “Why did this decision look like the best (or, perhaps, the least bad) choice to the bad apple at the time?”

The question is whether discipline and forward-looking risk reduction can be held in balance. Can we hold people accountable and still stay mindful of the future — that is, can we give the “good guys” in the system something to do besides trying to hunt down and punish the “bad guys.”

#### **Swiss cheese: Why this approach is not enough**

The “Swiss cheese” approach is an alternative conception of error that sometimes supplements the “bad apple” theory. In this view, error moves in a straight line from its origin (often in the act of a bad apple) to its tragic result unless it is blocked somewhere by one of a succession of barriers: a sequence of increasingly fine screens, each “inspecting” the output of the preceding screen. The system is envisioned as a model of defense in depth. So, in the criminal justice system, an erroneous “wrong man” prosecution must pass through a police supervisory screen, a crime lab screen, a prosecutorial screen, a grand jury screen, an adversary trial screen and an appellate review screen, among others, before it can take effect. This will happen only when — in a kind of

folk version of James Reason’s famous “Swiss cheese” model of accident causation — there is a hole in each of the screens and those holes happen to line up, allowing the error a clear path to its horrific final impact.<sup>14,15</sup>

Viewed in this way, the systemic problem that, for example, a wrongful conviction reveals is a failure in component *structures*. As a result, solutions are most often seen in structural terms. This interpretation of systemic failure offers two strategies for preventing wrongful convictions by making structural reforms: (1) We might independently patch holes in each screen internally by adopting new best practices, such as double-blind sequential lineup techniques in police investigations or reforming indigent defense services by providing checklists, or (2) we might add a new screen through a prosecutor’s conviction integrity unit or a post-conviction actual innocence commission.

The first approach appeals directly to officials’ natural inclination to keep problems “in house” — to “clean up our own mess.” (And, after all, in this view, repairing the hole in any single screen will be enough to block the path of error.) Blue ribbon commissions and working groups have pursued both approaches to generate specific “best practice” recommendations for reforms in components such as eyewitness identification procedures.<sup>16,17</sup> Neither, however, gets at the issue of system reliability.

The fact is, no component of the criminal justice system functions in isolation. The work the prosecutors do is affected by choices the police make “upstream,” and the choices that the police make are often made in anticipation of what the “downstream” prosecutors and defenders will do. Any screen can open a hole in any adjoining screen. In addition, the options of all of the front-line operators are constantly shaped and reshaped by the distant actors who set their budgets, assign their caseloads and define their legal authority.

#### **Addressing System Reliability**

Either the “bad apple” or “Swiss cheese” orientation can improve the odds against another error, but because neither engages the systemic nature of the problems, the “solutions” they generate stop short of optimizing the system’s reliability. In fact, solutions that address only a single component may simply relocate the problem and

create new dangers. Medical safety experts, for example, have learned that “Nothing threatens safety so much as the complacency induced when an organization thinks that a problem is solved.”<sup>18</sup>

No new set of best practices or checklists can cover every circumstance, so an irreducible zone of discretion always survives, and operators must manage life within that zone.<sup>13</sup> The new sets of best practices and checklists that innocence commissions, technical working groups and other blue ribbon efforts generate have to be operationalized and executed, and they have to be maintained, monitored, evaluated and perhaps replaced when environments change or science or technology advances.<sup>18</sup>

Every new checklist comes under immediate and constant assault from caseload, clearance rate, budget, political, media and other environmental factors from the moment it is written. Workers at the sharp end of the system may feel forced to decide which of the new checklist's 10 steps they can live without *this* time. Triage is required, and workarounds multiply. No one had more (or more carefully devised) checklists than the National Aeronautics and Space Administration (NASA), but the agency launched Challenger and Columbia anyway.

Drift toward failure is a threat to the new best practices just as it was to their now discredited predecessors.<sup>15</sup> As Sidney Dekker observes:<sup>19</sup>

The organizational decisions that are seen as “bad decisions” after the accident (even though they seemed like perfectly acceptable ideas at the time) are seldom big, risky steps. Rather, there is a long and steady progression of small, incremental steps that unwittingly take an operation toward its boundaries. Each step away from the original norm that meets with empirical success (and no obvious sacrifice of safety) is used as the next basis from which to depart just that little bit more. It is this incrementalism that makes distinguishing the abnormal from the normal so difficult. If the difference between what “should be done” (or what was done successfully yesterday) and what is done successfully today is minute, then this slight departure from an earlier established norm is not worth remarking or reporting on.

Going “down and in” to find a single broken component will not be enough to explain these events and prevent their recurrence; we also have to go “up and out” to assess the complex environment that shaped the choice of the component, allowed the component to fail and made the failure catastrophic.<sup>15</sup> “Reliability” (and its opposite) in criminal justice can no more be seen in a single component than “wetness” can be seen in a single molecule of H<sub>2</sub>O. Both fine-grained local knowledge and alertness to the pressures from the system's larger environment are indispensable.

Many tragic mishaps could never have been predicted (and cannot now be completely explained) by reference to individual components. These tragedies are “emergent” events with origins in the “greater than the sum of its parts” zone found in all systems.<sup>15</sup> No structural fix provides permanent protection.

### Culture, Not Structures

Although the phrase “criminal justice system” is everywhere, the system does not present itself as an arrangement of gears and switches that can be fixed with a wrench or new spare part. One objection to applying the organizational accident model to criminal justice might be, “Where is this ‘organization’ you are talking about?” This is a fair question, but it is clear that the criminal justice process at least functions as an ecosystem, like a pond or a swamp in which something (funding, for example) dumped on the near coast has mysterious and unanticipated effects on the far shore. Improving property crime investigations by swabbing every crime scene could create a backlog of rape kits in the lab. A backlog in the lab means a backlog in the courts; a backlog in the courts means more pressure for plea bargaining.

The medical reformers, facing an analogous situation, became convinced that patient safety could not be dealt with as a matter of structure but must be addressed as a question of culture. They advocated that hospitals facing a rising tide of patient injuries should mobilize the findings of “human factors” researchers like James Reason, who argued that errors are inevitable in human performance and that the best path toward reliable performance in complex organizations is the creation of a “culture of safety.”<sup>14</sup>

A culture of safety exists when an organization:

1. Is informed about current knowledge in its field.
2. Promotes the reporting of errors and near misses.
3. Creates an atmosphere of trust in which people are encouraged to report safety-related information.
4. Remains flexible in adapting to changing demands (e.g., by shifting from steeply hierarchical modes into flatter team-oriented professional structures).
5. Is willing and able to learn about and adjust the functioning of its safety systems.

Ironically, we can see a critical vulnerability in the culture of criminal justice most clearly by noting the absence of a structural feature: a vehicle for “forward-looking accountability” that treats mistakes as sentinel events from which all stakeholders could learn the lessons that are important to preventing future harms.<sup>1</sup> Preventing future harms requires more than a catalog of current defects in existing screens; it also requires an understanding of the processes by which those defects were created — that is, the processes from which tomorrow’s defects will emerge. If we do not fully understand how each screen is related to the others (or how all of the screens are related to the entire environment), we will always stay one tragedy behind.

The police operate a “production stage,” during which they make the cases, often with the participation of the prosecutors. Then the prosecutors, together with defense lawyers and judges, conduct an “inspection stage” that culminates in an adversary trial, at which the law enforcement team is required to account for the work it has produced.

It is axiomatic in all industries that end-of-process inspection schemes, although they are necessary components of quality-control systems, are poor routes to achieving overall system quality.<sup>8</sup> Inspection processes tend to be captured by the people being inspected: people whose principal concern is their own security and who learn to “game” the inspection when they cannot evade it. Criminal justice practitioners are not exceptions to this rule.

Besides, the criminal trial is designed to protect an individual citizen; it is designed to inspect outcomes, not to improve processes. A jury that believes it has caught a faulty investigation says “not guilty,” but nothing more. An appellate court that believes an error is “harmless” does not probe further for the sources of the error. The inspection is entirely retrospective, and no one claims that its function is to analyze the investigative and charging processes and make those processes more reliable in all future cases.

### An Ethic of Shared Responsibility

The aftermath of an exoneration case like *Connick v. Thompson*,<sup>20</sup> in which the prosecutors were shown to have hidden proof of innocence, embodies a failure in forward-looking accountability.

In *Connick*, the trial prosecutor withheld crime lab results from the defense, removed a blood sample from the evidence room, and failed to disclose that Thompson had been implicated by someone who had received a reward from the victim’s family. The conviction and death sentence were ultimately overturned on appeal, but no one learned anything from the *Connick* appellate opinions about the deeper, abiding issues in the case’s narrative, and those issues were left to surface again in future cases.

From an organizational accident perspective, the question that *Connick* raises is not whether the choices of the front-line prosecutors as individuals were wrong; of course those choices were wrong. The real question is why the mistaken choices seemed to be good choices at the time.<sup>15</sup> Why did the prosecutors zig instead of zag? The answer cannot be that there was a missing structural element, because a formal structural element was firmly in place: *Brady v. Maryland*,<sup>21</sup> which requires the disclosure of exculpatory evidence, unquestionably applied to the buried evidence in the *Connick* case.

A sentinel event review process would take the opportunity to explore that question. It would ask what in the prosecutors’ environment motivated their mistaken choices and what accounted for the performance of other actors. Were the prosecutors so starved of resources by the city or state that they felt they could not successfully prosecute guilty violent offenders by following the rules?

Had their caseloads crept up to a level where competent, thorough practice seemed impossible? Did they feel that they were so swamped that they needed to bluff the defendant Thompson into a guilty plea by withholding the evidence that might have demonstrated his innocence? Did supervisory oversight slacken for the same reasons? Did they feel acutely vulnerable to irresponsible media or political pressure? Or did the prosecutors believe that the police department was so under-resourced and ill-managed that no prosecutors could ever convict anyone, no matter how guilty, if they played the woeful hand the police dealt them? Were they right? Had the prosecutors moved by small increments down the inculpatory-to-exculpatory spectrum over the years, withholding progressively more exculpatory material but seeing no negative impact from doing so?

Why did the defenders not find the evidence independently? Was it poor training? Inadequate funding? Caseload pressure?

Why did the detectives not know about and address the lawyers' failure to make use of the exculpatory facts that the police investigation had generated? Why did they decide to stand by silently and watch the trial unfold or cooperate in the suppression of the facts? After all, the police were likely to take most of the public blame for any error in the end. Did the prosecutor's office, over time, convince the police that a police practice of "Don't write it down" was a helpful supplement to their own practice of "Don't turn it over"? Were the detectives or the front-line prosecutors caught in the classic administrative double-bind: held accountable for an outcome they did not feel they had the authority to control or influence?<sup>13</sup> Were they like the Korean Airline copilots of the 1990s, described by Malcolm Gladwell in his 2011 book *Outliers*, who were culturally compelled to sit in deferential silence while the senior pilots flew the planes into mountainsides?<sup>22</sup>

If by studying a sentinel event — with all system stakeholders working together in a nonblaming review — we learn that the answer to any of these questions is "yes," or even "yes, up to a point," then we have uncovered something that we can address. This is where an organizational accident approach to the etiology of an error in the criminal justice system is helpful. An organizational accident, sentinel event review process can

allow us to see the consequences of small, incremental local decisions (e.g., raising the caseload by 10 cases or failing to document a single witness interview) that never show immediate and locally visible destructive impacts but contribute to emergent tragedies when they combine with other small errors and system weaknesses and eventually cascade.<sup>15</sup>

Through a sentinel event model, we can begin to recognize where and how correlations that are visible from 30,000 feet reach for, and ultimately affect, work on the ground. It is a model that makes visible hidden correlations between actions that led up to and contributed to the event. It does not allow actors to escape responsibility, but it does allow them to modulate and share responsibility by identifying all who contributed to the error and how they contributed.

Read about precursors from aviation and medicine at <http://nij.gov/topics/justice-system/documents/precursors.pdf>.

### Is Criminal Justice Ready for a Sentinel Events Approach?

The question, "Can you build a sentinel event review vehicle?" is useful only if it is asked in concert with, "If you build it, will they come?"

A number of precursors indicate that the criminal justice system in the U.S. may be ready for a sentinel event review process. To name just a few that have occurred in recent years:

- The Westchester County, New York, District Attorney arranged to have two judges, a former prosecutor and a defense attorney examine the wrongful conviction of Jeffrey Deskovic.<sup>23</sup>
- The Will County, Illinois, sheriff commissioned a review by law enforcement experts in a private consulting firm of the near-miss prosecution of a father wrongly accused of the murder of his daughter.<sup>24</sup>
- The city of Cambridge, Massachusetts, convened a diverse group to conduct an examination of its police practices after the highly publicized arrest of Harvard professor Henry Louis Gates.<sup>25</sup>

- The Milwaukee Homicide Review Commission is an effective, ongoing interagency group that takes a prevention-oriented, public health approach to the lessons from individual homicides.<sup>26</sup>
- The Allegheny County (Pennsylvania) Court of Common Pleas has explored a case review process that uses close examination of cases to illuminate chronic issues.<sup>27</sup>

These and other efforts show that criminal justice error reviews can analyze error without resorting to “gotcha” humiliation of the sharp-end operators.

For an overview of more criminal justice system efforts, see the appendix.

Numerous jurisdictions have demonstrated a broad willingness to work — often at a “blue ribbon” level — in diverse groups. However, these groups have generally focused on creating a product (e.g., a new set of best practices) and typically disband once the product is produced. They rarely deliver close analyses of specific events. Actual innocence commissions that focus on the quasi-adjudication of claims of wrongful conviction, such as the North Carolina Actual Innocence Commission, perform a different, retrospective role. Their goal is not to mobilize the culture-changing routine *practice* of learning from error that a sentinel event review contemplates.

Still, all of these efforts are encouraging harbingers. Fifteen years ago, a group that included prosecutors, police and defenders would have been an anomaly; today, it is an accepted approach to examining a perceived problem. Significantly, the diverse stakeholders who have participated in these efforts often describe them as among the most satisfying experiences of their professional lives. There seems to be room for the system’s adversarial traditions to coexist with an ethic of shared responsibility for just outcomes.

As promising as these precursors may be, the fact that nothing quite like a sustained, fully developed nonblaming approach that engages all stakeholders has yet appeared indicates that the course for any further exploration should be charted with care. This recognition led me to apply for a fellowship at NIJ — and led NIJ to support this investigation over the last two years.

## Listening to the Field: Reactions From Criminal Justice Stakeholders

In assessing whether a novel sentinel events approach could succeed in introducing forward-looking accountability into criminal practice, raising the right questions with the right people became very important.

Two sources of relevant questions were readily available. The first was the rich body of theoretical and empirical literature that examines the diffusion of innovation, asking, “Which innovations take hold and flourish? Why?” The second was a more recently developed body of business literature analyzing the decision of whether to bring a new service or product to market.

Read about the framework for evaluating field receptivity at <http://nij.gov/topics/justice-system/documents/field-evaluation.pdf>.

Finding the right people to answer the questions derived from these disciplines was not a complex task: The idea was to talk to as many stakeholders as possible. During my fellowship, I engaged many stakeholders in many forums. My work included encounters — sometimes brief, sometimes extended — with crime victims; victims’ advocates; police executives; police investigators; police labor representatives; prosecutors; defenders; judges; corrections experts; academics from law, criminal justice and allied social sciences; journalists; municipal risk managers; medical reform and patient safety leaders; violence prevention experts; plaintiffs’ lawyers for exonerees; civil lawyers defending misconduct cases; and print and online publication and dissemination professionals.

I used several vehicles to introduce basic sentinel event concepts to these stakeholders and to solicit stakeholders’ responses:

- **Publishing articles in journals aimed at stakeholder communities in law, criminology and criminal justice, policing and the judiciary.** The articles presented core concepts from the medical and aviation reform movements and the potential for a criminal justice sentinel event review for critique.<sup>28</sup>
- **Making presentations to — and receiving responses from — stakeholder audiences at numerous venues.** The venues included the Police

Foundation’s “Ideas in American Policing” series, the International Association of Chiefs of Police’s Wrongful Convictions Summit, the Innocence Network’s National Conference, the Executive Session on Policing and Public Safety cohosted by NIJ and the Harvard Kennedy School, and the National Defense Investigators Association’s annual meeting.

- **Conducting stakeholder interviews.** My interview outline was based on the diffusion of innovation and new service marketing research, but the interviews were conversational and allowed practitioners to discuss what they felt was most important.
- **Organizing a more formal set of focus groups.** These included a police executive group, a police investigators group and a prosecutorial/judicial group at the University of New Haven.

The conversations that occurred during my two-year fellowship at NIJ indicated that state and local stakeholders would welcome an effort to exploit the lessons of a sentinel event review process. That put NIJ at the threshold of a move forward. Still, there was a general sense that added doses of criticism and analysis were needed before NIJ could shape a concrete, testable effort. My NIJ colleagues were well aware of both the general theory of the diffusion of innovation and the specific lessons learned during the medical campaign against patient injuries. This led them to organize an all-stakeholders, expert roundtable modeled on medicine’s “communities of insight”: a group with members who could critique the application of “culture of safety” concepts to criminal justice and mobilize their personal networks in diverse practice communities to seek out early adopters and — just as important — to hear out skeptics.<sup>2</sup>

This sentinel events roundtable was held in May 2013 and included police leaders, an elected district attorney, defenders, criminal justice researchers, a medical safety expert, policymakers, a crime victim and others. The discussion exposed this wide range of stakeholders to sentinel event concepts, to each other’s concerns, and to the findings of various professionals and researchers already working in this area.<sup>29</sup> It provided NIJ with the opportunity to test in greater depth the idea of developing a criminal justice version of the culture of safety approach

that hospital medicine has found transformative. And, importantly, the roundtable provided a venue for developing the testable questions regarding a sentinel event review process, which is crucial to NIJ’s mission as a science agency.

The roundtable discussion, like the interviews I conducted during my fellowship, examined the potential for further exploration of a sentinel events approach in criminal justice and, particularly, how such an effort could capitalize on research regarding diffusion of innovation and new services development. Ultimately, as I found in my interviews of the wide breadth of criminal justice stakeholders, the consensus of the roundtable participants coalesced around the assertion of Mike Jacobson, then the director of the Vera Institute and a roundtable member, who said: “If you want to learn something, *do* something.” There was consensus that an experimental program — testing the potential of a systematic, nonblaming, all-stakeholder effort to learn from error in the field — would be a valuable next step.

### From Listening to Doing

After considering responses from the field and the expert advice of the roundtable participants, NIJ stepped across the threshold from listening to doing and launched the Sentinel Event Initiative (SEI).

In the spring of 2014, NIJ issued a solicitation for research to explore issues of organizational change and other features that could be unique to using an all-stakeholder, nonblaming error-review process in the criminal justice system. NIJ also selected three jurisdictions to participate as “beta” pilot sites. This ongoing project is receiving support from the Diagnostic Center of the Office of Justice Programs to execute preliminary prototypes of sentinel event reviews. Each beta site has formed an all-stakeholders team, selected a “sentinel event” in their jurisdiction, and is currently engaged in a nonblaming review process. As stated in the Introduction to this publication — and consistent with NIJ’s belief that the best way to learn is by testing carefully framed inquiries in the field — the beta site explorations are designed to further refine the “testable questions” that a future, more comprehensive experiment of a sentinel events effort could examine.

As NIJ continues to explore the viability of a sentinel events approach to learning from error in the criminal justice system, many of the issues identified by stakeholders during my two-year fellowship will be addressed, including, as briefly discussed below, system legitimacy, resources, liability and confidentiality, risk management, and leadership and collaboration.

#### **Professionalism, legitimacy and self-respect**

Research shows that people do not obey the law because they are certain they will be punished for their violations; people obey the law when they trust it and the people who administer it — when they are convinced that if they do obey the law they will get what they deserve and they will *not* get what they do not deserve.<sup>30</sup>

Criminal justice stakeholders recognize that the National Transportation Safety Board's post-crash analyses are an important source of public faith in the aviation system. Many would like to see the day when a district attorney announcing an exoneration could say, "We will wait for the report to see what went wrong," and have the public believe that the prosecutor has an objective analysis, not a whitewash, in mind. But the majority of criminal justice stakeholders I encountered do not see that day as having arrived, and they see barriers to its advent.

The practitioners who operate at the criminal justice system's sharp end whom I interviewed — the people who do the work on the streets and in the courts — were not primarily interested in the debate over the precise rate of wrongful convictions that fascinates scholars and commentators. For conscientious practitioners, any wrongful conviction is one too many. Practitioners — especially police practitioners — know that every innocent defendant imprisoned means a guilty criminal left free to find further victims, and this undermines public confidence in criminal justice. For sharp-end practitioners, wrongful convictions and other errors are usually seen as matters of workmanship, professionalism and ultimately, self-respect — not of public policy.

Stakeholders are convinced that the broad participation required by sentinel event reporting and review will produce its own benefits, distinct from — and potentially more important than — the value of the content of any reports. The *practice* of generating organizational error analysis can place local criminal justice systems on the

threshold of a fundamental cultural change. It can provide practitioners with a venue in which to express their commitment to accuracy.

One central lesson from the medical experience is that all of the contending and isolated communities of practice within the hospitals shared a hatred of patient injury, providing a common ground on which they can work together to evaluate past errors in order to eliminate future errors.<sup>31</sup>

Devising and operating experimental sentinel event reviews within local jurisdictions will help determine whether the stakeholders' ethic of shared responsibility for just outcomes in criminal justice can sustain a frank, nonblaming analysis of events that will allow the public to witness the professionalism and commitment of the system's practitioners in action and nourish public trust in the system and its operators.

#### **Time and money**

A sentinel events effort will not require new buildings or new technology or new staff, but it will not be free. An experimental effort to examine the feasibility of a sentinel event review process could develop an informed estimate of the level of local governmental and other support that would be needed to sustain the effort as an ongoing practice. At this point, it appears that the financial support necessary to attract and compensate pioneering participants in a criminal justice sentinel events effort may be quite modest, but a catalog of potential alternative sources of early-stage support, such as private foundations, is worth developing.

One challenge will be to develop a format that does not require local officials to sign a blank check in terms of staff time. There is, after all, a sense in which there is always more to be learned from an event. A key product of the preliminary explorations could be a better understanding of how much analysis of a sentinel event will be enough. In medicine, the Joint Commission on Accreditation of Hospital Organizations (JCAHO) successfully took the approach of publishing a model form for reporting on the "root-cause analysis" of sentinel events. A similar model in criminal justice may allow stakeholders to weigh their willingness to become early adopters of the idea and the efficacy of targeting a specific candidate event for a sentinel event review.

### Liability and confidentiality

Throughout my two-year NIJ fellowship, stakeholders' general reaction to the idea of exploring a sentinel event review process was extremely positive. That said, some reactions took the form, "Sounds great, but my chief (or union or district attorney or defense lawyer, etc.) will never go along." Sometimes these warnings were simply about a particular personality, but they often reflected deeper concerns. Many of these concerns — including inertia and the difficulty of translating the lessons of one field to another — are faced when trying to implement any innovation, but two key, related challenges stood out: concerns over liability and confidentiality.

It is clear that stakeholders will have to grapple with their fear of lawsuits or internal discipline and assess how these should be weighed against the potential benefits of future risk reduction. No one in local criminal justice leadership will willingly expose his or her agency and its staff to aggravated financial liability or gratuitous public humiliation. Financial cost is not the only — and possibly not even the most painful — potential harm practitioners fear. Public embarrassment, internal discipline, partisan political vulnerability, and harm to individual professional reputations are all seen as dangerous. Even stakeholders who voice willingness to offer broad disclosure on their own part express concerns about exposing their colleagues' actions to review.

Such concerns should not be overstated at this point. The general stakeholder response during my exploration was not that these issues make sentinel event analysis impossible. Stakeholders seemed to feel that the liability challenge was one challenge among others — and represents the sort of challenge that people are used to working through, not a deal-breaking obstacle. The stakeholders recognized that other fields, such as medicine, where the liability fears are acute, have found ways to cope with issues of liability and confidentiality.

Still, both real and imaginary liability issues will need to be investigated. Will a particular form of reporting and analysis prove necessary as we learn more through experimentation and exploration across a range of sentinel events? In cases of wrongful conviction, it could be argued that the worst exposure has already happened. In the review of a "near miss" event, liability concerns

are likely to be significantly less acute, since the most catastrophic harm was prevented. Criminal justice stakeholders who participated in NIJ's 2013 roundtable discussion and in other focus groups and forums seemed to agree that if you are going to be sued, then you are going to be sued, with or without a sentinel event review process. Indeed, once you have been sued, the usual discovery processes of civil litigation require very broad disclosure, far more extensive than a sentinel event discussion would likely provoke.

With respect to liability issues, then, the additional, marginal costs of engaging in a sentinel event review may turn out to be quite limited. And, of course, if the process results in systemwide changes that prevent similar errors in the future, the cost-benefit analysis might reveal that reductions in potential future liability more than compensate for the "risks" of transparency.

Other fields have deployed a broad array of protections and procedures designed to meet these concerns. JCAHO, for example, offers hospitals reporting sentinel events several ways to marshal facts and handle and retrieve documents, all designed to protect confidentiality. And, within the Justice Department, the Office for Victims of Crime has supported significant work on developing elder abuse review teams: *Elder Abuse Fatality Review Teams: A Replication Manual* provides an illuminating picture of the paths that demonstration projects in diverse jurisdictions took in addressing and resolving confidentiality questions.

Each jurisdiction is likely to present its own complex legal landscape of peer-review privileges, open-meeting laws, attorney work-product privileges, and public-record laws. Because the exposure of local stakeholders and the vehicles that might shelter them will vary from place to place, the most satisfactory resolutions of confidentiality issues are likely to be locally designed. The considerations may shift depending on, for example, whether the organizer of the review team is a local judicial entity, a city attorney, a police department or a school of criminal justice. In some jurisdictions, for instance, a sentinel event review conducted by a school of criminal justice or the judiciary might provide a shield against Freedom of Information Act and public records requests.

Local stakeholder teams may decide to negotiate customized agreements for each sentinel event that they review. Ultimately, this learning-from-error approach envisions the self-conscious study of issues such as confidentiality that are (and will always be) implicated in the risk/liability calculations. The identification — and defense — of a common ground on confidentiality is indispensable to sentinel event reviews, and the design of future confidentiality provisions should be a common subject of investigation as we continue to experiment with a sentinel event review process. Simply put, local system participants must carefully discuss and agree on — through, for example, a Memorandum of Understanding — the confidentiality rules under which they will operate.

### **Risk management**

The hospital environment is no less complex than the criminal justice system. Both encompass many stakeholders with conflicting and overlapping interests, all acutely concerned with potentially devastating exposure to professional liability. The modern medical approach to accepting error as an inevitable feature of human performance and working to provide resilient protections against its dangers has paid dividends not only in cutting the risks of future error but also in increasing public understanding (and reducing the number of lawsuits) when errors are voluntarily disclosed.<sup>32</sup>

There was a general consensus among the stakeholders encountered during my reconnaissance that error prevention as a risk management issue has moved onto (or at least into the range of) the criminal justice agenda in their jurisdictions. Fear of liability drives many decisions and may provide a goad toward preventive action; yet it may also inhibit steps toward all-stakeholder reform. Many criminal justice stakeholders feel that the time is ripe for considering incident liability and risk-reduction concerns in tandem: for an examination that identifies and makes explicit the currently submerged trade-offs between the strategies and tactics involved in pursuing one goal or the other.

### **Local leadership and collaboration**

Initiating a local sentinel event review will require innovative leadership. Although someone in a leadership role must convene other stakeholder groups and encourage them to marshal resources to perform a

nonblaming, forward-looking sentinel event review, the “culture of safety” model requires that no single stakeholder can “own” the effort. Leadership does not mean control, nor can this type of initiative be rammed down the throats of subordinates within or across silos. The effort must be collaborative.

Success will depend not only on avoiding single-silo dominance but also on reaching beyond the usual actors in the criminal justice system’s sharp end. In many of my discussions with criminal justice practitioners, including at the NIJ roundtable, it became clear that simply convening the district attorney, the public defender and the chief judge would not fully exploit the SEI model. Participation by those familiar players will be necessary, but it will also be important to involve other stakeholder communities, such as state and local government risk managers, victims, employee unions, researchers, academics and exonerees.

### **Choosing sentinel events**

The most productive cases for pioneering sentinel event reviews will not always be the biggest or the most notorious or the most shocking cases. Many experts at the NIJ roundtable noted that there is no particular correlation between how much can be learned from an episode and its “bigness.” In fact, notoriety might inhibit the innovative efforts of early adopters, and smaller events could yield the most informative accounts.

Much can be learned from a sentinel event review of “near miss” events that are rarely studied — or barely even noticed — now. The narrative of an individual mistakenly arrested because of a show-up misidentification on the night of a crime and freed six months later by DNA results or by the late discovery of important cell-phone records<sup>33</sup> can be as instructive as an exoneration after a trial and sentencing. In fact, because documents and memories in “near miss” cases are easier to access, a “near miss” episode might be more informative. A “near miss” review could be regarded as accounting for a sort of success by stakeholders (medicine sometimes refers to these as “good catch” events), perhaps diminishing fears of liability and embarrassment. By cultivating an awareness of the value of a “near miss,” or a “good catch,” a sentinel event review begins to build a feedback loop into criminal justice operations that is currently missing.

The shift of focus from blame to risk in a sentinel event review can engage events beyond the traditional “spectacular” incident, where public outcry or overwhelming media pressure compels a review. One of the greatest values of undertaking a sentinel event review is that a jurisdiction’s leaders can show that they choose to engage — without pressure from the media or the public — in a forward-looking process to learn and prevent future errors.

### **Recognizing limitations and managing expectations**

As the criminal justice community explores the value of a sentinel event review process, it is important to recognize resource limitations and manage expectations regarding the final product. Most jurisdictions lack the resources required to produce an exhaustive report such as the three-volume study produced in Canada after the exoneration of Guy Paul Morin.<sup>34</sup> The goal should be to be accurate and useful, not to be perfect, and participants should acknowledge the process’s limitations. In the end, the shift from assigning blame to understanding risk should make the inevitable imperfections and gaps in a review record less daunting. Unlike a strictly disciplinary review, a sentinel event review should allow for the intelligent drawing of inferences and even for the consideration of hypothetical alternative explanations.

### **Transformative Goal and Modest Means**

NIJ’s Sentinel Event Initiative marks a cautious first step toward an ideal of forward-looking accountability. By the “testable questions” it has framed, NIJ indicates that it fully recognizes the possibility of failure. When tested, routine sentinel event reviews may prove to be a bad idea or one of those good ideas that cannot be executed.

Still, encounters with hundreds of criminal justice stakeholders during my two years as a Visiting Fellow at NIJ have convinced me that sentinel event reviews can be transformative if they can be successfully performed. They may present an opportunity for building a criminal justice community in which, as in aviation and medicine, the lessons of sentinel event reviews mobilize a continuous conversation among practitioners, researchers, policymakers and citizens. To appreciate the power for improving criminal justice outcomes that such a community might generate, one need only review the 16 commentaries by diverse criminal justice stakeholders in this publication.

Beyond the benefits that sentinel event reviews would provide for the local jurisdiction, they could also offer the raw material for a voluntary program of learning from error on a much larger scale. A national template for error review — enacted locally and informed and challenged by diverse local experiences — could substantially mitigate the fragmentation of the criminal justice system and the isolation of its practitioners. Reading analyses of a distant system’s experience could alert practitioners to dangers latent in their own local systems. Reading analyses of remote near misses could reveal both dangerous latent features and potential fail-safe devices or procedures that are not present locally. Such a template would require a vehicle for sharing the results of local reviews — perhaps via a “Wiki” or other online tool. But it is precisely this kind of sharing that would promote ongoing, interjurisdictional conversations that could counteract the endemic tendency of today’s best practice standards, which are designed only to provide a minimum floor for performance, calcifying into a disciplinary ceiling that blocks further improvements.

At the beginning of the medical reform movement, Lucien Leape observed that “[e]rror is an inevitable accompaniment of the human condition, even among conscientious professionals with high standards. Errors must be accepted as evidence of systems flaws, not character flaws.”<sup>10</sup> The same is true in criminal justice. There is no reason to avert our eyes from episodes of dishonesty and incompetence when they occur — and they do occur. But cutting the risks of future harm requires working continuously to understand and repair our system, not just slaying the occasional dragon.

Building a culture of safety in criminal justice can begin with a simple commitment to the routine, candid, nonblaming examination of as many errors — completed tragedies and “near misses” — as we can reach. An effort to adopt modern medicine’s experience to contemporary criminal justice can hold the researchers’ statistical findings in productive tension with the gritty narratives of victims, exonerees and front-line operators. It can be both modest and ambitious at the same time: modest in the financial 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.

In medicine, sentinel event reviews helped hospitals introduce a transformative culture of patient safety by putting forward-looking accountability at the center of operational performance. Achieving a comparable transformative effect in criminal justice will require leadership, thoughtfulness and — perhaps above all — collaboration.

There are, of course, no guarantees that the successes of aviation and medicine can be transplanted into the complex and idiosyncratic environment of criminal justice. Still, when the DNA catalog of wrongful convictions delivered a shock in the criminal justice world, the system's operators responded to that shock with extensive investments of time and energy to try to make things right.

As commendable as these efforts have been, they have, for the most part, been isolated within a single stakeholder's stovepipe — and the Sentinel Events Initiative seeks to explore whether the return on these investments can be compounded if we analyze criminal justice errors as “organizational accidents” in which complex events comprising small mistakes combined

with each other and with latent conditions hidden in the system to produce unexpected tragedies. Introducing an organizational accident approach to criminal justice does not call for a domineering, one-size-fits-all federal mandate. A nationwide commitment to fostering the local practice of routinely developing National Transportation Safety Board-style factual reports via a sentinel event review process will provide a more accurate and useful understanding of the causes and means of preventing recurrent errors.

Working steadily on organizational error analysis creates an increased system consciousness among the practitioners who staff the criminal justice system. The forward-looking accountability that this practice creates can be an important — and arguably indispensable — element of a new criminal justice professionalism. Today's police lieutenants, for example, will make better police captains next year thanks to their participation in the rigorous organizational accident analysis of a known error or near miss. All of the system's stakeholders will gain a better understanding of their individual responsibility for the system's collective outcomes from working on all-stakeholder reviews.

### About The Writer

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# COMMENTARIES

## Moving Beyond a Culture of Defensiveness and Isolation

By John Chisholm

As an Army 2nd Lieutenant in the 1980s, I participated in a major reform instituted by the United States military to improve system performance. It centered on the adoption of an objective process to review all operations conducted across the spectrum, from small unit missions to strategic decisions. The reason? Failure. The military services understood they had failed to critically challenge themselves during the Vietnam War and the years that followed, resulting in poor performance and, in some cases, tragedy. The military recognized that to achieve success in a lethal, complex and challenging environment, it had to develop and explicitly demand a culture of accountability in its leaders by teaching them to critically analyze their performance.

The process was known as the “after-action review,” and it taught leaders to assess every mission, regardless of the outcome, to extract valuable lessons learned. The emphasis was primarily on analyzing the things that went wrong as opposed to highlighting and emphasizing success. The goal was to encourage leaders to honestly acknowledge and learn from mistakes in training so you minimized those mistakes when lives and mission success were on the line. It also encouraged nonlinear thinking and initiative by junior leaders (like me), by elevating the status of all participants and treating them as equals.

The military also recognized that most missions involve multiple organizations, often with diverse responsibilities and priorities. Every after-action review convened all the system actors to discuss their role and performance. The process did not seek blame; it sought clarity and elevated even small support players to coequal status in the discussion. It was not uncommon to learn that the most undervalued part of the operation was the primary cause of failure.

The National Institute of Justice (NIJ) Sentinel Events Initiative looks to develop a similar process in the criminal justice system by looking at significant events in the justice process that resulted in failure. I believe this is important because the criminal justice system has not developed the kind of systemic accountability culture pioneered by the military and by experts in such diverse fields as aviation safety and medicine.

Let me be clear — there is plenty of appropriate accountability in the existing adversarial system followed by appellate review. But that tends, in my view, to reinforce a culture of defensiveness and isolation, where the review is focused on the actions of prosecutors, judges and defense attorneys in their respective roles, not on the entire system. My experience as a prosecutor and an elected official teaches me that, in the context of public safety, we cannot afford to limit ourselves to viewing the system in such exclusive ways. Creating a better justice system requires us to expand our definition of the critical actors involved in any event, from citizens, police, corrections, pretrial services, public defenders and defense bar, as well as prosecutors and judges. And we have to create a process where everyone feels empowered to speak the truth about his or her role in any given event.

All-stakeholder, nonblaming, forward-looking sentinel event reviews are by definition retrospective, but if structured properly they can have tremendous prospective value in developing the tools to minimize or prevent failure in the future. A wrongful conviction is by definition a system failure. High recidivism rates, high victimization rates, crowded and inefficient jails and dockets, and historically entrenched pockets of crime are all signs that the system is strained and, as a consequence, more likely to fail in the basic charge of protecting public safety.

NIJ selected three jurisdictions to isolate an event, bring together everyone who had a role in the event, and, in a disciplined, structured way, analyze what occurred, what the actors knew at the time they made decisions, and what could be done to prevent the occurrence in the future. My jurisdiction, Milwaukee, is one of these. We will analyze a tragic event involving a juvenile on supervision for an armed robbery who committed a horrific murder while under supervision in the community. The goal of our review of this “sentinel event” will be to better understand how this event happened and examine the implications across the spectrum of responsibility. What was the juvenile’s history with the court system, and what risk factors did the system determine applied to his situation? Should he have been waived to adult court for the first offense? Should information related to his status have been shared with more system actors (juvenile records are closely guarded in Wisconsin)? What were the intervention opportunities, and ultimately, how could a similar event be prevented in the future?

Some of the lessons learned may implicate discrete actions by a select few; others will have systemwide implications, requiring policy changes and training, structural reorganization and perhaps even legislation. This, indeed, is the “forward-looking” aspect of performing this type of review. With technical assistance provided by NIJ, we hope to create a model tool that can be applied to other decision points in varied areas where we experience notable failures.

Milwaukee is not unique in the challenges of policing a major urban population afflicted with high rates of poverty, unemployment, crime, educational dysfunction and a host of other social challenges. Nor are we unique in our desire to address the needs of our community in a fair and effective way. However, the reality is that we rarely take the time to reflect because we are consumed by the exigent needs of the present. This deprives not only us but future generations of public servants with the lessons learned from hard experience.

It is human nature to close ranks when bad things happen, and the criminal justice system is a deeply human endeavor, reflecting the best and worst of our society. Unlike other systems that have engaged in thoughtful systems analysis, like medicine, our nation's criminal justice system is not infused with the scientific method, nor are we a linear authority model like the military, where once the order is given, everybody must comply. But we can learn from those systems and incorporate the methods they used to improve their respective fields of expertise.

The criminal justice system is increasingly recognizing the need to open up and collaborate with experts from the academic and public health sectors. We can learn from them — and they just might learn a thing or two from us.

### About The Writer

John T. Chisholm is the District Attorney of Milwaukee County. He expanded his nationally recognized Community Prosecution program, designed a Child Protection Advocacy Unit, and formed a Public Integrity Unit to focus on public corruption and a Witness Protection Unit to thwart crime victim and witness intimidation. Mr. Chisholm chairs the Milwaukee County Community Justice Council, is a member of the NIJ-funded Executive Sessions on community corrections, and chairs the Board of Directors of the Association of Prosecuting Attorneys. He also serves on the Milwaukee Homicide Review Commission and the Governor's Council on Offender Reentry boards. Mr. Chisholm is a graduate of Marquette University and the University of Wisconsin Law School.

## To Learn Something, *Do* Something

By Michael Jacobson

On the wall of the main conference room in the Vera Institute of Justice is a quote from its founding director, Herb Sturz. It says, “A wonderful way to develop knowledge is by doing something.” That quote, for me, acutely summarizes my feelings about the next step in the National Institute of Justice’s (NIJ’s) Sentinel Event review process. Given the dynamics of criminal justice policymaking in the United States, there is a yawning need to build a capacity at local and state levels to conduct post-facto and evidence-based reviews of high-profile or significant events (whether they be wrongful convictions, prison riots, heinous crimes committed by parolees or unjustified use of force by law enforcement officers, among hundreds of others) in the criminal justice system. It is an essential government function that, I would argue, is in desperate need of this process and the knowledge that would result from any serious effort to plan and demonstrate sentinel event reviews.

Why do I say that criminal justice especially is in “desperate need” of a well-structured, substantive, research-based and nonpolitical review for meaningful or sentinel events? Because no area of public policy has, over the last 40 years, been more heavily politicized and had policy driven by high-profile or sentinel events more than criminal justice. This is especially true of our policies around punishment, sentencing and incarceration. Every field, of course, has its own high-profile cases or failures. Doctors make mistakes, and patients can die as a result. Yet a case of a doctor who amputates the wrong leg doesn’t lead to the elimination of all amputations. High school students can leave school being functionally illiterate, yet that doesn’t lead to the elimination of high school. Faulty construction on a bridge can lead to a fatal collapse, yet we still build bridges. In all those cases, these fields have their own version of a sentinel event review process that can lead to specific and practical policy proposals to better change practice going forward.

In crime policy, however, a parolee committing a barbaric and sociopathic crime can and does lead to almost immediate policy changes — but not based on a fact- and policy- and procedure-based review — no, it is based on the (understandable) collective public anger and political outrage that something like that could occur, and the jump to the “obvious” solution that parole should be eliminated and sentences severely increased is easy. And that cycle of high-profile crimes is followed by public anger, cries for “justice,” and politicians eager to garner the cheap political capital that follows from ratcheting up punishment, eliminating most judicial discretion. This results in stuffing our prisons and jails with 2.3 million people — an end result that almost every piece of research now says is an unjust and ineffective, in pure public safety terms, use of scarce public resources.

Crime is not just an emotional issue that is capable of provoking intense personal and public reaction but is also a “democratic” one in that almost everyone has an opinion about what to do about crime and criminals — “lock ‘em up, execute him, treat him, etc.” Whether you are a cab driver or a brain surgeon, educated or not, an expert or not, opinions will flow like water about what needs to be done, whether it be about Richard Davis (a parolee who brutally murdered Polly Klass, an 11-year-old girl in California), Bernie Madoff or just a couple of kids who steal from the corner store. Not so with issues like how to build a bridge, how to educate special needs kids, how to mitigate environmental disasters, or how to slow the growth of communicable diseases. In those cases, the public will (usually) defer to the experts. In criminal justice policymaking, however, the public and their political representatives have become the “experts” that drive criminal justice policy — a field that over the last several decades has been almost immune to evidence and knowledge in the face of its overwhelming politicization, despite the fact that the entire issue of crime and why some people commit it and others don’t and what to do with those who do involves the most complex issues of human behavior, psychology, poverty, drug use and mental illness.

### Buffering the political winds

So then, the introduction of a process that is at once a buffer between the political winds that have dictated much of our criminal justice policy and all the complex issues that are ultimately involved in sentinel events seems like an obvious gap in the field — a process, if done correctly, that the public and their political representatives can have some faith in.

Back to Herb’s quote, it is time to do and learn something in this area. The process by which NIJ begins to plan for these sentinel event reviews should be rigorous and draw on the best practice in other fields (and there is a lot of best practice in other fields — medicine, aeronautics, transportation), but in short order there should be some number (not a lot — start small) of demonstration projects that test this notion of expert and evidence-based reviews in criminal justice. Will they all work perfectly? Almost certainly not; even the most rigorous planning and design processes do not always result in projects that are successful. But some will be, and even ones that fail — because the politics are too difficult, because agencies refuse to work together, because labor/management issues are too intractable — will be valuable because we will learn from their missteps, develop knowledge and do it better the next time. And in making criminal justice policy, we have a lot of room to do better.

### About The Writer

Michael P. Jacobson, Ph.D., is the Executive Director of the Institute for State and Local Governance at the City University of New York (CUNY), where he also teaches sociology in the Graduate Center. From 2005 to 2013, Dr. Jacobson was the director of the Vera Institute of Justice. Before that, he was a professor at the CUNY Graduate Center and the John Jay College of Criminal Justice. He served as the New York City Correction Commissioner from 1995 to 1998, and was the city's Probation Commissioner from 1992 to 1996 and Deputy Budget Director of the New York City Office of Management and Budget from 1984 to 1992. Dr. Jacobson is the author of *Downsizing Prisons: How to Reduce Crime and End Mass Incarceration* (New York University Press, 2005).

## No Sticks: Safe Spaces and a Desire to Get Ever Better

By Maddy deLone

Over the past few years there has been an increased focus on sentinel events, all-stakeholder reviews, and learning from error in the criminal justice system. While the fact of wrongful convictions — and particularly what we have learned from studying the DNA exonerations — has propelled it, the discussion does not start or stop there. When I was approached by the National Institute of Justice to participate in a multistakeholder discussion, my thoughts quickly pulled me back in time to the mid-1980s when I was working as a health care administrator on Rikers Island in New York City, running a clinic providing health and mental health care in a 2,600-person jail.

At that time, whenever there was an unexpected death (a suicide or a death in a jail, rather than in a hospital), the Mayor's office (and later the City's Criminal Justice Coordinator) convened a meeting of all stakeholders to review what had happened and to figure out what could be done to prevent such adverse outcomes in the future. The purpose of the meeting was always to improve practices. The group was referred to as the Prison Death Review Board (PDRB).<sup>1</sup> The group was made up of representatives from all relevant agencies and facilities, including representatives from the Mayor's office, the then-Department of Health and the Department of Mental Health, the Department of Correction, the Office of the Chief Medical Examiner, the Health and Hospitals Corporation, the Board of Correction (the independent oversight agency of the City Department of Correction), and other health care providers (often contract providers) involved in the care of the deceased.

In preparation for the meeting, the Board of Correction staff gathered all relevant documents and reports from every agency involved and interviewed jail staff, prisoners in the area who had known or observed the person who had died, and others who might shed light on what had happened. The Board of Correction circulated a draft report prior to the meeting, but the most useful part of the process was the meeting that took place to review and supplement the Board's draft report.

In those meetings, which were always treated as confidential, I recall robust discussions of what had gone wrong. Whether it involved, in a prison suicide, for example, a failure to detect a mental health history on intake, insufficient supervision on a housing block, a problem with medication availability for a period preceding the event, problems with noncollapsible hooks (which were often used for successful suicides by hanging) or other observed and experienced problems, there was a full airing of the factors that contributed to the ultimate tragic outcome. In those meetings, missed opportunities for better collaboration between correctional staff and mental health staff were identified, needs for additional correctional staffing in some housing areas could be raised, and the inadequacy of the quality or quantity of specific clinical services was broached. Because all stakeholders were present — including the Mayor's office with its ability to change policy at the highest levels of the government — when significant process errors were identified, they could be corrected.

Several elements of the process were important for the successful outcomes:

1. Everyone agreed that the bad outcome was bad, and everyone wanted to prevent it from happening again.
2. Everyone at the table had a role in the outcome. There were opportunities to look inside and outside one's own agency. In a discussion where every player could have done better, but no one could have solved the problem alone, there was real opportunity and incentive for problem solving.
3. The events and the reviews were pretty contemporaneous, so that the suggestions for changed practices and policies had potential to save lives in real time.
4. Someone was tasked with staffing the effort. Board of Correction staff and its consultants were given the time and resources to pull together information — it was not an additional task added to already too-full plates of agency staff. The Board staff created a synthesized report that formed the basis of the important discussion that followed.
5. The conversations occurred in a "safe space." The conversations were protected, much like privileged quality assurance discussions in health care settings. This allowed people to admit mistakes more freely on the road to improving the system.

Thinking about transferring this sort of process into the broader criminal justice arena has led me to think about what might have made the PDRB process even more powerful. What if, in the case of a jail suicide, the police, prosecutor, defense attorney and judge had been in the room? What other ideas about system change might have been suggested? Perhaps the expansion to the "whole

system” would have diluted the ability to actually implement changes. Perhaps it would have gotten closer to a root-cause analysis or fundamental reform.

As local criminal justice systems get together to try out an all-stakeholder review process, the PDRB’s experience should provide some useful guidance. The process is possible. Better solutions came about through the PDRB because everyone recognized that systemic problems were the cause of preventable deaths. There were no sticks — or threats of penalties — in the process, just the desire to do much better. There is a lesson in there.

### About The Writer

Madeline deLone is the Executive Director of the Innocence Project, a position she has held since 2004. She began her career as a health care administrator. In the late 1980s, as the Deputy Director of the New York City Board of Correction, Ms. deLone was a member of the New York City Prison Death Review Board, a multidisciplinary and multiagency group that reviewed deaths in New York City jails. She is a graduate of Harvard and Radcliffe Colleges, holds an S.M. in Health Policy and Management from the Harvard School of Public Health, and a J.D. from New York University School of Law.

### Note

1. This process apparently started in the early 1970s in an effort to improve health services. In 1991, when the Board of Correction passed its standards governing the provision of health services in the jails, the Prison Death Review Board was codified as a required part of the Minimum Standards of the New York City jail system.

## The Dilemma of the Moral Imperative

By Bernard Melekian

By its very nature, the practice of policing produces a conflict between two moral imperatives — to adhere to the legal process and to maintain social order. This conflict is exacerbated because these imperatives travel on two distinct, noncomplementary timelines: the timeline of the judicial process and the timeline of action on the street.

In no arena of the criminal justice system is this conflict more evident than when reviewing the actions of the uniformed patrol officer. The patrol officer serves as the gatekeeper for entry into the criminal justice system. In essence, everything that occurs after he or she acts merely serves to affirm or negate the officer's original decision.

Two distinct sets of principles and stakeholders define the conflict between these moral imperatives. On one hand, the officer is expected to adhere to the principles of the law and the Constitution. Her stakeholders in this quest are the courts, where she is evaluated based on whether or not she adhered to rules, policies and laws. The search for "truth" is often seen as secondary to adherence to process. On the other hand, the officer serves both the public and his peers, who demand that he serve the societal good — that is, he must maintain social order and affirm the public expectation that wrongdoing is always punished.

Although the officer may understand intellectually that his role is, in theory at least, merely to serve as an agent of the judicial process and not the final arbiter, his experience often conveys an entirely different message. Moreover, it is not automatic — or even easy — for a front-line officer to remember that he is part of a system.

In the street, officers are often presented with situations that demand, or appear to demand, instant resolution. From the moment the officer arrives at the scene of an incident, pressure to resolve the situation quickly comes both from the people who called and from the policing system (i.e., dispatch), which needs the officer to resolve the situation to return to service. This second factor can be mitigated by a leadership philosophy that emphasizes problem-solving or by working in an environment in which a significant number of calls are not holding at any one time, but the pressure cannot be removed completely.

These conflicting expectations — quick resolution and adherence to process — do not always lend themselves to easy resolution. On the contrary, the effort to resolve the moral dilemma often creates a sense of ambiguity and ambivalence that lends itself to lapses in ethical decision-making.

In the movie *Tombstone*, Val Kilmer's character, a gunslinger and a gambler, performs an action significantly at odds with his normal values: he is found reading a religious book while on his deathbed in a church-run hospital. When asked why, he says, "It appears my hypocrisy knows no bounds."

What he was attempting to say was that the situation in which he found himself did not lend itself to easy adherence to a set of principles, which, although logical in the two-dimensional setting of a conference room, did not assist him in the three-dimensional world (sometimes called reality) in which he was functioning. Similarly, the patrol officer often finds himself in situations that resist, or at least appear to resist, the ability to navigate between conflicting sets of principles and expectations. Life on the street often requires "workarounds."

### Real-world values

The two-dimensional construct asks: What is the officer permitted to do or prohibited from doing? The real-world values construct asks: What should the officer do under the circumstances that present themselves? Replacing a rigid set of laws and policies with a more straightforward statement of values would allow the officer to make decisions within a broader and hopefully more flexible sphere of values orientation.

Supporting this paradigm should be a nonblaming, all-stakeholder review of a critical incident— a sentinel event — that could provide a safe environment where practitioners can discuss life on the borderlands where the two moral imperatives meet and sometimes clash. Such a review would provide the opportunity for people to articulate the rationale for their decisions. Analysis would not stop at whether the officer utilized a "workaround"— whether he or she zigged instead of zagged — but would address why and how the system put him or her in a position where that seemed like the best or "least bad" choice available.

Even where the decision was ultimately proved mistaken, recognizing that it was made with good intentions might provide a means of communicating and refining stakeholder expectations. A discussion based on values compliance rather than strictly on adherence to rules might allow us to bridge the conflicting moral imperatives that patrol officers face.

### About The Writer

Bernard Melekian is the president of The Paratus Group, a public safety consulting company. In 2013, he retired from a long career as a public servant, most recently as the Director of the Office of Community Oriented Policing Services (COPS). Before that, Dr. Melekian was the Police Chief in Pasadena, California, where he also served as acting Fire Chief and Interim City Manager. He served in the U.S. Army from 1967 to 1970 and retired from the Coast Guard Reserves in 2009 after 28 years, including two tours of active duty. Dr. Melekian holds a B.A. and an M.P.A. from California State University at Northridge and a Doctorate in Policy, Planning and Development from the University of Southern California.

## Front-end and Back-end Solutions

By Dan Simon

It is patently obvious that mistakes abound in our personal lives and professional worlds. Who has never forgotten where they placed the car keys, failed to recall the name of a person just introduced at a dinner party, or shown up to a meeting at the wrong time? Likewise, every so often, physicians miss critical symptoms, NASA launches space vehicles that are not flightworthy, and politicians misjudge the public reaction to their miscues and transgressions. Yet many law enforcement personnel routinely insist that the criminal justice system errs rarely, if ever, and many deny reaching an incorrect result in any given case. How, one wonders, could the criminal justice process — unique among all other complex social systems — operate flawlessly?

In truth, the criminal justice process is not, and cannot be expected to be, flawless. The inherently complex process relies on the contributions of hosts of legal actors, including witnesses, investigators, lawyers, jurors and judges. The process is driven by these actors' memories, inferences, judgments and decisions, and the ensuing verdicts are unlikely to be any better than their constitutive ingredients. These inputs are, of course, the matter of psychological study. A vast body of experimental psychological research indicates that although people perform these tasks fairly well, a certain degree of error and bias inevitably creeps in.

The key challenge facing reformers is how to prevent these errors from affecting the accuracy of the process. Analyses of known false conviction cases reveal that, on occasion, the mistaken verdict stemmed from the normal failings that affect every human. We can call these spontaneous errors. Far more often, however, faulty verdicts are driven by mistakes that were actually caused or exacerbated by the investigative procedures themselves. It is indeed disheartening that investigative procedures, which are intended to merely collect evidence, can actually introduce error into the process. We can call these induced errors. The fact that the investigative process can induce error should not be surprising, given that the majority of current investigative procedures are based not on scientific research but on age-old intuitions and habits that vary widely from one jurisdiction to the next. Psychological research shows the many ways in which these procedures can go wrong and provides a detailed framework for correcting them.

It follows that the focal point of criminal justice reform should be to instill best practice procedures that are based on scientific research (coupled with greater transparency of the investigative procedures). By enhancing the accuracy of the evidence on the front end of the process, we are bound to reduce the prospect of mistaken arrests, prosecutions, convictions, post-conviction proceedings and the punishment of innocent defendants, just as we are poised to reduce the incidence of erroneous releases and acquittals of the guilty.

The logic of best practice procedures is well entrenched in the fields of medicine and aviation. One could not imagine undergoing surgery by a physician who resorts to a substandard surgical technique or by a team of doctors and nurses who have not been briefed on the case. Indeed, surgical errors have been appreciably reduced by the recent introduction of a three-part presurgical procedure that includes verification of details pertaining to the patient and the surgical procedure, a marking of the surgical site, and a timeout for ensuring that all members of the team are on the same page. Likewise, one could not imagine boarding an airplane knowing that the company uses an outdated flight manual or that the pilots neglected to prepare themselves on the procedures for entering the airspace at their destination.

### A vital complement to best practices

But mistakes and near misses occur even when best practices are followed meticulously. This suggests that we need some form of intervention at the back end of the process to provide a retrospective analysis of what went wrong. Such sentinel event reviews are bound to provide a vital complement to best practice procedures. First, where best practices are not yet in place, sentinel event reviews will likely demonstrate the need for introducing them. Second, sentinel event reviews offer a good opportunity to examine the limitations, unintended consequences and possible failures of best practices so as to improve them. Third, sentinel event reviews can shed light on how best practices actually work in real-life situations, highlighting how they interact with other practices, professional skill, constraints and conflicting considerations. Most importantly, sentinel event reviews will provide the occasion and forum for communal self-reflection and reinforcement of the values of accuracy, professionalism and integrity.

In sum, the combined strength of the mutually reinforcing front- and back-end solutions are bound to offer a platform for cultivating the kind of scrupulous and inquisitive investigation that befits the solemn task of convicting the guilty and sparing the innocent.

### About The Writer

Dan Simon is a professor of law and psychology — with a focus on criminal justice processes — at the Gould School of Law, University of Southern California. He has been a visiting professor at Yale Law School and Harvard Law School. Before joining the Gould School of Law in 1999, Mr. Simon was on the faculty of the University of Haifa Law School. He also served as a human rights lawyer on the West Bank through the Association for Civil Rights in Israel. His book *In Doubt: The Psychology of the Criminal Justice Process* (Harvard University Press, 2012) examines the existing empirical evidence regarding weaknesses in the investigative and adjudicative processes. He earned an S.J.D. from Harvard Law School, an M.B.A. from INSEAD in France and an LL.B. from Tel Aviv University.

## Stepping Back to Move Forward: Recognizing Fallibility and Interdependency

By Mark Houldin

A commitment to equality under the law must encompass a willingness to honestly identify and remedy errors — whether the cause be individualized or systemic — and continue to strive to prevent violations of fundamental rights. Logical though these principles may seem, a root-cause analysis of justice system errors has largely evaded criminal justice policy.

Having served as a public defender in Pennsylvania at the time of the Luzerne County scandal, I witnessed the reaction to what has been called one of the greatest justice violations in American history. In this well-known event, it was uncovered that children charged with crimes in Luzerne County juvenile court were denied the most basic and fundamental rights, including the denial of access to a lawyer; coercion to plead guilty to minor offenses; removal from their families and communities; and commitment to juvenile prisons without regard to the law. What catapulted matters to such a high-profile event, however, was the allegation that the judges were receiving financial kickbacks for sending children to these for-profit prisons. During this time, I was representing youth in juvenile court in Pennsylvania, as well as assisting in training and supervising new attorneys.

In the wake of the public disaster, all three branches of Pennsylvania's government participated in the creation of a multistakeholder Interbranch Commission on Juvenile Justice. The Commission's charge was to thoroughly study the circumstances leading to the event in order to prevent similar occurrences in the state and to restore public confidence in the judiciary. While not officially a sentinel event analysis, the diversity of interests represented and the Commission's sweeping charge bear striking resemblance to a sentinel event framework.

The Commission did not have an easy task. It was attempting to restore public faith in the judicial process while candidly exposing systemic flaws that could prevent future injustice. The detailed recommendations issued by the Commission after its review included the need for statewide funding for public defenders, implementation of newly created juvenile prosecution standards, creation of standards for juvenile probation officers, changes to court hiring procedures, and expedited appellate review for juvenile cases resulting in incarceration.<sup>1</sup> Despite the strength and breadth of many of the recommendations, their implementation to rectify the latent defects proved challenging.<sup>2</sup> Much of the conflict seemed to stem from a difficult balancing act: using the judicial corruption as a catalyst for analysis while not casting the entire Pennsylvania juvenile justice system as in disarray.

When presented with proposed changes in practice affecting local courtrooms and specific cases, previously displayed openness was replaced with palpable resistance. The barriers to implementing specific change are best illustrated by a common retort uttered often in courtrooms around the state: "We are not Luzerne." It was widely believed that while what occurred in central Pennsylvania was an atrocity, things were far different in "our" jurisdiction. The event was no longer a symptom of broader problems. The Luzerne scandal was seen as an outlier produced by a few unethical actors. Practice largely continued as normal, as silent solace was enjoyed in knowing that the accused judges were taken off the bench.

This is not meant as a critique of the work done in Pennsylvania post-Luzerne, as the efforts were quite remarkable. Multiple stakeholders adopted a common vision of the problem and produced a candid exposition of the many failures that allowed for such injustice to occur. Blame was not assigned to any one group; rather, the role of all system actors was examined and real improvements resulted.

This, I think, is an important lesson that can hopefully inform future attempts at learning from error. A learning-from-error culture shift at the policy level is a necessary prerequisite to local changes in practice. But at any level, culture change — especially in the law — is not simple. Dr. Lucien Leape, one of the key figures in sentinel event review reforms in medicine, wrote that doctors "come to view error as a failure of character."<sup>3</sup> The same could be said for lawyers, who are prone to strive for perfection and internalize deep conviction for their positions. In testimony gathered by the Luzerne Commission, for example, the President of the Pennsylvania Bar Association was asked why, in his opinion, members of the Luzerne County bar did not file misconduct complaints about the offending judges. In his answer, he pointed to an element of acculturation that I believe could fairly be made of professionals in many fields. "Behavior starts to be the norm to everybody," he said, "and nobody thinks things are that far off the mark; or they do, but they are uncertain and unsure about what they can do."<sup>4</sup>

Despite these dark times in Luzerne County, I nevertheless found cause for optimism. There was, among many, a willingness to embrace the need for improvement. After the Commission's report was issued, I mentioned my frustration to some peers at hearing the comment, "We are not Luzerne." One countered with a surprising and telling response: We embrace that saying, she said, adding that many attorneys who had been assigned to represent juveniles in Luzerne County were happy to be a part of the solution, in

crafting a system that lives up to its promise of justice and fairness. Later, when speaking publicly — whether to judges, attorneys or community members — many would lead with the phrase, “We *are* Luzerne.”

Although criminal justice is referred to as a “system,” the processes are less cohesive and complementary than this term indicates. Yet, the system’s individual components are inextricably intertwined: actions at one point along the axis of the justice process impact behaviors at other points in ways that are often overlooked. The sentinel event process that the National Institute of Justice is exploring offers an approach by which this interdependency can be illuminated. The more we understand how the whole system operates — be it across stakeholder groups or jurisdictional boundaries — the more likely we are to understand how our actions interrelate. The lessons of Luzerne convince me that we must become more comfortable talking about the fallibility of law and the criminal justice process. Hopefully, the sentinel event learning-from-error approach can move us in that direction.

### About The Writer

Mark F. Houldin serves as the Legal Representation Specialist at the Campaign for the Fair Sentencing of Youth. Prior to this, he was Defender Counsel at the National Legal Aid & Defender Association. He worked as a public defender for six years, handling a wide variety of criminal matters with a specialization in juvenile representation. Mr. Houldin has authored and contributed to a variety of publications and has been a frequent presenter on the right to counsel at national legal symposia and guest lecturer on Juvenile Law. He received his J.D. from Temple University Beasley School of Law.

### Notes

1. Interbranch Commission on Juvenile Justice, *Report* (Philadelphia, Pennsylvania: Interbranch Commission on Juvenile Justice, May 2010), <http://www.pacourts.us/assets/files/setting-2032/file-730.pdf?cb=4beb87>.
2. My observations are limited to events occurring through 2011 and are not intended as a thorough review of post-Luzerne reforms.
3. Leape, Lucian L., “Error in Medicine,” *Journal of the American Medical Association* 272 (23) (December 21, 1994): 1851-1857.
4. Interbranch Commission, note 1, at 36.

## Egg Heads Matter: Academic/Agency Partnerships and Organizational Learning

By Jack R. Greene

In many ways, understanding criminal justice sentinel events can be seen to mirror the poem of John Godfrey Saxe recounting the Indian proverb of the blind men describing the elephant: each offered different descriptions of the beast depending on what part of the elephant he was touching.

It was six men of Indostan  
To learning much inclined,  
Who went to see the Elephant  
(Though all of them were blind),  
That each by observation  
Might satisfy his mind....

And so these men of Indostan  
Disputed loud and long,  
Each in his own opinion  
Exceeding stiff and strong,  
Though each was partly in the right,  
And all were in the wrong!

So it has been with understanding sentinel events in criminal justice: to date, our organizational learning and policymaking have been based on a fragmented perspective. The sources of such “blindness” are many, but four are briefly considered here. In my view, all contribute to semantic and conceptual cloudiness, and each, when addressed systematically, provides an opportunity to improve learning and, hence, responses that steer away from such mishaps. Of course, errors in judgment, policy and practice will continue to occur, but a focus on an all-stakeholder, nonblaming review of sentinel events can allow us to see the beast for what it is: a highly complex system affected by individual failures. Moreover, addressing the four “blind spots” builds on National Institute of Justice (NIJ) efforts to bring research to bear on criminal justice policy and decision-making.

First, my experience has been that although people are the direct actors behind problems (bad decisions of police, prosecutors, judges or correctional officials) and are often identified with them (then publicly chastised), those problems are more deeply embedded in organizational policies and practices that often go unexamined — but which nonetheless greatly shape the attitudes and actions of justice system practitioners. There is a rich literature on organizational learning, organizational accidents (system failures) and sense-making that suggests that a broader understanding of organizational life must include how the organization takes on and processes information, especially negative information. Today we have moved well beyond simplistic notions of environmental pressures leading to organizational responses; we now understand that the relationships between organizations and their environments — and indeed among and between organizations — are complex. Needless to say, this understanding applies to our justice system as well.

Our justice system contains overlapping and divergent goals (stopping crime and violence while protecting individual liberties and improving institutional legitimacy) and reveals gaps in communications and recordkeeping systems (police arrests, court cases and correctional files) among other things. Overlaying all this “systems complexity” is the simultaneous and at times unrelenting influence of other actors in the broader policymaking arena (other government agencies, interest groups and private agencies). Although identifying systemic problems remains difficult, there are policy-relevant and organizational assessment tools that can shed light on these issues; systemic assessment requires systemic involvement. The rise of discussions about transparency in criminal justice creates a policy and political motivation and opportunity for such action; we are all in the tent, not just some.

Second, I have learned over many years studying the police that organizational learning most often occurs when problems are surfaced, analyzed and addressed systematically, seeking explanation and withholding blame. In many ways, government agencies and programs are too quick to identify failures as person- rather than system-driven, while at the same time seeking broader positive reflections on agency programs and their impacts. Simply put, we live in a good-news world. But in science and public policy, learning from failures is important, not only to sharpen policy options going forward but also to stop doing things that produce unintended or negative results. Like individuals, we sometimes have to clean the criminal justice attic, discarding old regimes and practices and making room for new ideas and ways of doing business.

Third, sense-making in criminal justice organizations often takes its cues from past problems rather than future remedies. Research on organizational sense-making suggests that rather than environmental cues reshaping organizational thinking and learning, organizations selectively use these cues and interpret them from the view of the organization, which is invariably backward leaning. Like many individuals, organizations select information and environmental inputs that are most congruent with existing premises (personal or organizational) and in doing so are partially bound to repeat historical mistakes. Changing the lens and focus of analysis, as well as the internal discourse toward matters of systemic failure, creates opportunities for repositioning organizational policy and practice. Current research associated with evidence-based policymaking and organizational legitimacy — as well as specific assessments of failures associated with wrongful conviction, failures of eyewitness identification, gaps in forensic analysis and the like — all point to the need for greater assessment of the quality and validity of criminal justice decision-making. Simply put, criminal justice decision-making and its consequences are rarely individually based; they involve complex agency and individual arrangements as well as competing social and political pressures for justice agencies to behave in certain ways.

Fourth, the academic community can play an important, analytically independent role in assessing sentinel events and brokering solutions. But it often fails to do so. My academic experience suggests that all too often academics have been positioned as social critics rather than honest brokers of information regarding agency success or failure. At the same time, agencies are often selective in their presentation strategies, showing only what they want the outside world to see. Nonetheless, universities and colleges, as producers and disseminators of knowledge, can play an important role in these matters — first by assessing sentinel events, systematically and independently, and then convening discussions within and across agencies about the findings of such assessments. NIJ partnerships that have been built between the academic community and the criminal justice agency world in the past can serve as an important platform for such efforts.

As a concluding observation, let me reiterate that a failure to learn from history serves only to repeat the mistakes of our past. Enhancing organizational learning and sense-making in criminal justice through systematic reviews of sentinel events can go a long way to addressing systemic failure and improving justice system legitimacy. To do less returns us all to Indostan.

### About The Writer

Jack R. Greene is a professor and former dean in the School of Criminology and Criminal Justice at Northeastern University. Recognized as one of the country's leading police scholars, Dr. Greene is widely published, including the *Encyclopedia of Police Science* and numerous articles, reports and policy papers on policing, both domestically and internationally. From 1984 to 1999, Dr. Greene was the director of the Center for Public Policy at Temple University, and he has also taught at the University of Wisconsin and Michigan State University. He holds a Ph.D. in Multi-Disciplinary Social Science (Sociology, Public Policy and Criminology), and is a Fellow of the Academy of Criminal Justice Sciences.

## An Opportunity We Cannot Afford to Lose

By Greg Matheson

There have been a few moments in my career when I was given the opportunity to participate in or bear witness to significant improvements in the criminal justice system. However, before I participated in the National Institute of Justice (NIJ) Sentinel Events Initiative roundtable last year, all of them focused on improving the delivery of forensic science services. The 2013 roundtable discussion gave me an opportunity not only to consider improvements to the system as a *whole* but also to provide input at the very beginning of developing this type of review process. The goal of this process is to create a structure in which significant errors, or “sentinel events,” regardless of where they occur in the criminal justice system, will result in learning and improvement of the entire system.

NIJ’s inclusion of a wide variety of criminal justice stakeholders guaranteed that multiple points of view and opinions would be heard and discussed. Though there were several differing suggestions as to what the review process might look like and where it should focus, it was generally accepted that the criminal justice system would benefit from a broader review of its sentinel events and thus acquire the ability to learn from the events and limit their recurrence in the future.

My experience as a criminalist, supervisor and director of a large metropolitan crime laboratory taught me that laboratory errors are rarely, if ever, the result of a single action or failure of an individual. By focusing only on the actions of a single analyst, I, as a supervisor or manager, would miss the opportunity to improve the laboratory and limit the possibility of the same error occurring over and over again. But I witnessed how improvements to forensic laboratory accreditation standards over the years provided crime laboratory management with the template to review an error or issue. The accreditation requirement to investigate and determine the root cause of an issue provides the opportunity for improvement in the laboratory as opposed to just placing blame.

A sentinel event in the criminal justice system, just like a laboratory error, does not occur due to a single action, individual or entity. Many failures must occur for an error to get through the entire criminal justice system and result in a failure of justice. However, law enforcement, including forensic science, is frequently the source of the first event in a sequence of system failures that eventually results in a sentinel event. As such, it is easy to see how a law enforcement individual or agency might be blamed because the error occurs, as Jim Doyle characterizes it, at the “sharp end of the stick.” The individual or agency is punished and the system moves on, failing to learn from the failure and take steps to prevent its recurrence. This process of focusing on blame, as opposed to learning and improvement, has resulted in the creation of negative chasms between the different “sides” in the process. A blame-oriented process often compels individuals to focus on avoiding blame (and, hence, punishment), which leads to less transparency and discourages sharing information. As a result, the entire system loses. By accepting and participating in a sentinel event review process, which is nonblaming and includes all stakeholders, each participant in the system can recognize and take responsibility for contributing to the event and improve the chances of it not recurring.

### Learning from medicine and aviation

In the roundtable discussion, we were given the opportunity to hear how the aviation and medical professions deal with sentinel events, how their processes were developed, and how improvements to their processes continue. Being presented with these examples was helpful because it demonstrated how these fundamentally different fields approached the nuts and bolts of a learning-from-error process. In bringing sentinel event review to the criminal justice system, we will, of course, need to forge our own specific process. The adversarial nature of our criminal justice system will make the process of developing a viable all-stakeholder, nonblaming, forward-looking sentinel event review process difficult. However, I believe that if we look at the system’s adversarial nature as a valuable checks-and-balances process — as opposed to the regularly held opinion of winning at all costs and placing blame — a nonblaming sentinel event review process can be developed.

At the roundtable, we held general discussions as to what constitutes a sentinel event and how we might initiate the development of a review process. The discussions were spirited and reflected the significant diversity of opinions and viewpoints consistent with the diversity of the participants. However, one thing became abundantly clear: For this idea to take root, we as a community must not get bogged down in the immensity of the issues but rather start with an obvious failure of the system, such as a wrongful conviction, create a system to deal with it, then expand it as our experience grows. By starting with a very focused issue, we can learn both the strengths and limitations of the system and the process by which a sentinel event review will work.

As the roundtable drew to a close, we reached another important agreement — a criminal justice system that values justice over anything else is paramount, and developing a sentinel event process that will guarantee continued improvement is an opportunity we cannot afford to lose. Moving forward with this concept is essential.

### About The Writer

Gregory B. Matheson is currently the President of FSLResources, which provides forensic science supervisors and managers with the tools they need to improve the delivery of forensic science services to the criminal justice system. In 2012, Mr. Matheson retired from the Los Angeles Police Department as the Laboratory Director. As a criminalist, he was court-qualified in toxicology, serology, crime scene investigation, and the examination of explosives, flammable liquids and vehicle lamp filaments. During his career, Mr. Matheson has held numerous leadership positions, including on the board of directors of the California Association of Criminalists, the California Association of Crime Laboratory Directors, the American Society of Crime Laboratory Directors and the American Board of Criminalistics.

## The Blame Game

By Jennifer Thompson

For some reason, it makes us feel better about ourselves, our neighbors and our world when we have someone to blame. It makes sense for us if we can find fault. Perhaps because it takes the pressure off of ourselves, making us feel absolved of responsibility or accountability. But blame and fault have never answered the big questions, such as, “How did this happen in the first place?” Why didn’t someone stop this before people were hurt? And if there is a solution, how do we implement it? Blame and fault-finding are simply Band-Aids on a large and hemorrhaging wound.

I understand this gut reaction to find someone or something to blame. As a victim of a brutal rape, clearly the rage and hatred I felt towards my attacker was and is understandable. There was a clear victim and obvious perpetrator. But when a DNA test showed that the man I had picked from a photo lineup, a physical lineup and in court was innocent, where and on whose shoulders does the fault lie? After 11 years of false imprisonment, Ronald Cotton walked out a free man. His family cried, the crowd cheered and the media was enchanted by his gentle manner. Suddenly there was a new victim and someone had to be blamed, and that someone became me. I, the victim of a violent rape, took the place of the offender. Revictimized, but with a twist. “Have you heard from the girl?” “Are you angry at the girl who picked you?” “How could you ever forgive HER?” No one could have punished me to the degree I punished myself. Fear, shame and guilt were my daily diet of choice. And I was alone to digest it all.

Ronald’s forgiveness was an enormous gift; it not only freed my heart but also my body. Our friendship has been a blessing, and I am grateful for it every day of my life. But what few people know and understand is that the public has been slow to grant me the same kindness, if it does at all. As I have traveled throughout the country and in speaking with the public, I am constantly seen as the villain, the person who “did this” to Ronald. Without fail, a person (sometimes several) raises their hand to ask a question: “Mr. Cotton, how can you forgive her? I could never forgive someone who did that to me.” I sit there, knowing that it was not *me* that did this to Ronald; it was Bobby Poole who did this to us — and it was a series of events that led me to pick Ronald out. There were systemic problems that helped to contaminate my memory and create the perfect storm. And yet, once again, I am alone. Another trauma, one more nightmare, misunderstood.

For 16 years, I have put my face out there, the face of mistaken eyewitness identification. The poster girl for getting it wrong. I will never regret doing this as I know I did it for all the right reasons, trying to make sense of what happened to me and to Ronald; but at times I have felt like a piñata, and rarely do I share these stories of what it has been like for me, because I sometimes get disgusting comments from men and judgments from readers of the book that Ronald and I wrote ... which have created wounds of a different sort.

### How do we fix it?

At the National Institute of Justice’s Sentinel Events Initiative roundtable in 2013, as I sat in a room in Alexandria, Virginia, listening to professionals and scholars discuss how to bring nonblaming, all-stakeholder reviews of wrongful convictions into the justice system, I felt like a fish out of water. While everyone had amazing ideas to contribute and brilliant thoughts surrounding his or her field, I thought to myself (as I often do during conferences), “But how do we fix this right *now*?” There is real suffering going on right now. Jimmy, Willie, Ryan and Calvin don’t have time to discuss which model — the review process that has worked in aviation or medicine — should criminal justice try to adopt. Regina, Jennifer, Yolanda and Debbie need to be protected now — we can’t afford to talk about what we are going to call the ongoing effort to bring a sentinel event review process into the justice system. And yet the problems and solutions are so huge, which finger do we put in what leak — and in which dike?

So let’s stop the blaming and searching for someone to burn at the stake. It will never solve the problems; it merely distracts us from what needs to be done. For me, it is a trickle-down effect. Policies need to be reformed, and better training and education are needed for those who are entrusted to protect and serve. I do believe a Sentinel Events Initiative would be of value. And I also believe that the victims in cases where mistakes have been made should have a seat at the table. That means victims like me, the crime victim — and victims like Ronald Cotton, the “system” victim. If all voices from across the criminal justice spectrum are present, a sentinel event review process could go a long way towards an open and honest discussion about the realities and inherent problems that impact not only the wrongfully convicted, the victims and their families but also the communities in which we live and our sense of trust in those who are required to protect and serve.

### About The Writer

Jennifer Thompson is an advocate for judicial reform. Her strong convictions were born of a brutal rape she suffered; her mistaken identification of the rapist was a factor in an innocent man, Ronald Cotton, being sent to prison — not once but twice — for the crime. Mr. Cotton was eventually freed nearly a decade after his first conviction when DNA testing proved his innocence. Since then, Ms. Thompson has successfully lobbied legislators in North Carolina to change laws so that Mr. Cotton and other wrongfully convicted people could be more generously compensated for mistakes made by the criminal justice system. Ms. Thompson has served as a member of the North Carolina Actual Innocence Commission, which instituted procedural reforms throughout the state, and she is currently a member of the advisory committee for Active Voices and the Constitution Project.

## Innocence Commissions: The Case for Criminal Justice Partnerships

By Russell F. Canan

The Innocence Project, a nonprofit legal clinic affiliated with the Benjamin N. Cardozo School of Law at Yeshiva University, has identified 316 post-conviction DNA exonerations in the United States since 1989. With the objective of ensuring the innocent not be arrested, tried, convicted, and sentenced, as well as convicting and sentencing those who commit crimes, many jurisdictions have examined the issue of wrongful convictions. Since 2000, several states have established innocence commissions to investigate wrongful convictions and propose reforms to the criminal justice system. Various branches of government and a bar association have used different means to establish these commissions. In five states, for example, judicial orders or efforts of judicial officers led to the creation of innocence commissions. Six state legislatures have passed laws forming commissions. One state bar association and one state governor created commissions. The active participation of the key actors in the justice system has proved to be a central factor in assessing the causes of wrongful convictions and creating proposals for meaningful reform.

In 2011, the Superior Court of the District of Columbia embarked on a close look into the causes of wrongful convictions. Following several local exonerations and at the suggestion of the Public Defender Service for the District of Columbia, Chief Judge Lee F. Satterfield established the Ad Hoc Committee on Wrongful Convictions — composed of judges, prosecutors, defense lawyers, police officers, members of the executive branch, a legislator and a scholar — to determine whether the District of Columbia needed an innocence commission.

Whether judges should be involved in such a committee was, however, robustly debated within the Superior Court. Some argued it would violate the separation of powers principle if judges appeared to legislate or appeared to tell the executive branch how to do its job. Along these lines, Chief Justice John G. Roberts, Jr., famously described the role of a judge as limited to that of an umpire, calling balls and strikes. It is beyond dispute that the neutrality of an umpire is essential when a judge adjudicates cases. In the context of innocence commissions, however, judges have a different role, and their participation in and leadership of reform efforts are appropriate.

Chief Judge Satterfield ultimately reached the conclusion that judicial participation was consistent with the court's role in achieving justice for all. In his letter creating the Ad Hoc Committee on Wrongful Convictions, he stated:

The Superior Court continues to be committed to adhering to the highest standards of justice for the residents of the District of Columbia. The case of Donald Gates has prompted this Court, and the broader criminal justice community, to reflect upon how we can improve upon these standards, and work together to ensure that no innocent person is convicted or imprisoned. We have already begun that process and we intend to continue, subject to the constraints of the separation of powers and the overarching imperative to preserve the independence of the judicial branch.<sup>1</sup>

With Chief Judge Satterfield's guidance in mind, the Ad Hoc Committee on Wrongful Convictions commenced its project in 2011. After nearly two years of work, it found that the District of Columbia met or exceeded best practices regarding false confessions, pre- and post-conviction access to DNA testing, access to post-conviction representation, evidence preservation, resources to the defense bar, and remedies for those defendants who are exonerated. Concrete reforms were proposed in the areas of eyewitness identification procedures and policies concerning informants. Additionally, the Committee recommended monitoring the performance of the recently established District of Columbia Department of Forensic Sciences to evaluate the reliability of forensic evidence in court.<sup>2</sup>

The experience in the District of Columbia demonstrated that all branches of the government, especially the judiciary, ought to be included in innocence commissions that propose reforms to the criminal justice system. Involvement from all criminal justice actors ensures that people who are on the ground and aware of the system's strengths and weaknesses are able to supply the most accurate information for a commission's analysis. Furthermore, these partners are the ones best poised to implement the recommendations made by such a commission.

Judges are in a uniquely advantageous position to facilitate the functioning of innocence commissions on a very practical level because of their role in the criminal justice system. First, judges — naturally regarded as authority figures in the criminal justice context — are able to set a tone of formality, cooperation, efficiency and order. Second, as trained, neutral mediators, judges can effectively manage the often contradictory viewpoints among participants who are traditionally adversaries. Third, judges, free from the duty of advocacy, can contribute a unique perspective that is essential to formulating appropriate reforms. Finally, as disinterested members with a deep knowledge of the criminal justice system, judges can guide an innocence commission toward reforms that are

both practical and necessary. In these ways, judicial participants are acting more as mediators and less like activist policymakers and, therefore, honor the separation of powers principle.

Judges promote the highest standards of justice by participating on committees exploring reforms of the criminal justice system. All criminal justice actors should be invested and have an active role in preventing wrongful convictions while pursuing society's interest in convicting the guilty. The history of innocence commissions has demonstrated that a collaboration of criminal justice partners — such as that envisioned by the National Institute of Justice in its exploration of a sentinel event review process — can produce results that will benefit all.

### About The Writer

Russell F. Canan was appointed to the Superior Court of the District of Columbia in 1993. He has worked in the Criminal and Civil Divisions and in Family Court and has served as the Presiding Judge of the Criminal Division, Chair of the Criminal Advisory Rules Committee, and Chair of Jury Management. Throughout his career, Judge Canan has been an adjunct professor at the Antioch School of Law, Georgetown University Law Center, the George Washington University Law School, Washington College of Law, and the University of the District of Columbia School of Law. He received his J.D. from Antioch School of Law.

### Notes

1. January 11, 2011, at 5, available at: <http://www.dccourts.gov/internet/documents/OIGReportLetterFromChiefJudgeSatterfield.pdf>.
2. Letter from Judge Canan to Chief Judge Satterfield regarding the Findings and Recommendations of the Ad Hoc Committee, February 12, 2013; see also Findings and Recommendations of the Ad Hoc Committee, February 12, 2013, available at: [http://www.dccourts.gov/internet/documents/Ad-Hoc-Committee-Findings-and-Recommendations\\_2-12-13CORRECTED.pdf](http://www.dccourts.gov/internet/documents/Ad-Hoc-Committee-Findings-and-Recommendations_2-12-13CORRECTED.pdf).

## High Expectations, Good Intentions and Normalized Policy Deviation: A Sentinel Event

By Jim Bueermann

When I was the police chief in a midsized Southern California city, I watched any number of “sentinel events” play out. I witnessed first-hand how effective a sentinel event review approach can be — and, although policing represents only one component in our complex criminal justice system, I believe that this approach promises similar dividends if it can be applied within the system’s other components and, most importantly, to the system as a whole.

In my department, one of our clear officer safety policies required that two officers respond to every burglary alarm. Not unlike other departments, however, 98 percent of our burglary alarms were false. Over time, environmental factors began to erode this two-officer policy; as patrol forces were steadily downsized, supervisors who “ran out of officers” during a busy shift would occasionally handle an alarm call by themselves, playing the odds that the call was going to be a false alarm. What began as a periodic practice increased at an incremental rate until it became commonplace. In other words, it became a normalized policy deviation.

One day, on a busy shift, a residential burglary alarm call came in from an outlying area where no officers were working. The dispatcher informed the shift sergeant that no officers would be available to handle the call for at least an hour due to higher priority calls. Based on past evidence, the sergeant believed the alarm was probably false (and therefore “no big deal”), so, rather than holding the call for an extended period, he decided to handle it by himself.

If you were casting a movie and in need of a prototypical police sergeant — big, athletic, clearly capable of leaping tall buildings in a single bound — this was your guy. Before joining the department, he had worked as a Customs Drug Interdiction Officer, swooping in on Blackhawk helicopters to stop major drug-smuggling operations. He was on the department’s SWAT team, was in great shape and had a dynamic, biased-for-action personality. His officers loved him because he cared about them, put their interests first, and always tried to make their work lives easier.

When he arrived at the residence where the silent alarm had been activated, he was confronted by a 4-foot wrought iron fence that surrounded the house. Spike-like tips topped the fence’s vertical bars. But this posed no obstacle to the sergeant who wanted to handle this “nuisance call” ASAP and get back to helping his officers with “real” police work. So, he took a short run at the fence, and, in his best hurdler’s form, vaulted perfectly over the fence.

Well, almost perfectly. His leading pant leg caught on one of the fence spears, causing him to begin a tumble-like fall over the fence. While most of him came down on the backside of the fence, his trailing thigh was impaled on one of the spikes. He was stuck, hanging halfway off the fence, with a 4-inch spear holding him to the top of the fence. Although he tried to pull himself free of the spike, he could not — so, about to pass out from extreme pain, he radioed for emergency assistance.

The burglary alarm was false.

The sergeant had made a bad choice and violated a policy — and this could have been a straightforward disciplinary matter. But, by making it clear that we were not interested in blame, I learned, through the leadership debriefing, *why* the policy violation had seemed like the right choice to the sergeant at the time. And, most important, I, as chief, and the entire department learned why it might seem like the right choice to another supervisor in the future unless we made some changes.

This is one of the central features of the sentinel event review process that the National Institute of Justice is exploring: not attempting to affix blame, but, rather, to determine why something happened in an effort to prevent it from happening again. In my department’s analysis of the incident with the sergeant, we concluded that the following factors had contributed to the event:

- The department’s crime control strategy emphasized fewer officers assigned to patrol duty and more to problem-solving units.
- These policies meant that, during busy shifts, patrol officers went call to call; this contributed to a widely held belief among patrol officers that there were never enough police officers to meet the public’s demand for service, which, in turn, resulted in sergeants trying to keep “nuisance calls” from their officers as much as possible.

- The chief and community had high expectations of the department's performance — and sergeants knew that their performance was evaluated, in part, on their shifts meeting these perceived expectations.
- Officers were aware of the general public's criticism of their salaries and benefits — and knew that a key to retaining them was to keep service levels as high as possible.
- Ninety-eight percent of all silent burglary alarm calls were false alarms.
- There was a widely held belief among patrol personnel that rapid response to calls for service prevented crime, which resulted in a hypersensitivity to "holding" calls for more than just a few minutes.
- The culture of policing in general, and specifically in our department, emphasized an action-oriented bias.
- Over time, sergeants had normalized their deviation from department's two-officers policy for responding to burglary alarms to minimize hold times during busy shifts — and had done so without problems.
- The department lacked a mechanism for gauging the actual behavior of its members within the context of workloads, expectations and policy.

The incident resulted in some stitches, a bruised ego and — after it became apparent that the sergeant would recover fully — a lot of good-natured kidding. But it could have turned out very differently. I firmly believe that our open discussions allowed us to consider the facts much more strategically and, in particular, to understand how the unintended consequences of good intentions and high expectations were affecting decision-making. By approaching our debriefing of this incident — this officer-safety "sentinel event" — from an "organizational accident" perspective, we truly *learned* from this error and were able to make important changes to the department's processes.

### About The Writer

Jim Bueermann is the president of the Police Foundation and a former Executive Fellow with the National Institute of Justice. Mr. Bueermann worked for the Redlands Police Department for 33 years, serving in every unit within the department, including as Chief from 1998 to 2011, during which time he developed a holistic approach to community policing and problem solving that consolidated housing and recreation services into the police department, a strategy recognized as one of the country's 25 most innovative programs by Harvard Kennedy School's Innovations in American Government. He is a graduate of California State University, the University of Redlands, the FBI National Academy, and California Command College.

## Using Sentinel Events to Promote System Accountability

By George Gascón

The impact of a wrongful judicial outcome in a criminal case can have a reverberating impact on entire communities. Whether real or perceived, the wrongful conviction of an innocent person or the wrongful acquittal of a guilty defendant can shake a community's trust in the criminal justice system. These long-term effects can last for years, resulting in increased apathy and cynicism and, in extreme cases, lead to civil unrest. It can also result in violent criminals escaping justice and sometimes victimizing others.

Although wrongful convictions and acquittals have devastating consequences for all involved, including the impacted communities, few systemwide solutions have surfaced to deal with the leading causes of wrongful judicial outcomes. The structure of our criminal justice system and the burden of proof beyond a reasonable doubt favor the value of preserving innocence — meaning that, as a society, we value the presumption of innocence and try to ensure that it is afforded to all defendants. Incapacitation of an innocent person is seen by many as more harmful than letting a guilty person go free. However, despite the best efforts of all of us who are committed to upholding ethical standards that protect individual liberty and public safety — both in the law and in our respective professions — wrongful outcomes still occur.

Often, the face of wrongful judicial outcomes involves wrongful convictions. These cases rightly garner substantial media attention. Whether the case in question includes technical errors that exacerbate potential bias or new evidence emerges, the system has the duty to remedy the wrongful judicial outcome. Further, when the wrong person is convicted of murder or other serious crimes, the true assailant is out, possibly hurting others, and an innocent person's life is ruined behind bars. Citizens are naturally in the position to question, "How could this happen?" And there are also cases where the person responsible is found "not guilty." These miscarriages of justice can be equally troubling.

Unfortunately, in either scenario it may take years, if ever, to uncover the mistake or mistakes that led to the harmful outcome. In addition, corrective measures are mostly focused on the actions of those directly involved with the case and little, if any, attention is given to the systemic failures. These cases are mostly viewed as aberrations within what is perceived as an otherwise well-running system. Few want to acknowledge that the frequency of wrongful judicial outcomes is probably substantially greater than what is readily known. Therefore, little effort is directed toward a systemic look at the problem, which, if pursued, would increase the professional and lay community's understanding of the dynamics that facilitate these mistakes. Instead, the focus is left on what went wrong and whom to blame on a case-by-case approach.

### Making systemic improvements

To make systemic improvements, we must create a safe environment, free of blame, for all criminal justice stakeholders. Under the leadership of the U.S. Department of Justice, practitioners and scientists must be able to come together with a clear direction to review a representative number of cases and identify breakdowns in decision-making throughout the judicial system. In the same way that an epidemiologist would set about finding pathogens and identifying a cure or treatment for the medical condition they cause, criminal justice system stakeholders must explore the root causes of wrongful judicial outcomes through an independent review. Under the safety of this depersonalized scientific quest for knowledge, effective solutions can be developed and new systems can be implemented that would correct existing problems and create an effective quality assurance loop. Continuous process improvement to both protect innocence and hold the guilty accountable could become the mantra for this movement.

In addition to the reflective examination described above, I believe that individual criminal justice stakeholders can continue to invest in basic prevention efforts while being engaged in the more systemwide, all-stakeholder reviews that the National Institute of Justice's Sentinel Events Initiative envisions. One essential step that I have taken as the lead prosecutor in San Francisco is to require that all of my staff receive wrongful conviction bias training. The training curriculum includes material on common contributing factors to bias and case studies from across the nation. This academic and case review is then combined with a viewing of the documentary film *After Innocence*. This film provides personal accounts that humanize those harmed by wrongful convictions, from prosecutors to defendants, and challenges viewers to confront the consequences of wrongful judicial outcomes. I feel that it is essential that prosecutors be reminded that quality case review reduces bias, and I ensure that my office brings the most appropriate charges and only files cases where we can prove beyond a reasonable doubt that the defendant committed the crime. The appropriate time must be devoted to each case to ensure that the prosecutor meets this ethical burden. Time and proper review are tools to reduce the possibility that a prosecutor may subconsciously filter for evidence that proves guilt while ignoring evidence that does not.

I believe that using a sentinel event review process to examine judicial outcomes will support prosecutors in maintaining public trust and ensuring public safety.

### **About The Writer**

George Gascón is the District Attorney for the City and County of San Francisco. He created the nation's first Alternative Sentencing Program to support prosecutors in assessing risk to determine the most appropriate course of action, and has created California's first Sentencing Commission in an effort to reform sentencing by applying evidence-based practices to prosecution. Mr. Gascón has 30 years of experience in law enforcement, including service as Assistant Chief of the Los Angeles Police Department, Chief of Police in Mesa, Arizona, and Chief of Police in San Francisco. He holds a B.A. from California State University and a J.D. from Western State University, College of Law.

## Cold Case Homicides: Ideal Candidates for Sentinel Event Review

By Frank P. Tona

A sentinel event — whether an outright error or a “near miss” — can devastate the lives of those who have been involuntarily placed into the criminal justice system. From my perspective as a cold case detective, avoiding the types of mistakes that can result in a sentinel event should be at the forefront of every law enforcement agency’s policies and practices.

One example of a sentinel event is a cold or long-unsolved case. Cases go cold for a variety of reasons: misidentifications by witnesses, overzealous prosecutions, ineffective counsel and poor evidence-handling practices, for example. Whether or not these cases are ever resolved, a longstanding cold case could provide a rich opportunity for a nonblaming, all-stakeholder sentinel event review.

The investigation of cold case homicides is a deliberate, ongoing process, where every step in the process is aimed at achieving timely justice. No homicide investigation begins as a cold case in the making, but as good-faith decisions are made by the investigators — decisions intended to lead promptly to a just outcome — errors can accumulate that have unintended consequences. For example, an investigator may use a specific approach to interrogate a suspect or may focus on the collection and analysis of certain evidence from the crime scene. Certain steps in the investigative process may be assigned to less experienced investigators who may miss important clues or misinterpret forensic data. It is likely that these errors will go undetected — and, therefore, unquestioned — as long as the case remains cold and unsolved. Even in cases where a long investigation results in a wrongful conviction, decisions along the investigative trail rarely are subject to the kind of thorough review that would identify systemic flaws that got the investigation off track.

I see great value in treating a cold case as a sentinel event. An all-stakeholder, nonblaming review could examine the questions, “Why did the case stay cold for so long?” “Did investigators rely too heavily on practices that may have yielded positive outcomes in the past and fail to consider alternatives?” This kind of review would allow us to examine the role of tunnel vision in the case going cold. I have seen from my own investigations that it can be very difficult to drastically change momentum during an investigation once I have established a clear and convincing theory. Equally difficult is attempting to convince colleagues their theories are not consistent with the evidence or statements made by witnesses or suspects. Only later, when the direction of the investigation can be measured against the outcome of a correct or wrongful conviction, can we really challenge our assumptions and discover the errors committed along the way. And, a sentinel event review might provide a type of benchmark to guide other cold case investigations.

This is not to say that adopting a nonblaming sentinel event review process will be easy. The culture within police departments is frequently conservative, with specific belief systems and, often, a bureaucratic management structure. Departments can become victims of their own policies and antiquated practices — and police managers are sometimes reluctant to make procedural changes, fearing that they could result in the unnecessary expenditure of human and fiscal resources.

### Operating at the sharp end

As I participated in the discussion at the National Institute of Justice roundtable in 2013, I could appreciate the potential of this type of learning-from-error review for officers like me who operate, as Jim Doyle puts it, “at the sharp-end of the stick.” Not only do police officers want to get the right person, we want to do so at the earliest possible moment before the perpetrator can claim further victims. But, because fallible human beings are involved in every step of the criminal justice process, error is an unavoidable reality.

This is why I think it could be very helpful to examine errors or bad outcomes from the perspective of law enforcement’s role in the entire criminal justice system. By collaborating with and seeking the input of other justice stakeholders, law enforcement investigators — especially, perhaps, cold case investigators — may be able to learn from costly mistakes and work to improve processes and decision-making procedures that could help avoid similar mistakes in the future.

**About The Writer**

Frank P. Tona has been employed with the Charles County, Maryland, Sheriff's Office since 2002. Currently a Corporal with the Patrol Division, Cpl. Tona served for seven years as a Detective. He is member of the department's Cold Case Review Team, Vice President of the department's labor union, and a member of the Hostage Negotiations Team. Cpl. Tona holds an undergraduate degree in criminal justice from SUNY-Brockport and a graduate degree from Norwich University in public administration.

## Building a Learning-From-Error Culture in Policing

By John R. Firman

The International Association of Chiefs of Police (IACP) agrees with the proposition that underlies the National Institute of Justice's (NIJ) Sentinel Events Initiative: errors do occur in the criminal justice system — as in any complex system or profession — and minimizing future errors demands a willingness to learn.

All too often, when new information comes forward about an error in our criminal justice system, we spend our time defending positions that are clearly untenable, rather than allowing lessons to guide improved practices. From the IACP's perspective, systemic reform initiatives within the justice system — particularly ones driven by all-stakeholder reviews of sentinel events — are key.

Indeed, a professional organization like the IACP has a duty to help implement system reforms using sentinel events as markers for change. In that regard, the IACP is engaged in a number of projects that illustrate our organization's commitment to innovative learning-from-error efforts. For example, the IACP is:

- Collaborating with the MacArthur Foundation and the Office of Juvenile Justice and Delinquency Prevention on ways to divert adolescents from long-term involvement in the criminal justice system.
- Working with the Office on Violence Against Women on learning from the “sentinel event” of uninformed or inappropriate response by the police to domestic violence, sexual assault, stalking and human trafficking crimes, which leaves victims even more vulnerable to further harm.
- Collaborating with the Public Welfare Foundation and the Pretrial Justice Institute to prevent the release from prison of dangerous individuals who then commit new crimes and the equally problematic detention of individuals who pose no continuing risk to the community.
- Working with the Department of Justice and the Innocence Project on ways to improve front-end police investigations and prosecutorial charging decisions to minimize focusing on the wrong suspect, which leaves the real offender free to commit new crimes.

Through work like this, the IACP is committed to bringing in the voices of nonpolice stakeholders — such as victims, juvenile corrections, prosecutors and private foundations — which, of course, is a key element of a sentinel event, learning-from-error review process. That said, we recognize that what NIJ's Sentinel Events Initiative is exploring is even more ambitious in that it involves getting the buy-in of all nonpolice stakeholders by also including, for example, the defense bar, city risk managers, crime lab directors, and even political leaders or the press, where appropriate.

I believe, however, that the IACP's ongoing work indicates that law enforcement is among the most forward-leaning of the stakeholders in the criminal justice system at this moment in time — a time where the understanding that human beings will inevitably err demands that we work toward a more systemic way to incorporate a learning-from-error process into our culture.

Professional law enforcement organizations like the IACP — the largest body of policing professionals in the world — can play a crucial role. Scientific research has found that major innovations that have revolutionized police practices — community policing, Compstat, and problem-oriented policing, to name only three — are diffused and take hold through “peer networks.” The IACP is one such professional peer network with access to the best and brightest police leaders (within management and the rank and file) that can assist in the diffusion of NIJ's innovative Sentinel Events Initiative.

The IACP strongly believes that sea changes in criminal justice practices must always begin with an openness to new information and a willingness to consider that new information with great care; indeed, this concept is what police legitimacy is all about, and it also lies at the core of a sentinel event review process. This is not to suggest that the work will be easy: law enforcement agencies have union issues, disciplinary procedures and other challenges that will have to be met head-on. But we can tackle these and other challenges. The IACP looks forward to helping explore the viability of this innovative learning-from-error process as a way to improve the reliability of the nation's criminal justice system.

**About The Writer**

John R. Firman is the director of the Research Division of the International Association of Chiefs of Police, the world's oldest and largest police leadership organization. He is in charge of the development and implementation of a national and international policy and research and evaluation program. Mr. Firman helped create and currently manages the National Law Enforcement Policy Summit Series, which addresses current and emerging issues in the policing profession. Prior to joining the IACP in 1994, he served as Associate Director of the Illinois Criminal Justice Authority. He is an adjunct lecturer for the Department of Law, Justice and Criminology at American University's School of Public Affairs.

## Punishment-Based vs. Education-Based Discipline: A Surmountable Challenge?

By Sean Smoot

In many police departments, cases of notoriety are commonly referred to as “Heater” cases. Because of the nature of the crime, who the victim is or who is accused of the crime, Heater cases — serial murders, serial rapes, crimes where the victim is a child, crimes involving celebrities or public officials — garner strong interest by the city government’s leaders, department leaders, press and the community. They get extra attention and scrutiny, and they remain in the spotlight unless or until they are solved. This puts extraordinary pressure on line officers and detectives.

Part of the sentinel event review approach that the National Institute of Justice is exploring is to get people to come out of their lanes, out of their stovepipes, out of a “that’s not *my* job” mentality and to assume greater system responsibility collectively. Even in routine policing cases, there is often fear of being singled out with blame landing on some poor schmuck, and everyone reverts to an “I’m just doing *my* job” mentality. Overcoming this will be a major challenge in making the sentinel events approach successful. In high-profile Heater cases, the fear of being singled out or blamed can become even more intense, making line officers even more reluctant to report operational errors or to disclose mistakes in a proactive or preventive way.

There is always the opportunity for post hoc review. But the goal — or one of the goals — of the sentinel events approach seems to be proactive, preemptive intervention: stopping the line, basically. But there currently is no clear mechanism for doing this. Heater cases, where the pressure is really on to make an arrest and get the case resolved, offer just one example of where some challenges lie in adopting a sentinel event review process.

Another challenge is defining what constitutes a sentinel event in the criminal justice system. Some would propose a definition that includes wrongful/erroneous arrest, wrongful/erroneous conviction, use of deadly force, pursuits and in-custody deaths/injuries. However, from the standpoint of the police officer, who is the “tip of the spear” in most, if not all, of these events, the prospect of adding yet another layer of conduct review is — regardless of its laudable goal — likely to receive a very negative reaction.

To understand this perspective, one needs to understand the jeopardy that officers feel each and every time they are involved in a significant event in the course of performing their duties. Most police departments have adopted the practice of “punishment-based” discipline, which is interested in placing blame and punishing for policy or procedure violations. This practice is not really compatible with the sentinel event philosophy, which is interested in identifying problems and preventing repetition of outcomes through policy or procedure modification and education.

For instance, when an officer is involved in the use of deadly force, he or she currently faces at least two, usually three and sometimes even more *adversarial* investigations and reviews:

**Criminal:** Typically, an officer’s conduct is reviewed rapidly by his or her own department’s homicide investigators (or those of a different agency) and then put before a state prosecutor for review. In many jurisdictions, state prosecutors have adopted a screening procedure that includes putting the case before a grand jury (even if the case is a clear-cut justified use of force).

**Administrative/internal affairs:** The department’s own internal affairs/administrative review often occurs at the same time as the criminal review. Usually, the officer is interrogated by a supervisor after being ordered to answer questions under threat of job forfeiture. These investigations are usually adversarial in nature, as they are designed to serve as a basis for departmental discipline.

**Civilian:** Some departments have adopted a civilian review mechanism. Often referred to as civilian review boards (CRBs), these entities play various roles and have varying powers depending on the jurisdiction. Some CRBs review the department’s investigation and may make inquiries, but have no power to recommend discipline, or to approve or disapprove of investigation conclusions; other CRBs have subpoena powers and full authority to recommend charges or even to mete out discipline.

**Civil litigation:** Almost finally, the officer’s conduct is then reviewed by his or her employer’s (or his or her employer’s insurance carrier’s) civil defense counsel. Of course, many, if not most, of these situations wind up in civil litigation against the officer, his or her employer or both.

Notice I say “almost finally” because the Department of Justice can also decide to conduct a review of the officer’s conduct, which could include a criminal investigation or review under the United States Code. And, of course, the officer’s conduct will also be

scrutinized by the public and the news media, who will eventually, at the least, get a significant portion of all of the aforementioned investigations and, in some jurisdictions, may legally obtain the complete investigatory files.

In light of the foregoing, it should not be difficult to understand why police officers would be wary of participating in an additional investigation/review, such as that envisioned in a sentinel event review process.

That is not to say that officers lack interest in learning from mistakes or errors. No one wants to repeat bad outcomes over and over again. However, officers don't see investigation and review of significant occurrences through an unmodified lens. Officers approach review processes cautiously, if not hesitantly, out of an ingrained sense of skepticism. Even though an honest review might, and should, prevent repeating avoidable negative outcomes, they often fear that the process will not be an honest one.

To help prevent police from viewing a sentinel event review as “another opportunity to fire me,” “another opportunity to prosecute me,” or “another opportunity to sue me,” it must not be regarded as another criminal, internal affairs or civil review. For sentinel event reviews to be effective and practical, they must be a cooperative effort that affords the types of protections provided in the medical context, where state and federal laws protect the privacy of participants and prevent the disclosure of information to *anyone* outside of the sentinel event review. Accordingly, the medical professionals who participate can do so without threat of prosecution or discipline and without the fear that their statements will later be disclosed to the press or a plaintiff's attorney.

Unless the sentinel event process is honest and trustworthy, with adequate legal protections — including use immunity, privacy, confidentiality and nondisclosure, for example — police officers, who have the very best information about how things really work and what really happened, will not be motivated to fully participate. The sentinel event review approach will have a better chance of success if departments can abandon the process of adversarial/punitive-based discipline, adopting instead “education-based” disciplinary procedures and policies.

### About The Writer

Sean Smoot is the Director and Chief Counsel for the Police Benevolent & Protective Association of Illinois and the Police Benevolent Labor Committee, where he is responsible for providing legal services for more than 7,500 legal defense plan participants. He regularly represents police officers in discipline and discharge and civil rights cases. Since 1996, Mr. Smoot has served on the Advisory Committee for the National Law Enforcement Officers' Rights Center. He was a police and public safety policy advisor to the Obama-Biden Presidential Transition Team. Mr. Smoot received a B.S. from Illinois State University and a J.D. from the Southern Illinois University School of Law.

## Reducing Failure: A View of Policing Through an Organizational Accident Lens

By Jon Shane

It is well settled that all complex businesses — including medicine, aeronautics and transportation, petroleum, petrochemical and nuclear production — are at risk for an organizational accident.<sup>1</sup> The question, then, is whether policing is also a complex business. In fact, research over the past seven decades has shown that it is — and never have those complexities been so eloquently stated as here:

“...one may well wonder how any group of men could perform the tasks required of policemen. The citizen expects police officers to have the wisdom of Solomon, the courage of David, the strength of Samson, the patience of Job, the leadership of Moses, the kindness of the Good Samaritan, the faith of Daniel, the tolerance of the Carpenter of Nazareth, and, finally, an intimate knowledge of every branch of the natural, biological, and social sciences. If he had all of these, he might be a good policeman.”

– August Vollmer, *The Police in Modern Society*<sup>2</sup>

To add to this complexity, it is important to note that policing is itself an element of a larger and even more complex criminal justice system. In fact, this is the foundation on which a sentinel event review process rests. Although I explore here only one “stovepipe” in the system — the police — it is crucial to keep in mind that an all-stakeholder, nonblaming review of an error necessarily involves all the other criminal justice players.

The issue for the police — both in their own complex environment and as a part of a complex system — is to balance the competing demands of policy and practice; management and line function; intent and execution. This requires a framework that moves beyond individual blame and accounts for the context in which the error occurred. An individual accident results from the acts of people following properly established procedures. This view examines the active failure from the individual operator’s perspective and does not account for the contextual and precipitating factors impinging on the operator, nor does it reach the middle and upper ranks that are responsible for policy and supervision. It is accusatory and resides in a culture of blame, which reduces officers to secrecy and silence. Little is accomplished beyond affixing blame.

When the accident is viewed through an organizational lens, however, the context reveals that the individual inherited rather than instigated the accident, such as when acts or omissions result from insufficient or absent policy; weak supervision; workaround solutions and accepted past practices that are informally adopted by employees and tolerated by management; failing to learn and train from prior events and precursors; or budget reductions that compromise safety. This approach — which considers the error as the starting (rather than the ending) point for investigation — seeks to isolate and correct the causes to ensure they are minimized or eliminated in the future.

A sentinel event review process, however, considers that the individual is situated inside a larger bureaucracy that likely ensnared him or her through latent policy weaknesses, deviant cultural practices and poor supervision (organizational accident method). Pursuing an organizational accident framework focused on support, accountability<sup>3</sup> and professional development does not stop at the singular or obvious error. It always attempts to understand the behaviors, conditions and contributing circumstances behind the act or omission that supported the error. Only once these associated phenomena are understood in their context can future errors be avoided through policy development and training.<sup>4</sup>

The policing field is fraught with production hazards (e.g., arrests, traffic stops, custodial interrogations, identification procedures, search and seizure activities, vehicular pursuits, using force), largely because the tactical, political, social and legal environments are intertwined, competing and complex. One case study of a police field identification procedure (show-up) — what might be described as “routine surgery” in the medical context — revealed 49 errors during the investigation.<sup>1</sup> Therefore, policing is well poised to accept the lead in adopting a systems approach to organizational accidents since police behavior during the initial stages of an investigation usually has downstream implications for the other actors in the system — prosecutors, defense attorneys and judges. Although the police should take a leadership role in adopting the organizational accident framework, what may at first glance seem to be an isolated upstream (police) error is influenced by the reciprocal downstream actions, expectations and informalities of interpersonal workgroup relations<sup>5</sup> that ostensibly offer plausible deniability for others in the system who are indisputably connected to the police. The downstream operators are not blameless simply because they are distant from the upstream active failure in time and space.<sup>6</sup>

One example of policing that has implications for the larger criminal justice system is wrongful conviction based on using confidential informants (CIs). Often seen as indispensable to police work, the CI is an accident waiting to happen if not managed properly through

policy, supervision and training. The Center for Wrongful Conviction at Northwestern University Law School cites informant testimony as the leading cause of wrongful convictions in capital cases.<sup>7</sup> Previous research involving CIs suggests they may not be properly managed by the police,<sup>8</sup> and preliminary findings from new research that examines published police policies on CIs show that those policies have latent weaknesses that relate to testing a CI's integrity, supervision and training before deploying the CI<sup>9</sup> — the very types of weaknesses that contribute to operator error. If the police deploy a CI without testing his or her integrity, supervising the CI and providing training for the officer and the CI, the chemistry for a profound accident exists.

Death, injury, false arrest, wrongful conviction and other police errors should be valued opportunities for full disclosure and professional development, rather than viewed as acceptable risk or collateral damage. Police practices are on the precipice of legitimacy yet again, particularly given the worldwide rise in egalitarianism and leveling of hierarchical institutions.<sup>10</sup> There is an opportunity to adopt a standard review methodology and embrace each error as a learning experience that improves transparency, strengthens community support and reaffirms the police commitment to professionalism.<sup>11</sup> Or, police leaders can retreat — as medicine and aviation leaders did in the early stages of their learning-from-error reform movements — into a defensive posture that keeps errors and their learning value hopelessly locked away from progressive police managers eager to improve practices.

### About The Writer

Jon M. Shane is an Associate Professor in the Department of Law, Police Science and Criminal Justice Administration at the John Jay College of Criminal Justice, where he focuses on police policy and practice, including situational crime prevention. Dr. Shane retired as a captain from the Newark Police Department after 20 years, where his service included many operational and administrative assignments. He has worked with law enforcement agencies across the country and internationally, developing policy and conducting performance audits and research and management studies to measure performance. Published in a number of professional journals, Dr. Shane currently also serves as a senior research associate for the Police Foundation and as a subject matter expert for the Center for Problem Oriented Policing.

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## Appendix

As part of its preliminary investigation into the feasibility of using a sentinel event review approach in the criminal justice system, the National Institute of Justice (NIJ) and the Office of Justice Programs looked at other learning-from-error efforts that share certain significant features with a sentinel events approach to improving justice outcomes, including:

- Do “all stakeholders” participate?
- Is there an emphasis on “nonblaming”?
- Is the approach routine and ongoing?
- Are the findings publicly disseminated?
- Is there an emphasis on being “forward-looking” or on future prevention?

We found a number of learning-from-error efforts that incorporated some of these features; brief descriptions are provided below. These examples — although not intended to be exhaustive or comprehensive — may provide readers with additional context for understanding the distinctive approach of NIJ’s Sentinel Events Initiative.

### Cambridge Review Committee on Arrest of Professor Henry Louis Gates, Jr.

The final report, *Missed Opportunities, Shared Responsibilities: Final Report of The Cambridge Review Committee*, is available at [www.cambridgema.gov/CityOfCambridge\\_Content/documents/Cambridge%20Review\\_FINAL.pdf](http://www.cambridgema.gov/CityOfCambridge_Content/documents/Cambridge%20Review_FINAL.pdf)

The Cambridge Review Committee included a diverse group of stakeholders.

With respect to a “nonblaming” element, the Committee stated that it “was not charged with writing an ‘after-action’ or fact-finding report, or with assigning blame either to Sergeant Crowley or to Professor Gates . . . Rather, the Committee was charged with identifying the lessons that can be learned from the incident and the implications of those lessons for the policies, procedures,

and mission of the Cambridge Police Department and the city of Cambridge as well as other police departments and cities across the nation.”

With respect to the “routine/ongoing” element, this was not an ongoing, routine process but rather a singular review of one incident.

### Child Fatality Review Teams

Child death review teams — also known as child fatality review teams — review child abuse, negligent fatalities and suspicious child deaths. They exist in most states and seem to have nonblaming and forward-looking principles at their core:

- “Results of these reviews may be used to improve services, advocate for change, and conduct public awareness activities, ultimately for the purpose of preventing future child maltreatment deaths.” See the Child Death Review Teams section of the U.S. Department of Health and Human Services: [https://www.childwelfare.gov/responding/review\\_teams.cfm](https://www.childwelfare.gov/responding/review_teams.cfm)
- “Reviews focus on what went wrong and how can we fix it, not who is at fault and who should we blame.” See *Examining Child Fatality Reviews and Cross-System Fatality Reviews to Promote the Safety of Children and Youth at Risk*, by Y. Yuan, T. Convinton and L. Oppenheim: [http://www.childdeathreview.org/Promo/WRMA\\_August2012.pdf](http://www.childdeathreview.org/Promo/WRMA_August2012.pdf)
- “The purpose of fatality reviews: To conduct a comprehensive, multidisciplinary review of child deaths, to better understand how and why children die, and use the findings to take action that can prevent other deaths and improve the health and safety of children.” <http://www.childdeathreview.org/cdrprocess.htm>

### Domestic Violence Fatality Reviews

“The mission of the National Domestic Violence Fatality Review Initiative (NDVFR) is to provide technical assistance for the reviewing of domestic violence related

deaths with the underlying objectives of preventing them in the future, preserving the safety of battered women, and holding accountable both the perpetrators of domestic violence and the multiple agencies and organizations that come into contact with the parties.” <http://www.ndvfri.org>

From “Domestic Violence Fatality Reviews: From a Culture of Blame to a Culture of Safety,” by N. Websdale, Michael Town and Byron Johnson (1999), *Juvenile and Family Court Journal*, Vol. 50, No. 2 (Spring):

“Fortunately, there are workable models in the fields of medicine and aviation upon which to draw. These models teach courts and communities that, with vigor, honesty, and candor, they can build reliable systems that value accountability and help prevent future death and injury from domestic violence. Because domestic violence deaths exhibit predictable patterns and etiologies, they are preventable. We argue that the establishment of domestic violence fatality review teams is one effective way of reducing domestic violence homicides. After briefly outlining the scope and extent of domestic violence related deaths, this article discusses the history of domestic violence fatality reviews and presents several models that appear to be both effective and fair.

“Traditionally, these tragedies [domestic violence fatalities] have resulted in finger pointing, anger, fear, frustration, and distrust. Sometimes, this finger pointing has found voice in the form of editorials, lawsuits, and legislative hearings. These forms of finger pointing, sometimes referred to as ‘tombstone technology’ in fields such as aviation and nuclear power, have not been productive. They can result in accusations of stonewalling and cover-ups. Consequently, many community members, including judges, court administrators, elected officials, prosecutors, law enforcement officials, and battered women’s advocates are looking for workable and fair models to review domestic violence

fatalities, with a view to preventing future deaths. This search is not for the fainthearted since it requires a paradigm shift from a culture of blame to a culture of safety.”

### **Milwaukee Homicide Review Commission**

“The Milwaukee Homicide Review Commission (MHRC) strives to reduce homicides and non-fatal shootings through a multi-level, multi-disciplinary and multi-agency homicide review process. The MHRC is comprised of law enforcement professionals, criminal justice professionals and community service providers who meet regularly to exchange information regarding the city’s homicides and other violent crimes to identify methods of prevention from both public health and criminal justice perspectives. The MHRC makes recommendations based on trends identified through the case review process. These recommendations range from micro-level strategies and tactics to macro-level police change.” <http://city.milwaukee.gov/hrc>

“Partners represent key stakeholders from multiple levels (city, regional, county, and state), disciplines, and agencies (governmental and private, including community service providers). At each homicide review meeting, partners participate in an intensive discussion and examination of individual homicide and intentional crime incidents. Through this process, trends, gaps, and deficits within the already existing systems and programs designed to prevent and reduce violence are identified and recommendations are made to strengthen these systems and programs.” <http://city.milwaukee.gov/hrc/overview>

### **New York State Justice Task Force**

“The Task Force includes representatives from all participants in the criminal justice system — judges, prosecutors, defense attorneys, members of law enforcement, legislators, executive branch officials, forensic experts, victim’s advocates and legal scholars — from across the State.” <http://www.nyjusticetaskforce.com>

“The Justice Task Force was formed with the belief that, while these cases of wrongful convictions are tragic, we can learn a valuable lesson from each of them. By closely examining new exonerations in New York to determine

how the criminal justice system failed, the Justice Task Force hopes to identify any recurring patterns and practices that may be contributing to wrongful convictions in this state.” <http://www.nyjusticetaskforce.com/mission.html>

### Elder Fatality Review Replication Manual

This was a project of the Office for Victims of Crime, the National Adult Protective Services Association, and the American Bar Association Commission on Law and Aging. It promotes fatality review teams.

From *Elder Abuse Fatality Review Teams: A Replication Manual*, by L. Stiegel, <http://apps.americanbar.org/aging/publications/docs/fatalitymanual.pdf>:

- “Hospital physicians use the ‘Morbidity and Mortality Review’ process to examine what went wrong with a medical procedure and determine how the same problem could be avoided in the future. Car manufacturers examine accident-related deaths or injuries to learn how to design and build a safer car. Service providers in the child abuse and, more recently, domestic violence fields analyze deaths that were caused by abuse or deaths of persons who were known victims of abuse previously in order to change the system’s response to victims and avoid similar outcomes.”
- “Other issues do not arise immediately, but they must be addressed before a team can start reviewing cases. These issues include creating a culture of avoiding ‘blame and shame’; preparing policies and procedures, protocols, or memoranda of understanding; deciding what to call the team; and, most importantly, ensuring that necessary confidential information can be shared and obtained and that confidential information and team deliberations and products are protected from voluntary or involuntary disclosure outside of the team.”

See also Neil Websdale, Michael Town and Byron Johnson, “Domestic Violence Fatality Reviews: From a Culture of Blame to a Culture of Safety,” *Juvenile and Family Court Journal*, Vol. 50, No. 2 (Spring 1999).

### Wisconsin Criminal Justice Study Commission

This commission started with discussions between the Criminal Law Section of the Wisconsin State Bar and the University of Wisconsin Law School and the Marquette Law School about studying the errors that had produced wrongful convictions; those discussions were followed by a national conference hosted by the American Judicature Society. (See Keith Findley, “Learning from Our Mistakes: A Criminal Justice Commission to Study Wrongful Convictions,” *California Western Law Review* 38 (2) (July 2005).

With respect to the “nonblaming” element, the Wisconsin Criminal Justice Study Commission’s charter states: “The goal of our commission will not be to point fingers or assign blame for past mistakes, as some might understandably fear. And while the wrongful convictions of Steven Avery and others are a major stimulus for the commission, the commission’s role will not be to identify specific cases of wrongful conviction. Rather, the overriding purpose of the commission will be to produce the best possible criminal justice system, one that justly convicts the guilty and not the innocent.” <http://law.wisc.edu/fjr/clinical/ip/wcjsc/files/charter.pdf>

### Trial and Error, Center for Court Innovation

“The Center for Court Innovation, with the support of the U.S. Department of Justice’s Bureau of Justice Assistance, has embarked on a multi-faceted inquiry designed to promote trial and error in criminal justice reform. The Center is examining efforts to improve the criminal justice system that did not achieve the results that were intended in an attempt to learn lessons and promote innovation going forward. At its heart, this is an effort to encourage honest self-reflection and thoughtful risk-taking among criminal justice agencies.” <http://www.courtinnovation.org/topic/trial-and-error>

In 2010, the Urban Institute published *Trial & Error in Criminal Justice Reform: Learning from Failure*, <http://www.courtinnovation.org/research/trial-and-error-criminal-justice-reform-learning-failure>

*Daring to Fail: First-Person Stories of Criminal Justice Reform*, a collection of interviews with leading criminal justice thinkers about failure, was published in 2011. <http://www.courtinnovation.org/research/daring-fail>

### North Carolina Innocence Inquiry Commission

With respect to the “all-stakeholders” element, the North Carolina Innocence Inquiry Commission includes a Superior Court judge, a prosecuting attorney, a defense attorney, a victim advocate, a member of the public, a sheriff and others. <http://www.innocencecommission-nc.gov/index.html>. For a synopsis of innocence commissions in North Carolina and 11 other states, see M. Tate, “Commissioning Innocence and Restoring Confidence: The North Carolina Innocence Inquiry Commission and the Missing Deliberative Citizen,” *Maine Law Review* 64 (2) (2012). [http://mainelaw.maine.edu/academics/maine-law-review/pdf/vol64\\_2/vol64\\_me\\_l\\_rev\\_531.pdf](http://mainelaw.maine.edu/academics/maine-law-review/pdf/vol64_2/vol64_me_l_rev_531.pdf)

### Allegheny County Comprehensive Case Reviews

With respect to the “all-stakeholders” element: “Virtually everyone who had been involved with these defendants had been invited to attend and share observations: judges, prosecutors, defense counsel, human service providers, probation, police, and staff from the courts and the jail.”

With respect to the “nonblaming” element, in a discussion of lessons learned: “Emphasize that no one will be criticized. Many participants, when told that they were invited to a case review meeting with the presiding judge, figured they must have done something seriously wrong. Thus it was crucial to keep the discussions focused on how the system functioned, not on any particular person’s performance.”

With respect to the “ongoing/routine” element: “Allegheny County will plan to resume its case reviews in October and to continue holding them periodically until the issues generated are not sufficient to justify the preparation time. If that point is reached, it will be strong evidence that the county’s criminal justice system has changed for the better.”

<http://www.alleghenycounty.us/WorkArea/DownloadAsset.aspx?id=35204>

### Other projects that may contain key elements of a sentinel event review approach:

- Eyewitness Identification Task Force: Report to the Judiciary Committee of the Connecticut General Assembly.

<http://www.cga.ct.gov/jud/eyewitness/docs/Final%20Report.pdf>

- Florida Domestic Violence Fatality Review Team.

<http://www.fcadv.org/departments-children-and-families-and-florida-coalition-against-domestic-violence-create-statewide-do>

- Comprehensive Operational Assessment, Criminal Investigative Unit, Sheriff, Will County, Illinois.

[http://www.scribd.com/fullscreen/47496706?access\\_key=key-d7dvwhg1k4m4ipsr1oi](http://www.scribd.com/fullscreen/47496706?access_key=key-d7dvwhg1k4m4ipsr1oi)

This report was commissioned by the Sheriff’s Office of Will County, Illinois, and prepared by a private consulting company. Although it reviews a case (the kidnapping, sexual abuse and murder of Riley Scott) from the perspective of only a single “silo” (policing), rather than all criminal justice stakeholders, it represents a forward-looking, learning-from-error review of the wrongful arrest of Riley’s father.

- Hennepin County Blind Sequential Lineup Project.

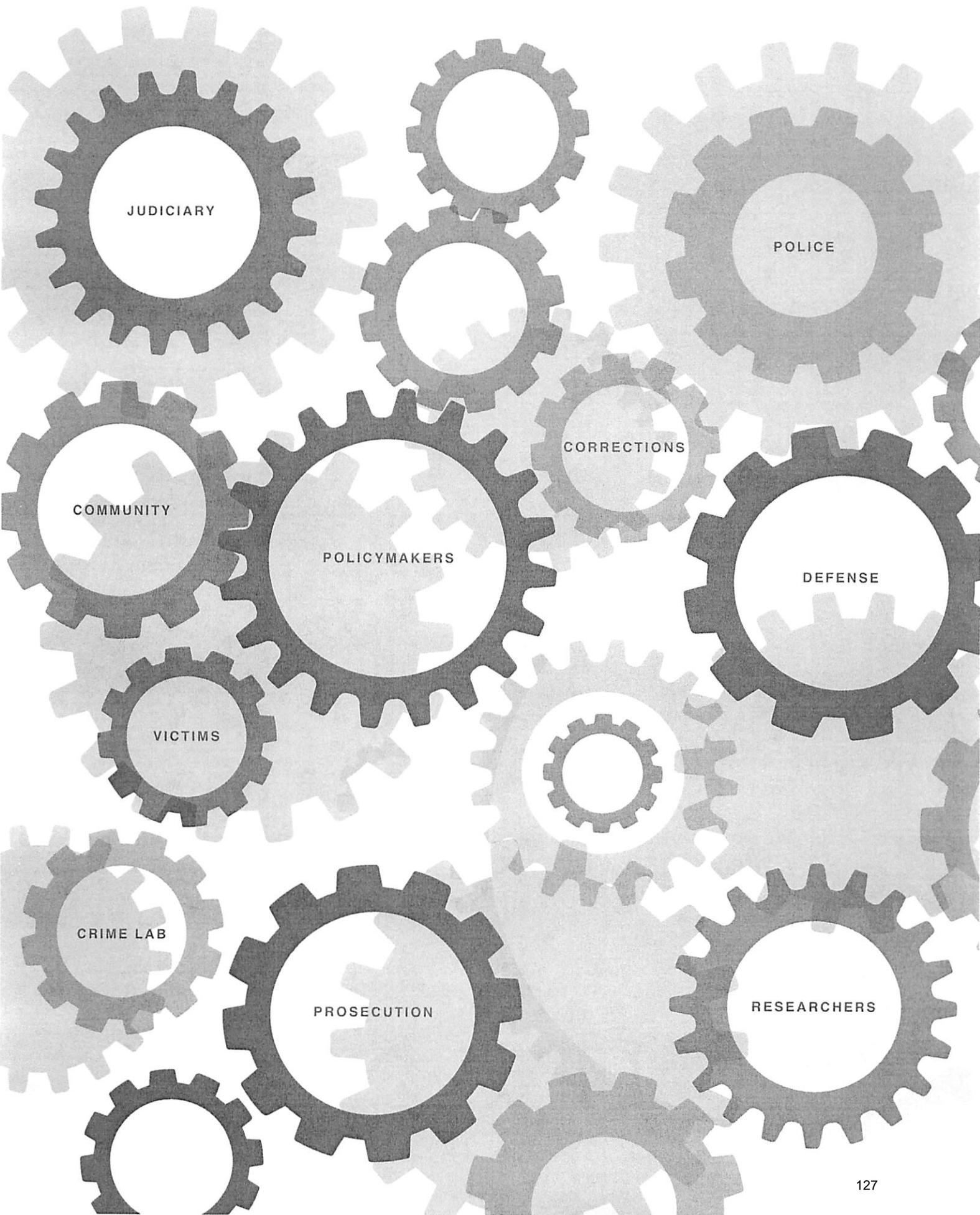
This eyewitness identification project was supported by Grant No. 2004-IJ-CX-0044 awarded by the National Institute of Justice.

<https://www.ncjrs.gov/pdffiles1/nij/grants/246939.pdf>

- Philadelphia Women’s Death Review Team.

[http://www.phila.gov/health/pdfs/2004\\_2006\\_PWDRT\\_final.pdf](http://www.phila.gov/health/pdfs/2004_2006_PWDRT_final.pdf)

- Report on the Conviction of Jeffrey Deskovic.  
<http://www.westchesterda.net/Jeffrey%20Deskovic%20Comm%20Rpt.pdf>
- Task Force on Eyewitness Evidence, Suffolk County, Massachusetts.  
[http://www.innocenceproject.org/docs/Suffolk\\_eyewitness.pdf](http://www.innocenceproject.org/docs/Suffolk_eyewitness.pdf)
- Vera Institute Prosecution and Racial Justice Program.  
<http://www.vera.org/centers/prosecution-and-racial-justice-program>
- District of Columbia Superior Court Ad Hoc Committee on Wrongful Convictions.  
[http://www.dcappeals.gov/internet/documents/Ad-Hoc-Committee-Findings-and-Recommendations\\_2-12-13CORRECTED.pdf](http://www.dcappeals.gov/internet/documents/Ad-Hoc-Committee-Findings-and-Recommendations_2-12-13CORRECTED.pdf)
- National Firefighter Near Miss Reporting System.  
<http://www.firefighternearmiss.com/index.php/home>
- Praxis Safety and Accountability Audit.  
[www.praxisinternational.org](http://www.praxisinternational.org)
- Organizational Learning in Policing.  
<http://www.policefoundation.org/content/organizational-learning-policing>



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## *Preventing and Addressing Wrongful Convictions*

*by Robert J. Milan*

### A Case Study

On October 18, 1986, 23-year-old medical student Lori Roscetti left her school library at approximately 1:00 a.m. after studying. At 4:40 a.m. her body was found next to her car on a railroad access lane on Chicago's near west side. Lori had been beaten to death. Her skull was crushed by a chunk of concrete, her ribs were broken and semen was recovered from her body.

In January of 1987 the investigation focused on suspects previously arrested for breaking into railroad boxcars near the scene of the Roscetti murder. M, 17 years of age, who committed some of those burglaries, was questioned regarding the Roscetti murder. M. eventually gave a court-reported confession implicating 14-year-old C, 17-year-old L, (C's cousin) and 17-year-old O. C also gave a court-reported confession to the Roscetti murder. L and O did not make incriminating statements.

In return for a 12-year sentence for Aggravated Kidnapping, M. testified against L. Three separate jury trials were held for the remaining defendants and all three were convicted of the rape and murder of Lori Roscetti, and all three were sentenced to natural life.

During post-conviction proceedings in 2001, the DNA extracted from the semen found on Lori's body and clothes was compared to the four defendants. No match was found. While the DNA testing was being performed, the Cook County State's Attorney's Office conducted an extensive investigation. Over 100 people were interviewed and dozens of new DNA profiles were compared with those from the crime scene. People who were originally interviewed in 1986 were swabbed, as were a number of new suspects. The DNA profiles were entered into the state and national databases, but no matches were found. In December 2001, the previously convicted defendants were released from prison and their cases were dismissed.

In January 2002, Bernard Roach contacted the police and informed them that his brother, Duane Roach and friend Eddie Harris told him that they committed the Roscetti murder. Bernard's information was verified when the DNA profiles from Duane Roach and Eddie Harris matched the semen stains from Lori's body. When arrested, Duane Roach and Eddie Harris gave detailed videotaped confessions to the Roscetti murder and sexual assault. Later they both pleaded guilty to 75 years in the Illinois Department of Corrections.

### THE WARNING SIGNS

Wrongful convictions are the greatest threat to public confidence in a prosecutor's office. Over the past ten years DNA evidence has demonstrated that wrongful convictions are a national problem. The Cook County State's Attorney's Office has been particularly disturbed by several high profile cases from years past which proved to us that defendants had been convicted of crimes they did not commit. As a result, our office developed a training session for our attorneys focusing on wrongful convictions and specifically false confessions. In the sessions, we use videotapes that show seemingly voluntary confessions, which ultimately turned out to be untrue. The lesson is a dramatic one – and one that all prosecutors should learn.

We have studied local and national cases and have found patterns in these cases. Based on these patterns, we have developed warning signs for prosecutors to use in order to avoid charging the wrong individual with a serious offense. This article is designed to outline these warning signs and advise other prosecutor's offices how to deal with a wrongful conviction.

#### 1. Beware of the nexus between the crime and arrest.

Invariably, investigations that lead to wrongful convictions go awry from the very beginning. A detective relies on a confidential informant who identifies an innocent party. A detective relies on an anonymous phone call, identifying the wrong party. A well-meaning eyewitness misidentifies someone from a mug book. The detective focuses on the person who discovered the body. All of these situations are classic examples of how an investigation can go awry and lead to a wrongful conviction.

As prosecutors we must examine and test the nexus between the crime and arrest. Prior to charging, we should interview the eyewitness to the crime and test the witnesses' credibility and ability to observe the crime. We should go to the scene to determine if the witness could have seen the crime and the perpetrators. Prior to charging, prosecutors should interview the confidential informant to determine his credibility and his source of information. Whatever led the police to the suspect must be examined and tested by the prosecutor prior to charging.

#### 2. Beware of cases where co-defendants have no connections with each other.

In a number of cases in Illinois and nationwide, prosecutors were unable to link co-defendants together. Individuals who had never met were identified from mug books and charged as co-defendants for terrible crimes. Obviously at the time of charging no attempt was made to link these individuals together. Prior to charging prosecutors must do everything possible to connect co-defendants and if you cannot, you may have a serious problem with your case.

#### 3. Beware of confessions from mentally challenged suspects and juveniles.

It is truly difficult to believe that anyone would ever con-

ness to a horrible crime that they did not commit. However, it has become readily apparent from the Roscetti case and others that some people do. Often times, these confessions are taken from very young adults, teenagers or people with low IQ's. A well meaning detective can focus on such a person and during a lengthy interrogation confront the person with enough information that later, that individual may give what appears to be a meaningful confession. Prosecutors should interview and test the suspects to determine the competency level of the person. Also, prosecutors should require that the confession be fully corroborated prior to charging. If the confession does not make sense in light of the physical evidence and other evidence that you have, you may have a problem.

4. Beware of charging before all physical evidence is examined.

This is easier said than done. Crime labs are often overwhelmed with lab requests, leaving prosecutors forced to make charging decisions without vital information. Uninformed decisions lead to wrongful convictions. Prosecutors should collect as much information as possible regarding physical evidence prior to charging.

5. Beware of unbroken alibis.

It is not uncommon for a prosecutor to be confronted with a situation in which two witnesses identify a suspect from a lineup as a killer. This suspect tells the police that at the time in question he was with his girlfriend and his brother. That girlfriend and brother must be interviewed and that alibi should be broken prior to charging, even with two "eye-witnesses." If you cannot break that alibi you may have a problem.

6. Beware of single finger identification cases.

Many of the wrongful conviction cases that have occurred across the country were the result of misidentification by well-meaning witnesses. In these cases, prior to charging, the prosecutor should interview the witness and test the witnesses' credibility and ability to observe. Also, the prosecutor should attempt to corroborate the witness' story with other evidence—the car, clothes, prints, proceeds, weapons, etc.

7. Analyze the rap sheet.

Is this a one-hit wonder or the wrong guy?

We have all seen cases in which an individual with no criminal background suddenly commits a horrible crime. It happens, but it is uncommon. Prior to charging an individual with a serious crime, analyze his rap sheet. If his criminal history is incompatible with this crime, give the case a closer look. In the Roscetti case three of the four wrongfully convicted young men had little or no criminal background. Duane Roach, one of the real killers, had a series of convictions for violent sexual assaults of women.

#### PREVENTION AND RESTORING PUBLIC CONFIDENCE

1. Create an atmosphere in your office that accepts the possibility of misidentification, false confessions and wrongful

convictions. Every prosecutor should feel comfortable telling his supervisor that he has concerns with a current or past case. Such concerns should never be frowned on but encouraged.

2. A prosecutor's office should have some type of review prior to charging. Felony review accomplishes three goals. First, it screens out cases that cannot be proven beyond a reasonable doubt. Second, prosecutors are able to make solid cases stronger prior to charging by making constructive suggestions to police. Third, a thorough review of a case by a prosecutor prior to charging will greatly decrease the chance of a wrongful conviction.

3. Listen to defense attorneys who are adamant about their client's innocence. Sometimes they are right. If a defense attorney raises reasonable concerns, we have a duty to reinvestigate that case. Often times we hear prosecutors say, "twelve citizens found him guilty beyond a reasonable doubt, that's good enough for me!" If there are legitimate questions regarding the case, that type of response is irresponsible. In a questionable case, consider a meaningful reinvestigation that includes re-interviewing everyone involved and if DNA is available, test it. If feasible, create a unit that reinvestigates questionable cases, as we did in Cook County.

4. Provide training regarding misidentifications, false confessions and wrongful convictions. It is important that all of your felony prosecutors are aware of these possibilities. By using an actual case, prosecutors can see how these mistakes occur and how to prevent them in the future. Also, urge and participate with your local police departments to conduct similar training sessions.

5. If you uncover a wrongful conviction, it is your duty to find out how it happened. The public and judiciary will demand that such questions be answered.

6. You must assign open-minded prosecutors and investigators to reanalyze a case. You must have confidence that the people who conduct the reinvestigation will search for the absolute truth and not attempt to justify the original conviction.

7. If you uncover a wrongful conviction, be prepared for ludicrous explanations. In the Roscetti case, some members of law enforcement theorized that the original defendants raped and murdered Lori and later, Harris and Roach had sex with the body. Remember that the original prosecutors and investigators have a vested interest in the original case. Follow the physical evidence and common sense and be prepared for ridiculous theories.

8. Be prepared for cases in which your final decision is not clear-cut. Most crimes don't have DNA. The Roscetti case provided irrefutable evidence that we prosecuted the wrong individuals. Most of the time, you will not have this type of evidence which may require you to make the really tough call.

9. If you dismiss a case based on a wrongful conviction, be prepared to address a clemency petition or pardon request because the defense will make such requests.

10. In order to prevent misidentifications, consider informing witnesses, prior to viewing a lineup or photo array, that the suspect may not be in the lineup or photo array. This admonishment will prevent the witness from having any expectations prior to the identification process. Also consider having lineups and photo arrays conducted by police officers that don't know who the suspect is. This will prevent any possibility or accusation that an officer improperly affected the lineup. Also, consider documenting verbatim what the witness said when the witness identified the suspect.

11. Consider videotaping or audio taping all interrogations of suspects on homicide cases. This will definitely decrease the chance of false confessions for homicides and also protect law enforcement from false accusations of coerced confessions.

What we've outlined in this article are suggestions borne of examining and re-examining the methods by which we approved and prosecuted cases that led to wrongful convictions. It is our hope, that through this process we were able to develop strategies that would better assist our prosecutors, as well as yours, in the search for truth and justice and the elimination of prosecutorial errors. Exposing and learning from these past missteps can only lead to restored confidence within the criminal justice system and more importantly restored public confidence. ❖



Robert J. Milan is a career prosecutor who has spent the last 16 (sixteen) years with the Cook County State's Attorney's Office. He worked his way up through the Felony Trial Division to Supervisor of the Felony Review Unit. He served as Chief Deputy State's Attorney and was appointed the First Assistant State's Attorney of Cook County in

April, 2003. ❖

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## Steven Avery

### After exoneration in rape case, he apparently committed a murder

Convicted in 1985 of a rape and attempted murder in Manitowoc County, Wisconsin, Steven A. Avery was exonerated by DNA tests in 2003. The tests established that the crime had been committed by Gregory A. Allen, who had been a logical suspect from the beginning but was not pursued.

In 2007, Avery, then forty-four, was convicted, based on DNA, of a murder that occurred after his release. He thus became the only defendant ever to have been exonerated of one crime and convicted of another by DNA.

The second victim was Teresa Halbach, a twenty-five-year-old photographer whose mutilated body was found on Avery family property in Manitowoc County after she disappeared on Halloween afternoon in 2005.

The rape of which Avery was wrongfully convicted occurred on July 29, 1985. That conviction rested on an erroneous identification by the victim, thirty-six-year-old Penny Ann Beerntsen. As Beerntsen jogged along a lonely stretch of the Lake Michigan shoreline near the town of Two Rivers, the man belatedly identified as Allen grabbed her from behind, dragged her into a wooded area, raped her, and strangled her until she lost consciousness. When she regained consciousness, she crawled back to the beach, where a young couple wrapped her in a towel and walked with her until they found her husband, who already had called police. An ambulance took her to a hospital. Among evidence put into a rape evidence kit were thirteen pubic hairs thought to have been left by the rapist.

Beerntsen described her assailant as white, stocky build, long sandy hair, brown scraggly beard, no glasses, and brown eyes. The description fit both Avery and Allen. The only discrepancy of note applied equally to both — their eyes were not brown but blue. The local sheriff, Thomas Kocourek, promptly pegged a suspect — Avery, then twenty-three, a father of five with two prior burglary convictions. Six months before the Beerntsen attack, Avery had been accused of trying to abduct the wife of one of Kocourek's deputies.

A photo of Avery was placed into an array of nine photos shown to Beerntsen six hours after the attack. She identified Avery, who was arrested the next day at his home in the town of Two Rivers. The array inexplicably did not include a photo of Allen. For twelve days preceding the crime, he had been under surveillance by the Manitowoc Police Department as a suspect in a recent series of sex related crimes — including an indecent exposure and apparent attempted rape on the very beach where Beerntsen had been attacked. The surveillance had entailed a dozen or so daily checks on the thirty-two-year-old Allen. On the day of the Beerntsen attack, however, the police were occupied with other matters and checked on him only once.

During Avery's trial in December 1985, Beerntsen identified him in open court. When District Attorney David Vogel asked if she had any doubt that he was the man, she replied, "There is absolutely no question in my mind." The only physical evidence suggesting a link between Avery and the crime came from Sherry Culhane, a state forensic serologist, who testified that a hair recovered from a shirt of Avery's was inconsistent with his and his wife's hair but consistent with Beerntsen's.

Avery took the stand and gave a detailed account of what he had been doing during, before, and after the crime. The defense then called sixteen alibi witnesses. Most were relatives, friends, or acquaintances of Avery's, who might be viewed as biased, but one unquestionably was independent — Patricia Lax, a clerk at a paint store in Green Bay, who had no personal connection to Avery. She testified that Avery, accompanied by his wife and five children, had purchased a gallon of paint from her the afternoon of the crime. The store was forty-five miles from the crime scene, and a checkout tape fixed the time of the purchase at only a little more than an hour after the attack. It was hardly conceivable that, in the time allotted, Avery could have made it from the crime scene to a parking area, nearly a mile away, changed out of his blood-stained clothes, gone home, loaded the children into his pickup, driven forty-five miles to the store, picked out the paint, and paid for it.

As strong as Avery's alibi seemed, Beerntsen's positive identification trumped it. On December 14, 1985, after a little more than four hours of deliberation, the jury found Avery guilty. The following March, Judge Fred Hazelwood<sup>2</sup>

sentenced him to thirty-two years in prison. The Wisconsin Court of Appeals unanimously affirmed the conviction. In 1995, Avery won a trial court order for DNA testing of biological material obtained from scrapings of Beermtsen's fingernails, but the results failed to exclude Avery.

By early 2002, however, DNA technology had advanced to a point that the pubic hair recovered from Beermtsen at the hospital seventeen years earlier could be tested. Over the objection of the prosecution, a legal team from the University of Wisconsin Law School Innocence Project — Keith Findley, John Pray, and Wendy Paul — obtained a court order for the testing to be performed by the Wisconsin Crime Laboratory. On September 10, 2003, the laboratory released a report positively identifying the hair as Allen's — leaving no doubt that he, not Avery, had raped Beermtsen.

The identification was possible because Allen's DNA profile was in the FBI's Combined DNA Index System (CODIS) as a result of his conviction for a Green Bay sexual assault — a crime that would have been prevented had he been investigated for the Beermtsen crime a decade earlier. For the Green Bay crime, Allen had been sentenced to sixty years in prison — an extended term imposed because he had been identified as the perpetrator of other sex crimes that likewise would have been prevented if the 1985 investigation had been more thorough.

On September 11, 2003, on a joint motion of the Manitowoc District Attorney and the Wisconsin Innocence Project, Avery was released from prison, having served eighteen years and forty-eight days. Most rape victims who have made erroneous identifications leading to wrongful convictions have never acknowledged their mistakes, but Beermtsen was different. She not only apologized to Avery, but her mistake set her on a mission to reform eyewitness identification procedures — an effort that succeeded in March 2005, when the Wisconsin Department of Justice adopted a model eyewitness identification protocol that held the promise of significantly reducing eyewitness identification error. Under Wisconsin law, Avery qualified for \$25,000 in automatic compensation — \$3.78 for each day of his wrongful imprisonment. In 2005, Avery settled a civil rights claim against Manitowoc County for \$400,000, most of which went for legal fees in the Halbach case.

The murder case went to trial in February 2007 before a jury and Manitowoc County Circuit Judge Patrick Willis. The prosecution, led by Calumet County District Attorney Kenneth Kratz, introduced evidence that blood from both Halbach and Avery was found in her car, that her car key was found in Avery's residence with his DNA on it, and that Halbach's DNA was on a bullet fragment found in Avery's garage. Avery's defense was that sheriff's deputies had planted the evidence to frame him. On March 18, 2007, after nearly five weeks of testimony and three days of deliberation, the jury found Avery guilty of first-degree intentional homicide carrying a mandatory life sentence.

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— *Keith Weghorst and Rob Warden*

# THE MYTHOLOGY OF ARSON INVESTIGATION <sup>a</sup>

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## ABSTRACT

Unlike in many other fields of scientific inquiry, progress in fire investigation is held back by the burden of an entrenched mythology. Despite the fact that it has been fifteen years since NFPA 921 was first published, some fire investigators still rely on “misconceptions” about the meaning of various fire effects and fire patterns.

This paper will explore the development and promulgation of the mythology of arson investigation. Certainly, there is no reason to believe that anyone ever set out to promulgate something that was not true. It is likely that many myths came about as a result of unwarranted generalizations. For example, an investigator might observe a pattern of spalling around the remains of a gasoline container and make an association of gasoline with spalling. The next time that spalling is observed, gasoline is inferred.

Some myths arose because of intuitively “obvious deductions.” The notion that gasoline burns hotter than wood is an appealing one, as is the notion that a narrow V-pattern indicates a “rapid fire.” The problem is that the term “rapid” is never defined, thus making it impossible, in many cases, to actually design an experiment to test a particular hypothesis about the significance of a particular indicator. Even when an indicator can be shown by direct evidence to be of no value, resistance to change and a culture of “circular citations” allow the myth to live on.

Many of the myths were gathered by the Law Enforcement Assistance Administration (LEAA) and published in *Arson and Arson Investigation Survey and Assessment* (1977), and although they were reported with appropriate cautionary language, the cautions were not heeded. And when the “indicators” were listed by what should have been the ultimate authority, the cautions were lost. No less an authority than the National Bureau of Standards (NBS then—now NIST) published a *Fire Investigation Handbook* (1980), which stated that crazed glass meant rapid heating, shiny alligator blisters meant that a fire burned “faster than normal,” and narrow V’s indicate “fast-developing, hot fires.”

In the 1980s, one American text after another referred to the NBS publication or to another publication that cited the myths published in the LEAA report. These circular citations continue in books still in print. Interestingly, many of the myths never gained much credibility in the United Kingdom because the major “go to” textbook, Cooke and Ide’s

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<sup>a</sup> This paper is essentially a distillation of Chapter 8 from the author’s textbook, *Scientific Protocols for Fire Investigation*, CRC Press, 2006.

*Principles of Fire Investigation* (1985), either did not repeat the myths, or provided an accurate interpretation of the significance of indicators such as crazing and spalling.

In 1985, when the National Fire Protection Association (NFPA) Standards Council became sufficiently concerned about the validity of fire investigations, it appointed a Technical Committee to address the issue. Seven years later, the Committee and NFPA produced the first edition of NFPA 921, *Guide for Fire and Explosion Investigations*. The howls of protest from fire investigation “professionals” were deafening. If what was printed in that document were actually true, it meant that hundreds or thousands of accidental fires had been wrongly determined to be incendiary fires. No investigator wanted to admit to the unspeakable possibility that they had caused an innocent person to be wrongly convicted, or a family to be wrongly denied their life savings. The profession was in denial.

In 1998, the Technical Committee on Fire Investigations, responding to public pressure, removed the word “misconception” from the titles of several paragraphs in the chapter on pattern development in the optimistic but mistaken belief that previous editions of the document, which was still not accepted in many organizations, had relieved the profession of these misconceptions.

The myths are slowly dying out (or being “*Dauberted*” out), but there are still practitioners who use them today, with disastrous consequences. Examples of the continued promulgation and application of the mythology since 2000 will be presented, as will the debunking of the myths as set forward in NFPA 921.

## **THE DEVELOPMENT AND PROMULGATION OF MYTHS**

The introduction and persistence of mythology in arson investigation is an unfortunate part of the history of the discipline, and is a subject that many fire investigators do not like to think about. Some would like to pretend that the myths have died, in the hope that people would gradually forget about them and they would not be a problem anymore. It is this failure to address a serious problem in the training and education of fire investigators that causes the myths to persist. The unfortunate consequence is that innocent lives are destroyed by well-meaning but ignorant investigators. The purpose of this paper is to expose those myths, and to the extent possible, attempt to understand why they came into being, and why some of them still persist. The hope is that new investigators, or those considering entering the discipline, may be spared the necessity of having to “unlearn” things that are simply not true.

Just as has been learned from the study of Greek or Roman mythology, no single reason exists to explain why a myth develops. Certainly, no reason exists to believe that any investigator deliberately set out to promulgate something that was not true. It is likely that most myths came about as a result of unwarranted generalizations. For example, an investigator might observe that in a garage fire, a pattern of spalling surrounds the remains of a gasoline container, and makes an association of gasoline with spalling. The next time he sees spalled concrete, he infers that gasoline must have been involved.

Some myths arise because of “intuitively obvious deductions.” The notion that gasoline burns hotter than wood is appealing; as anyone who has ever started a wood fire knows, it is much easier to start it with liquid fuel. And certainly after a short time, a fire started with gasoline, is throwing off much more heat than the fire burning wood only. Therefore, the flame temperature must be higher, right? Wrong! But even Paul Kirk, arguably one of the finest forensic scientists of his time, bought into this notion. In the first edition of Kirk’s *Fire Investigation* (1969) he described the utility of examining melted metals.

Whenever any residues of molten metal are present at the fire scene, they will reliably establish a minimum temperature for the point of their fusion in the fire. The investigator may use this fact to advantage in many instances, because of the differences in effective temperature between simple wood fires and those in which extraneous fuel, such as accelerant is present.<sup>1</sup>

To this day, investigators sometimes infer the presence of accelerants when they observe a melted aluminum threshold.

The notion that crazed glass indicates that the glass was rapidly heated was appealing enough that Brannigan, Bright and Jason, three respected fire researchers at the National Bureau of Standards (now NIST), allowed it into the *Fire Investigation Handbook* (1980). Some authors have declared that crazed glass is sufficiently useful that the size of the crazing cracks can indicate proximity to the area of origin.<sup>2</sup>

It is the **publication** and continued promulgation of myths that ensures their longevity. If an “arson school” decides to use a text containing the mythology in its training courses, hundreds of investigators can be exposed to this false “gospel.” Those who take few refresher courses, fail to keep up with the literature, and attend few meetings may never be exposed to updated ideas and new research.

The question naturally arises as to why fire investigation espouses (or has espoused) such a wide variety of myths, whereas DNA analysis, a forensic discipline derived from molecular biology, has many fewer myths to expunge. To some extent, the answer lies in the nature of the practitioners. In forensic DNA, the leaders in the field are trained scientists. If someone told them that crazed glass resulted specifically from rapid heating, they might remember an experiment in undergraduate chemistry lab that they tried to save from overheating by adding some water, only to watch the glass beaker craze when the water touched it. Thus they might consider an alternate explanation for the observation of crazing. During their education, scientists are supposed to acquire what Carl Sagan referred to as a “baloney detector,” otherwise known as natural scientific skepticism. However, one need not possess a science degree to be appropriately skeptical. Sagan wrote:

The tenets of skepticism do not require an advanced degree to master as most successful used car buyers demonstrate. The whole idea of a democratic application of skepticism is that everyone should have the essential tools to effectively and constructively evaluate claims of knowledge. All science asks is to employ the same levels of skepticism we use in buying a used car.<sup>3</sup>

Presented with the notion that large shiny alligator blisters occur only on wood surfaces that have been rapidly heated, a scientist will say, “Show me the data!” while an apprentice fire investigator will absorb the “knowledge” from his experienced mentor. When someone with an advanced degree publishes the myth and maybe even an apparent explanation for why it is so (albeit with no real data), the apprentice internalizes the fallacy as fact, making retraining difficult. And once the investigator uses the myth to send someone to prison, he is extremely reluctant to question the myth’s authority, lest he be forced to admit to an unspeakable error.<sup>b</sup>

Much of the mythology about fire investigation was collected by the Aerospace Corporation, under a contract to the Law Enforcement Assistance Administration (LEAA) in a 1977 booklet entitled *Arson and Arson Investigation: Survey and Assessment*. To their credit, the authors of this survey pointed out, “Although burn indicators are widely used to establish the causes of fires, **they have received little or no scientific testing.**” They recommended, “a program of carefully planned scientific experiments be conducted to establish the reliability of currently used burn indicators. Of particular importance is the discovery of any circumstances which cause them to give false indications (of, say, a fire accelerant).” In a remarkably prescient statement, they added, “A primary objective of this testing would be to avert the formidable repercussions of a court ruling on the inadmissibility of burn indicators on the grounds that their scientific validity had not been established.” Despite this prediction, serious challenges to the myths did not become common until NFPA 921 was published. Part of the reason for the acceptance of the mythology may be that no less an authority than the National Bureau of Standards gave its blessing to many of the myths. In section 1.1 of the *Fire Investigation Handbook*, which two National Fire Academy staffers are credited with contributing, most of the myths from the LEAA report were reprinted without a single caution of the type found in the original study. Having the imprimatur of such an august body as NBS, fire investigators and textbook authors believed (incorrectly as it turns out, but who knew?) that the myths had been scientifically tested.

The LEAA study provides as good a jumping off place as any for the study of the myths of fire investigation. Here is the list from the survey.

**Alligatoring effect:** checking of charred wood, giving it the appearance of alligator skin. Large rolling blisters indicate rapid intense heat, while small flat alligatoring indicates long, low heat. (This myth was repeated in the NBS *Handbook*.)

**Crazing of glass:** formation of irregular cracks in glass due to rapid intense heat—possible fire accelerant. (This myth was repeated in the NBS *Handbook*.)

**Depth of char:** depth of burning of wood—used to determine length of burn and thereby locate the point of origin of the fire.

**Line of demarcation:** boundary between charred and uncharred material. On floors or rugs, a puddle-shaped line of demarcation is believed to indicate a liquid fire accelerant. In the cross section of wood, a sharp distinct line of demarcation indicates a rapid, intense fire. (This myth was repeated in the NBS *Handbook*.)

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<sup>b</sup> Though rare, such admissions happen. A Texas fire marshal, commenting on the execution of Cameron Todd Willingham, stated the following in the Chicago Tribune: “At the time of the Corsicana fire, we were still testifying to things that aren't accurate today, **They were true then, but they aren't now.**”

**Sagged furniture springs:** because of the heat required for furniture springs to collapse from their own weight (1150° F) and because of the insulating effect of the upholstery, sagged springs are believed to be possible only in either a fire originating inside the cushions (as from a cigarette rolling between the cushions) or an external fire intensified by a fire accelerant.

**Spalling:** breaking off of pieces of the surface of concrete, cement or brick due to intense heat. Brown stains around the spall indicate the use of a fire accelerant.<sup>4</sup>

In addition to the misconceptions listed in the LEAA report, the following myths have also been widely promulgated:

**Fire load:** Knowing the energy content (as opposed to the energy release rate) of the fuels in a structure was believed to allow an investigator to calculate the damage that a “normal” fire should produce in a given time frame.

**Low burning and holes in the floor:** Because heat rises, it was widely believed that burning on the floor, particularly under furniture, indicated an origin on the floor.

**V-pattern angle:** The angle of a V-pattern was supposed to indicate the speed of the fire. (This myth was printed in the NBS *Handbook*.)

**Time and Temperature:** By estimating the speed of a fire, or establishing the temperature achieved by a fire, it was believed that an investigator could determine whether it was accelerated.

Many of the myths about fire investigation were addressed in the first two editions (1992, 1995) of NFPA 921. In the chapter on fire patterns, there were several paragraphs entitled “Misconceptions about \_\_\_\_\_ (char, spalling, v-patterns, inverted cone patterns).” While the Technical Committee felt it important to shine a spotlight on these myths, many in the fire investigation community railed against the notion that any of them had ever harbored any misconceptions about anything. They insisted, and the committee acquiesced to a change in the 1998 edition, that section titles be changed to “Interpretation of \_\_\_\_\_,” as if removing the word “misconception” would remove the misconception.

## ALLIGATORING

The *Fire Investigation Handbook* contains some useful information, but it starts out with a myth-filled chapter on how to determine origin and cause. Chapter 1 of the *Handbook*, states:

In determining whether the fire was a slowly developing one or a rapidly developing one, the following indicators may be used: a) Alligating of wood—slow fires produce relatively flat alligating. Fast fires produce hump-backed shiny alligating.<sup>5</sup>

The 1982 IFSTA (International Fire Service Training Association) manual unequivocally states:

If alligatoring is large, deep, and shiny, the fire spread extremely rapidly. Large alligatoring should be considered an indication of the nearby presence of a flammable or combustible liquid.<sup>6</sup>

Nowhere is it stated what the difference is between a “fast” fire and a “normal” fire. The lack of a definition of these subjective words not only renders the “indicators” of a fire’s progress meaningless, it also makes it nearly impossible to design an experiment that tests the indicator’s usefulness. The Army’s Field Manual 19-20, *Law Enforcement Investigations*<sup>c</sup> provides a slightly different interpretation of alligatoring when it states:

When wood burns, it chars a pattern of cracks which looks like the scales on an alligator’s back. The scales will be the smallest and the cracks the deepest where the fire has been burning the longest or the hottest. Most wood in structures char at the rate of 1 inch in depth per 40 to 45 minutes of burning at 1400° to 1600 °Fahrenheit — the temperature of most house fires. (*Thus combining three misconceptions in a single paragraph!*)<sup>7</sup>

O’Connor’s *Practical Fire and Arson Investigation* (1986) stated:

Deep alligatoring (large rolling blisters) on an exposed wooden surface ordinarily indicates an intense, rapidly moving body of flame. This condition may be associated with the use of an accelerant.<sup>8</sup>

The second edition of the book (1997) is far more cautious, the authors having been brought up to speed on this subject. The newer text states:

It has been suggested that the presence of large shiny blisters (alligator char) and the surface appearance of char, such as dullness, shininess or colors have some relation to the presence of liquid accelerant as the cause, but no scientific evidence substantiates this. The investigator is advised to be very cautious in using wood char appearance as an indicator of incendiarism.<sup>9</sup>

They have not completely given up on the myth, however. The 1997 text shows a photo of “a heavy rolling char...caused by the rapid intense movement (extension) of heat and flame.”

Randall Noon, in his 1995 *Engineering Analysis of Fires and Explosions*, wrote:

In the same way that a hunting guide interprets signs and markers to follow a trail of game, a fire investigator looks for signs and markers which may lead to a point of origin. For example, a fast, very hot burn will produce shiny type wood charring with large alligatoring. A cooler, slower fire will produce alligatoring with smaller spacing and a duller appearing char.

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<sup>c</sup> The Manual was originally published in 1985, and reprinted in 1995. In 2005, The Army “updated” the Manual, but many of the misconceptions (alligatoring, crazed glass, narrow V-patterns) remain. The fact that the Manual now mentions NFPA documents makes it even more dangerous than the previous editions. The 1995 document is still available to the public through several internet vendors.

Noon then goes on to explain “scientifically” why this is should be so.

As heat impinges on the piece of wood, the water in the surface material will evaporate and escape from the wood. The rapid loss of the water at the surface is also accompanied by a rapid loss of volume, the volume which the water formerly occupied. The wood surface then is in tension as the loss of water causes the wood to shrink. This is the reason why wood checks or cracks when exposed to high heat or simply dries out over time. Of course, if the heat is very intense, more of the water “cooks” out, and the cracking or alligatoring is more severe.<sup>10</sup>

The scientific-sounding explanation (though it is rubbish) lulls the reader into believing that the author actually knows what he is talking about. This kind of exposition in many books that repeat the myths has enhanced their credibility and thus their longevity.

The final word on this and most other myths may be found in NFPA 921. Here is what it says about alligatoring:

**6.5.5 Interpretation of Char.** The appearance of the char and cracks has been given meaning by the fire investigation community beyond what has been substantiated by controlled experimentation. It has been widely stated that the presence of large shiny blisters (alligator char) is proof that a liquid accelerant was present during the fire. This is a misconception. These types of blisters can be found in many different types of fires. There is no justification that the appearance of large, curved blisters is an exclusive indicator of an accelerated fire. Figure 6.5.5, showing boards exposed to the same fire, illustrates the variability of char blister.

**6.5.5.1** It is sometimes claimed that the surface appearance of the char, such as dullness, shininess, or colors, has some relation to the use of a hydrocarbon accelerant or the rate of fire growth. There is no scientific evidence of such a correlation, and the investigator is advised not to claim indications of accelerant or fire growth rate on the basis of the appearance of the char alone.

The referenced figure is a photograph taken by Monty McGill, which was first shown in *Kirk's Fire Investigation*, Second Edition. It is the definitive evidence that debunks the myth of the shiny alligator. For our friends in the UK, we note the fact that Dougal Drysdale prefers the term “crocodiling.”

## **CRAZED GLASS**

It is unclear why anyone ever thought that crazing of glass indicated rapid heating. Perhaps a piece of crazed glass was observed near the known origin of a fire, and one influential investigator reached the wrong conclusion and repeated it to a large group of seminar attendees. However the notion began, it achieved widespread acceptance. Unlike most myths, this one has proved especially amenable to testing, but until 1992, nobody bothered to make the effort.

The NBS *Handbook* stated, “Window glass fragments in large pieces with heavy smoke deposits usually indicates slowly developing fires. Crazed or irregular pieces with light smoke deposits indicate a rapid buildup of heat.”<sup>11</sup> Both statements are false, but crazing is our focus for now.

The Army’s Field Manual, *Law Enforcement Investigations*, states, “As a general rule, glass that contains many cracks indicates a rapid heat buildup. Glass that is heavily stained indicates a slow, smoky fire.”<sup>12</sup>

IFSTA’s *Fire Cause Determination* stated:

A window with small crazing (minute cracking), and perhaps with light smoke accumulation, is probably near the point of origin, its condition suggesting intense and rapid heat buildup. Large crazing and a heavy smoke accumulation suggest slow heat buildup and remoteness from the point of origin.<sup>13</sup>

The IFSTA manual may have been the source used in *Practical Fire and Arson Investigation*, (O’Connor, 1986 and O’Connor and Redsicker, 1997), which repeats the notion that crazing implies a “rapid and intense” heat buildup, and that if the crazing is “small,” it is close to the area of origin. A larger crazing pattern, on the other hand, “implies that it may have been located in an area some distance away from the point of origin.” The misconception about crazing follows an extensive discussion of the types of glass that an investigator may encounter, complete with softening points, chemical compositions and applications. The reader thus is led to believe that the writers know all about glass.

DeHaan, who today warns against reading anything into a finding of crazed glass and lists it under “Myths and Misconceptions,” still believed the myth in 1991. He stated, “Crazed glass, where the fractures or cracks resemble a complex road map in the glass, is certainly indicative of a very rapid buildup of heat sometime during the fire.”<sup>14</sup> Getting closer to an understanding of the true cause of the phenomenon, he went on to state, “Small cratering or spalling of the glass is more likely due to a spray of water hitting a hot pane of glass during suppression.” By the time the fourth edition of *Kirk’s* was published, in 1997, DeHaan acknowledged the work by this author that proved that crazing is **only** the result of rapid cooling.<sup>15</sup>

In the study conducted by the author following the urban wildland fire in Oakland, CA in 1991, crazed glass was one of three “indicators” examined. We observed that all of the crazing occurred at those parts of the fire where there had been active suppression efforts, suggesting that water was associated with crazing. Later, in a series of laboratory experiments conducted by the author, we demonstrated that crazing is never caused by rapid heating, and can only be caused by rapid cooling.<sup>16</sup>

It is interesting to note that crazing of glass as an indicator of rapid heating is a myth that never caught on in the United Kingdom. This is almost certainly because in the UK, the most widely read fire investigation text, *Principles of Fire Investigation*, correctly identified “the appearance of many small conchoidal fractures on one surface of the glass,” as being the

result of rapid cooling from extinguishment water.<sup>17</sup> The authors of that text did not use the term “crazing.” The absence of the crazing myth in the UK lends credence to the proposition that it is **publication** in apparently respectable texts that is responsible for the perpetuation of the mythology of arson investigation.

## DEPTH AND LOCATION OF CHAR

In 1979, Aetna Life & Casualty published a brochure-style handbook, authored by John Barracato, which espoused as many myths as any publication ever printed on the subject. On the subject of depth of char, the booklet entitled *fire... is it arson?* states:

The speed at which a fire burns is an important indicator of its cause. A fire not involving accelerant (such as gasoline or other flammable liquid) burns at the rate of 3/4 inch per hour into pine wood. The investigator should ask the fire department how long and intensely the fire burned, then carefully inspect any charred wood to see if there is a reasonable correspondence between the length of time the fire burned and the degree of damage it caused.<sup>18</sup>

Exactly this type of analysis was put forward in the case of *Commonwealth v. Han Tak Lee*. (1989). The investigator in that case made the following observations:

- (a) the fire burned for a total of 28 minutes,
- (b) fire burns one inch in 45 minutes (note: this is a more commonly cited charring rate than Barracato’s 3/4 inch per hour), and
- (c) 2 by 10s, were completely consumed.

Therefore, the fire **must** have been accelerated because it would take 4.5 hours to burn through a 2 by 10. This of course, assumed that the fire would only burn in one dimension, as opposed to attacking the wood from both sides. He estimated the time required to burn a 2 by 4 at 1 hour 43 minutes at 1780° F.<sup>19</sup> The investigator was misled by two myths, one, that the depth of char could be used to determine reliably the time of burning, and two, a uniquely-held belief that only one dimension of the wood would be attacked by the fire. If we assume, for the sake of argument, that fire burns one inch in 45 minutes, then it should take only 34 minutes to burn through a 1 1/2 inch piece of wood, assuming it is attacked from both sides. This investigator had both his premise and his implementation of that premise wrong. NFPA 921 states unequivocally that depth of char measurements should not be relied on to determine the duration of the burning.

## LINES OF DEMARCATION

This is one of the more complex myths in fire investigation because, in some instances, lines of demarcation can be used to tell exactly what happened, whereas in other instances, lines of demarcation are just lines. The threshold question is whether the compartment where the lines occur experienced full room involvement. Let us be clear. There are times when a fire pattern is so obviously caused by an ignitable liquid that further analysis truly is “the icing on the cake,” to coin a phrase. Once a fire progresses to full room involvement, however, it is no

longer valid to make a determination using visual cues alone, and there are some who maintain this should never be done. Sharp, continuous, irregular lines of demarcation between burned and unburned areas are frequently cited as evidence of the use of ignitable liquids. It is true that ignitable liquids can produce such patterns on carpeting, and many arson seminars include staged fires that are extinguished early, so that investigators can learn to recognize “pour patterns.” What is not evident from these incipient test fires is what happens after the room becomes fully involved.

Lines of demarcation can occur for no apparent reason. The intensity of radiation falls off as the square of the distance from the source to the target, so at some point, perhaps a sharply defined point, insufficient energy exists to maintain combustion. This property, as well as the random nature of some burning, can result in sharp lines of demarcation.

Protection patterns can be produced by irregularly shaped pieces of gypsum drywall, which fall from the ceiling and provide protection to whatever floor they land upon. Clothing on the floor has also been known to produce alternating areas of exposure and protection.

In a ground-breaking study of burn patterns caused by burning pools of gasoline and kerosene, Putorti demonstrated that even on wood and vinyl floors, the edges of the patterns produced are not necessarily all that sharp.<sup>20</sup> The only definitive pattern he found that could reliably be associated with the use of ignitable liquids was the “doughnut” pattern on carpeting, caused by protection at the center of the pattern by the presence of liquid fuel that had not yet evaporated.

Lines of demarcation in the cross section of charred wood have been cited since 1980 as an indicator of the speed of a fire. The *Fire Investigation Handbook* stated, “A distinct line between charred and uncharred portions indicates a rapidly developing fire. Lack of a distinct line usually indicates a slow, cooking process, thus, a slowly developing fire.”<sup>21</sup> O’Connor (1986) and O’Connor and Redsicker (1997) both provide a diagram of a cross section of a piece of lumber showing a sharp line of demarcation indicating a rapid spread, and a gradual line of demarcation indicating a slow-burning fire. DeHaan (2002) states, “One indicator that is more reliable [than the surface appearance of char] is the appearance of the charred wood in cross section. When a charred beam is cut crosswise, the gradation between the charred layer and the underlying undamaged wood is more gradual with a slowly developing fire.” He then goes on to provide a perfectly reasoned analysis of why this should be so, but, like O’Connor, provides neither data (though he also provides a drawing), nor a definition of what is meant by “sharp,” “gradual,” “fast,” or “slow.” It seems to be a case of “I know it when I see it.” To his credit, DeHaan cautions that a fast-developing fire may or may not be accelerated. Nonetheless, this is the type of “data” that an investigator may use to incorrectly “eliminate” a smoking fire, since smoking fires are not “fast-developing.” (Actually, once a smoldering fire started by a cigarette makes the transition to flaming combustion, the speed of fire growth is not distinguishable from a fire ignited by an open flame.)

Some of the more frequently debated sections of NFPA 921 deal with determinations made by observing lines of demarcation. While it is silent on the observation of cross sections, the document contains a whole section devoted to caution in the interpretation of burn patterns

on the floor. NFPA 921 contains more cautions on this subject than on any other. The reason for the abundance of cautions on the subject of interpreting lines of demarcation is simple—the errors caused by this particular misinterpretation have been legion.

## SAGGED FURNITURE SPRINGS

The Aetna booklet *fire...is it arson?* (1979) advised fire investigators to photograph furniture springs, “because their appearance can help the investigator document the area of origin. Severely sagging springs can indicate that a flammable liquid was involved and created heat intense enough to cause the springs to sag.”<sup>22</sup> Carter, on the other hand, writing in *Arson Investigation* (1978) stated that collapsing all or part of a coil spring was an indication of a cigarette starting the fire.<sup>23</sup>

In the Han Tak Lee case, smoking in bed was ruled out because the bedsprings had lost their temper. Clearly, this is an area of much confusion. In 1989, Tobin and Monson, two FBI laboratory scientists, subjected furniture springs, both loaded and unloaded (with and without weights on them), to different fire conditions, and basically concluded that the condition of the springs is of little probative value in fire investigation.<sup>24</sup> DeHaan correctly states that varying degrees of spring damage can provide some insight about the progress of a fire but cautions that the collapse of springs cannot be reliably used to determine whether a fire was incendiary.<sup>25</sup> NFPA 921 states that the value of analyzing the furniture springs is in comparing the differences in the springs to other areas of the mattress, cushion, or frame. Comparative analysis of the springs can assist the investigator in developing hypotheses concerning the relative exposure to a particular heat source.

## SPALLING

There exists no more misunderstood and misused indicator than concrete spalling. It has been the pivotal “indicator” in many major fire cases, and has been the subject of numerous contentious articles in the *Fire and Arson Investigator*. To this day, arson cases are made on the basis of spalled concrete. Kennedy’s “Blue Book,”(1977) had the following comments on spalling:

Spalling caused by flammable liquids burning is usually found at low levels because the flammable liquid vapors are heavier than air and tend to go down.  
... Regardless of the composition of the concrete or brick, the indicator is the spalled area or areas indicating the burning of accelerants....  
...The spalling temperatures are usually much higher than the temperatures found in the normal dwelling or commercial building fire. Therefore, we know that accelerants were used.<sup>26</sup>

IFSTA’s *Fire Cause Determination* provided the following statement on spalling in 1982:

Concrete floors and assemblies that have spalling should be examined closely. The spalling may be an indicator of the use of accelerants. If the accelerants had adequate time to soak in before ignition, the spalling will follow the flow pattern of the liquid. Spot spalling is not a clear indicator of the use of

accelerants. Further, it is not unusual for spot spalling to result from severe fire exposure.<sup>27</sup>

This semi-cautious language is typical of what has been written about spalling. Skeptics have always questioned the relationship between ignitable liquids and spalling. These include Harvey French in 1979, Fred Smith and Jack Mitchell in 1981, Bruce Ettling in 1984, Charles Midkiff in 1990 and Bernard Beland in 1993. Some fire investigators simply ignored all these skeptics, and ploughed on with their case making.

One of the largest insurance bad faith awards in Alabama history was the result of a fire investigator, who relied on a “trail of spalling” in addition to other “indicators” to conclude that the cause of a fire was arson. It did not help that the fire chief stood on the “trail” before the fire reached the basement. Nor was the court impressed with the shape of the “trail” when it learned that its shape resulted from the investigator shoveling a trail.<sup>d</sup> When the slab was completely cleared, it was found that the entire slab had spalled, and no “trail” of any kind had ever existed.<sup>28</sup>

Fire investigators have argued endlessly about the characteristics of an accelerant-induced spall versus a naturally occurring one. A brownish, or pinkish halo around the hole was thought to indicate the presence of burning hydrocarbons<sup>e</sup>. Numerous slides and photos were exchanged, but in the end, the consensus was that the skeptics were right.

The evolution of DeHaan’s thinking is instructive. In 1991 he wrote, “As a fire indicator, spalling can indicate the presence of such suspicious sources of localized heating as a chemical incendiary or a volatile petroleum liquid.” In the next edition (1997), the language was moderated to the following: “As a fire indicator, spalling can indicate the presence of a significant fuel load of ordinary combustibles, as well as the presence of suspicious sources of localized heating as a chemical incendiary or a volatile petroleum liquid.” By the fifth edition of *Kirk’s* (2002), spalling had been relegated to DeHaan’s list of “Myths and Misconceptions.”

Most of what is written about spalling today wishfully refers to misconceptions formerly held. NFPA 921 has, since its inception, warned about misinterpreting spalling. Overall, 921 states that the importance of spalling to the fire investigator lies in the documentation and analysis of a heat source.

One way to tell whether an investigator is keeping up is to look at the way he spells spalling. Some people spell it “spalding” and some spell it “spaulding.” The origin of the misnomer is

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<sup>d</sup> The court’s characterization of the testimony of the investigator is instructive. “The court concludes that not only is [the investigator’s] testimony as a whole completely void of credibility, but the presentation of his testimony borders on the perpetration of a fraud upon this court. For [the investigator] and [the insurance company] to present to this court a case so heavily dependent upon “spalling” as this case, when it is indisputable that [the investigator] selectively cleared only those areas of the floor which supported this incredulous theory is reprehensible.”

<sup>e</sup> Cook and Ide (1985) reported that the color change was probably a result of the dehydration of yellow colored hydrated iron oxides, which turned pink or reddish brown at about 300 °C.

probably the past tense of the word spall. One sees spalled concrete. People who don't know any better add the "d" and call the process spalding or spaulding. Such people have apparently never read a text or even an article on the subject, and are quite beyond hope.

## **FUEL LOAD**

In one of the early attempts to bring a quantitative approach to the practice of fire investigation, French (1979) described a methodology by which a fire investigator could determine whether the fire behaved in a "normal" manner. He described the process as follows:

The heat energy production of fuels is extremely important to any competent fire investigator in determining fire load in the premises or equipment under investigation, again in respect to its potential in affecting temperature rise and spread and the time spectrum....

Fire load of any given space may be established by knowing the type of combustibles in storage, their calorific heat producing capacity in Btu's per lb., the total weight of the combustibles in storage, and the square-foot capacity of the space.

The formula is as follows: multiply the calorific contents in Btu's per lb. by the total weight of the contents or materials in pounds. Then, divide the result by the area in square feet. The answer is fire load per square foot.

National Bureau of Standards and American Standards as well as the National Fire Protection Association and British time/temperature curves are in general agreement as to what temperature rise may be expected in various occupancies, with known fire loads, particularly during the first two hours of combustion.

For example, with sufficient oxygen to support continuing combustion, fires in buildings may be expected to attain 1000 to 1200 °F during the first 5 to 10 minutes, accelerating on the curve to approximately 1500 °F in the first half hour and with temperatures reaching the order of 1700 °F at one hour.<sup>29</sup>

Carroll, writing in *Physical and Technical Aspects of Fire and Arson Investigation*, adopted a similar approach, but instead of fire load, urged investigators to use the flame-spread index described earlier in his text. The vaguely defined process was described in two paragraphs as follows:

Using this flame spread index (available from Underwriters Laboratories, Inc.), a fire investigator can determine the comparative rate of how fast a fire should or should not have spread under normal circumstances by comparing the burning rates of known fires and the standard ASTM (American Society of

Testing and Materials) time/temperature fire exposure chart shown in Figure 10.

Figure 10 shows the temperature acquired as a function of time, which has been found to be the average temperature 8 feet off the floor.<sup>30</sup>

Carroll also wrote, “By knowing the fire load of the building, i.e., the material available for the creation of heat, a reasonable approximation of the highest temperatures attained can be made and compared with temperatures to be expected had an accelerant been used.”

Neither Carroll nor French understood that the “Standard Time/Temperature Curve” had nothing to do with the behavior of any fire. The Standard Time/Temperature Curve describes the way a furnace should be operated in order to compare the fire resistance of various building assemblies. Unfortunately for many fire victims, including Han Tak Lee in Pennsylvania, this approach resulted in numerous determinations of a fire behaving “abnormally,” and this in turn resulted in wrongful prosecutions and convictions.

This particular misconception about fire behavior did not receive as much acceptance as some of the other myths, possibly because it involved math. There were enough practitioners using this “quantitative” approach that the NFPA Technical Committee on Fire Investigations felt the need to address the issue in NFPA 921 in the chapter on basic fire science:

**5.4.1 General.** The term fuel load has been used to indicate the potential severity of a fire and has been expressed in terms of Btu (British thermal unit) or pounds of fuel per square foot of floor area. An example is provided in 5.4.1.1

**5.4.1.1** The Btus were expressed in wood equivalent based on 8000 Btu per pound. The fuel load was determined by weighing the fuel in a room and converting the weight of plastic to 2 pounds of wood using 16,000 Btu per pound as a value for plastic (1 pound of plastic equals 2 pounds of wood). The total Btus (or pounds of fuel) were divided by the area of the room floor. While this approach can be a measure of the total available if all the fuel burns, **it does not depict how fast the fire will develop once it starts.** (*Emphasis added*).

**5.4.1.2** The rate of fire growth as determined by witness statements is highly subjective. Many times witnesses are reporting the fire growth from the time of discovery, which cannot be directly correlated to ignition time. The rate of fire growth is dependent on many factors besides fuel load, to include fuel configuration, compartment size, compartment properties, ventilation, ignition source, and first fuel ignited. The rate of fire growth as reported by witnesses is not reliable or supported independent evidence of an incendiary fire.

## 5.4.2 Heat Release Rate

**5.4.2.1** Total fuel load in the room has no bearing on the rate of growth of a given fire in its pre-flashover phase. During this period of development, the rate of fire growth is determined by the heat release rate (HRR) from burning of individual fuel arrays. The HRR describes how the available energy is released. This quantity characterizes the power — energy released per unit time (Btu/sec or kilowatts) — and is a quantitative measure of the size of the fire. A generalized HRR curve can be characterized by an initial growth stage, a period of steady-state burning, and decay. The largest value of the HRR measured is defined as the peak heat release rate.

These values should only be considered as representative values for comparison purposes. Fuel items with the same function (e.g., sofas) can have significantly different HRRs. The actual heat released rate for a particular fuel item is best determined by test.

Despite this warning about fuel package variability, some allegedly scientific fire investigators insist on their right to estimate the HRR of an item of furniture, and then opine whether it will have sufficient radiant energy to ignite a nearby item. Usually the estimate is at the low end of the HRR scale, which may range from 500 to 2,500 kW for an armchair for example. The investigator then “deduces” that because the fire did spread, there must have been multiple points of origin.

### LOW BURNING AND HOLES IN THE FLOOR

A common misconception is that because heat rises, fire burns up and out and will not burn downward unless it has “help.” This simplistic explanation of fire behavior has formed the basis of many an arson investigator’s determination of incendiary cause and plays very well with a jury that has no knowledge of flashover.

In Carroll's 1979 text, he discusses multiple low points and states, “The discovery of a low point should not be considered the end of the search, since more than one low point may be discovered. This is particularly true in arson fires.” He states further that, “Every effort should be made to determine whether multiple low spots are accidental or deliberate. If they have been set in an incendiary effort, these would be considered evidence of arson.”

Carroll states, “Significant differences in char depths at two different low points would indicate an accidental low point.”<sup>31</sup> If the low points or holes in the floor are all about equally charred, the use of multiple holes to indicate multiple points of origin could arguably be justified by referring to this alleged learned treatise.

The IFSTA manual, *Fire Cause Determination*, espoused a similar misinterpretation when it stated, “Low levels of charring are good indicators of a flammable liquid having been used. For example, accidental fires are unlikely to burn the bottom edge of furniture or the bottom edge of the door.”<sup>32</sup>

The Army's *Field Manual* succinctly restates the popular myth

Liquid accelerants leave evidence of low burn. That is, they show burning on the floor of the structure. A normal fire chars only the upper portion of a room. Floor damage in natural fires is usually limited to about 20% of the ceiling damage. Low burn, shown by complete charring of large areas of the floor or the baseboards, is not natural.

Nor is fire burning downward natural. Fire burning downward is a prime indicator of the use of a flammable accelerant. Patterns burned in wood floors or holes in a floor may show that an accelerant was used.<sup>33</sup>

Kirk was one of several workers who disagreed with the notion that holes observed in a burned floor necessarily indicated the presence of an ignitable fluid. In 1969, he wrote:

In many instances, the lowest burn is a floor surface or region directly under a floor. These points are sometimes difficult to evaluate and often lead to error in interpretation. For example, there is a whole burned in the floor in a region away from any walls or other objects that could carry a fire upward by providing fuel in the path of the flames. It is not uncommon for the investigator to assign the cause to the use of a flammable liquid. Such an interpretation is more often incorrect than otherwise. On a tight floor, it is always incorrect, unless holes or deep cracks are present. **Lacking such conditions, flammable liquids never carry fires downward.** (*Emphasis in the original*).<sup>34</sup>

NFPA 921 has dealt with this myth in a straightforward admonition:

**6.17.2.2.** Like other areas of low burning, holes in the floor can be produced by the presence of ignitable liquids, glowing embers, or the effects of flashover or full room involvement.

It is this warning in NFPA 921 that drew the ire of many fire investigators who believed they had been properly trained to recognize artifacts indicative of the use of liquid accelerants, even in fully involved compartments. There is no doubt that they had been trained, but that training had no validity.

## **THE ANGLE OF THE “V”**

The “V” angle myth has been published by many authors. It goes like this: The sides of a “normal” conical fire plume are angled 15 °From vertical. The faster a fire burns, the slower it will spread laterally and the closer the angles will be to vertical. Conversely, the slower a fire burns the further the angle will tilt from vertical. Like most of the myths presented in this paper, no scientific support exists for this myth, however, it is a deceptively appealing notion. The NBS *Fire Investigation Handbook* stated that the V pattern should be examined

to determine whether the fire was a slowly developing one or a rapidly developing one. Without defining rapid and slow, the intent was apparently to let the indicator do the defining. The authors stated:

Fire patterns — a wide or diffuse V pattern generally indicates a slowly developing fire. A narrow sharply defined V pattern generally indicates a fast developing, hot fire.<sup>35</sup>

The Army's 1985 *Field Manual* states,

Fire burns up and out. It leaves a V-shaped char pattern on walls and vertical structures. A fire which is hot and fast at the point of origin will leave a sharp V pattern. A slow fire will produce a shallow V.

The new, allegedly updated, Army *Field Manual* (2005) repeats the same misinformation.<sup>36</sup>

Carroll took a more quantitative approach, at least as far as the angles were concerned:

A normal fire, consuming wood, plastic or electrical insulation, would burn with a “V” pattern of approximately 30° measured vertically. If an accelerant was used, or if highly combustible material was involved, the “V” would be narrower as the temperature of the fire increased, due to the additional heat content of the accelerant or flammable liquid. This would cause a faster rise of heat and flame, resulting in a “V” pattern of approximately 10° depending on the heat flux generated by the accelerant.<sup>37</sup>

Noon (1995) devotes an entire section of his book to burning velocities and V patterns. This discussion is accompanied by equations to help the investigator determine the ratio of the upward burning rate to the lateral burning rate by finding the tangent of the angle of the V.

O'Connor (1986) and O'Connor and Redsicker (1997) repeat the story:

The breadth or width of the V (also called the *funnel pattern*) is affected by (and hence, indicative of) the buildup, progression, speed and intensity of the fire. An intense rapidly moving fire produces a narrow the pattern whereas a slow, less intense fire produces a wide V pattern. The angles of the boundaries average between 10 and 15°.<sup>38,39</sup>

In the third edition of *Kirk's Fire Investigation*, DeHaan urged caution in the interpretation of the pattern angles when he stated, “Although it is sometimes claimed that the more vertical the sides of the V, the faster the initial fire (and therefore the more suspicious), one can appreciate that the nature of any wallcovering and conditions of ventilation have important effects on the shape of the pattern, and must be taken into account.”<sup>40</sup> By the fourth edition, he came right out and said, “The angle and width of the V are not dependent on the rapidity of ignition of the fuel.”<sup>41</sup>

Since it was first published in 1992, NFPA 921 has contained a section on the interpretation of V patterns, and describes the equation of angles with speed as a “misconception.” The current (2004) edition makes the following statement:

**6.17.2.2.** The angle of the borders of the V pattern does not indicate the speed of fire growth; that is, a wide V. does not indicate a slowly growing fire, or a narrow V does not indicate a rapidly growing fire.

It is both amazing and disturbing that when the Army revised their *Field Manual* in 2005, and stated that the revision contained information from NFPA, they would continue to include the V angle myth despite the fact that NFPA 921 had disparaged this myth through five editions over 13 years.

## **TIME AND TEMPERATURE**

A fire that burns “hotter than normal” or “faster than normal” is thought to indicate an accelerated fire. Actually, fire temperature and the perceived speed of the fire are not valid indicators of a fire’s cause.

A major misconception underlying many false determinations of arson is that the temperature achieved by a particular fire can help an investigator evaluate whether a fire was “normal” or “abnormal,” with an abnormal fire being attributed to incendiary activity. Higher than “normal” temperatures indicating a set fire is such an appealing notion that even Paul Kirk bought into it, as previously discussed. To this day, investigators sometimes infer the presence of accelerants when they observe a melted aluminum threshold.

Kennedy, discussing the fusion of copper, wrote:

Copper fuses at 1980 °F, which is very high. Therefore, if we find fused copper or beaded copper wires, we are immediately alerted because we have an unusually high temperature that must be explained. The normal burning of a structure would not cause temperatures in the 2000 °F range, which is necessary to fuse or melt copper.

What could cause copper to fuse or melt? The burning of an accelerant such as flammable liquids, natural or LP gases or electrical shorts or arcing are some of the causes for “high heat” — meaning excessive temperatures.<sup>42</sup>

Barracato (1979) summed up the time and temperature equation as follows:

Fires which burn through entire floor sections, destroy large support beams in a relatively short period of time, or melt articles located in the area of origin such as metal, copper, aluminum or glass, are unusual. It takes tremendous heat to cause such damage and unless there is a rational explanation for the heat buildup — for example, if the room was used to store a highly flammable

material — it's very probable that the fire was intentional and an accelerant was used.<sup>43</sup>

Carroll, as discussed previously under “fire load,” presented the standard time/temperature curve from ASTM E119, *Standard Test Methods for Fire Tests of Building Construction and Materials*, and stated that it can be used as a basis in comparing the burning rates in structures. Carroll also stated, “if accelerant or other chemicals are present, temperatures can reach higher than on the standard fire curve.”<sup>44</sup>

Based on research that began in the late 1970s and continues until today, it is now well understood that there is valid definition of “normal” fire spread and also that the ASTM time/temperature curve has little relation to the behavior of a “normal” fire.

In the second edition of *Kirk's Fire Investigation* (1983), DeHaan somewhat moderated Paul Kirk's enthusiasm for interpreting melted metals, but still left readers with the suggestion that an abnormal fuel load, such as provided by an accelerant, will increase temperatures.<sup>45</sup>

Although the third, fourth, and fifth editions of *Kirk's* include a discussion of the fact that gasoline burns at essentially the same temperature as wood, it still states that temperature can be used to determine the presence of “enhanced draft conditions or unusual fuel loads,” when the data support only the former. Nonetheless, the modern text of *Kirk's* at least recognizes what blacksmiths and metallurgists have known for millennia: that increased ventilation, not a change in fuel type, causes increased temperatures.

NFPA 921, beginning with the first edition and continuing until today contains an admonition about placing too much stock in the perceived temperature of a fire. In the 2004 edition of the document, both temperature and speed of the fire are addressed, and investigators are warned to be cautious when interpreting temperature and speed. The following language appears:

**6.8.2.2** Wood and gasoline burn at essentially the same flame temperature. The turbulent diffusion flame temperatures of all hydrocarbon fuels (plastics and ignitable liquids) and cellulosic fuels are approximately the same, although the fuels release heat at different rates.

The speed at which a fire progresses is frequently used to imply that the fire is incendiary. While it is true that an accelerated fire burns faster than an unaccelerated fire, at least in its initial stages, serious caution is required when confronted with information about how rapidly a fire spread. Most observations about the “speed” of a fire are provided by eyewitnesses, but there have been reported instances of an investigator looking at a destroyed structure and, knowing the time from alarm to extinguishment, opining that the amount of destruction could not have occurred in that timeframe unless the fire had “help.” These conclusions are usually based on the misconception that the wood has a fixed burning rate, such as the often quoted “1 inch in 45 minutes.”

A study by the editors of *Fire Findings*, published in 1995, revealed that witnesses might make very different observations about a fire, even if their sightings are only a few minutes apart.<sup>46</sup> This study, which involved the actual burning of a two-story house, resulted in the findings that fires may only appear to start rapidly and tended to dispel the widely held (but incorrect) belief that if a fire appears to start quickly, accelerants must have been involved. If an eyewitness only notes the existence of a fire at the point where it breaks out a window, the progress thereafter will be rapid indeed, regardless of the cause.

In the fifth edition of *Kirk's Fire Investigation*, DeHaan published a time/temperature curve for a fire in a "typical furnished room" with no accelerants that shows flashover occurring just 210 seconds (3.5 minutes) after ignition. This curve looks nothing at all like the "standard time/temperature curve" from the ASTM test method.<sup>47</sup>

Thus, while it is true that accelerants tend to make fires burn more rapidly, a rapidly burning fire does not necessarily indicate the presence of accelerants.

## CONCLUSION

Fire investigation involves the comparison of the investigator's "expectations" with his perception of the behavior of the fire. If those expectations are not properly "calibrated," the result will be numerous errors. In the 17<sup>th</sup> century, when the scientific community was first getting organized, it was understandable that misconceptions about fire, such as the phlogiston and caloric theories, should exist. What is surprising is that after three centuries of scientific examination of fire, myths have been added rather than dispelled.

Many of the myths have been taught to the individuals who are now in control of the fire investigation industry. These myths were promulgated by the National Fire Academy and by other entities involved in the training of fire investigators, and given the stamp of approval of one of the most prestigious and credible U.S. government agencies. To date, the misinformation has not been officially repudiated or "recalled." While most responsible training organizations no longer teach the myths, there are still plenty of fire investigators who have not been back to school since it was learned for certain that the "indicators of arson" that they learned were false. Further, the libraries of most fire investigators contain numerous texts that are filled with this misinformation. Even worse, there are still a few popular speakers and agencies training new investigators with the old mythology.

The sheer number of misconceptions, and their widespread publication in learned and not-so-learned treatises indicates that fire investigation, as a profession, still has very far to go.

## ABOUT THE AUTHOR

**John Lentini** began his career in forensic science with the Georgia Bureau of Investigation Crime Laboratory in 1974. He joined the private sector in 1977, and for 28 years he was the lead fire investigator for Applied Technical Services of Marietta, Georgia. In that capacity, he conducted more than 2,000 fire scene inspections, and more than 20,000 fire debris analyses. He is one of a handful of people on the planet certified to conduct both fire scene investigations and fire debris analysis, and has appeared as an expert witness on more than 200 occasions. Mr. Lentini is an active proponent of standards for fire and other forensic investigations, and has made many presentations on the proper use of science in fire investigations. He is a member of the National Fire Protection Association Technical Committee on Fire Investigations, and served for six years as the Chairman of ASTM Committee E30 on Forensic Sciences. His book, entitled *Scientific Protocols for Fire Investigation*, was published in 2006 by CRC Press.

Mr. Lentini started his own company in late 2006, and is now an independent consultant living in the Florida Keys and doing business as Scientific Fire Analysis. His resume can be downloaded at [www.firescientist.com](http://www.firescientist.com).

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### "I Did It" – Confession Contamination and Evaluation

*James L. Trainum, Detective (ret.), Metropolitan Police Department, Washington, D.C.*

"I did it." Those simple words, uttered by a suspect are the most powerful evidence in the world. Those words almost guarantee a closed case—and a conviction. They wipe away all doubt and overcome any evidence to the contrary. But should they?

**T**he ability to interrogate a suspect has long been one of the most valuable tools of law enforcement, but only relatively recently has the legal community begun to recognize its potential dangers—including the possibility of false confessions leading to a conviction of the wrong person.

False confessions are rarely the result of bad intent or malice by the investigator. Instead, they come about through a combination of factors, including the vulnerability of the suspect, the interrogation tactics and questioning styles that are used, and, most importantly, tunnel vision on the part of the investigator. The overwhelming confidence, referred to as the "Disease of Certainty" in the suspect's guilt is a major factor in each false confession case.<sup>1</sup>

The application of procedures such as videotaping confessions and performing confession evaluations, along with training in avoiding the potential pitfalls such as tactics or tunnel vision and awareness of potential "red flags" that might indicate a false confession, can help lead to both more reliable confessions and the ability to better differentiate between true and false confessions.

### The Thomas Case

In 1994, Lawrence O'Connell, a 34-year-old employee of the Voice of America in Washington, DC, was kidnapped shortly after leaving work. The kidnappers used both his ATM and credit cards at multiple locations before killing him and leaving his body by the Anacostia River. A grainy bank photo and a composite drawing of a female who was seen using O'Connell's credit cards was released to the media, resulting in multiple phone calls to the police department—one of which said that Susan Thomas (alias used to protect her privacy) resembled the person in the photo and the composite. This information was supported by a handwriting expert, who said that Thomas signed the credit card slips. Thomas was arrested and interrogated with standard court-approved interrogation techniques. Her confession included numerous details that "only the killer would have known." But many aspects of her confession did not match the known facts, and she apparently refused to provide police with some of the more mundane details. At the time, this refusal was credited to an attempt to protect someone. A real problem developed when, while conducting additional follow-up, investigators discovered that Thomas had an unshakable alibi. Additional investigation discredited the handwriting expert—there was no way that Thomas had forged the signature on the credit card slips. Though the case fell apart, and the charges against Thomas were dismissed, the Metropolitan Police Department (MPDC) continued to believe in her supposed guilt. After all, she had confessed, and the details that Thomas provided "proved" that she was present

when O'Connell was killed.<sup>4</sup>

In 1994, the officers of MPDC, like most people, believed that unless a suspect was tortured or mentally ill, a false confession was impossible. Today, it still remains counter-intuitive to believe that someone would confess to a crime her or she did not commit. This belief has been shaken with the advent of DNA analysis.

In the Thomas case, the suspect provided a wealth of details about the crime not known to the public. As it turns out, this is typical of most false confessions. In a recent study of 40 confession cases where the confession was confirmed through DNA evidence to be false, 97 percent of the confessions contained "surprisingly rich, detailed, and accurate information" including "inside information" about the crime known only to law enforcement.<sup>3</sup> So how is this possible?

Fortunately, the majority of the interrogation had been videotaped, not just Thomas's final confession. MPDC officers were able to study the interrogation in detail, discovering that the Thomas case could be considered a textbook false confession case.

This article will not attempt to address all of the factors that contribute to false confessions. Instead, through the lessons learned in the Thomas case and numerous other false confession cases, it will provide law enforcement management with some tools that will help them identify problematic confession evidence and minimize its impact on investigations. The policies and practices presented can also be applied to witness and informant evidence. False or mistaken witness evidence and lying informants, two major causes in wrongful convictions, share many of the same causation factors as false confessions.

## **Videotaping and Confession Reliability Evaluation**

### *Videotaping*

Mandatory videotaping of interrogations from start to finish has been promoted as a means to prevent false confessions. Though controversial at first, videotaping is rapidly becoming acknowledged by law enforcement as a best practice even by the leading interrogation schools in the United States. However, videotaping alone does not prevent false confessions. It may prevent the occasional rogue investigator from using improper or illegal tactics when interviewing witnesses or interrogating suspects, but many confirmed false confessions have occurred when the investigator used only standard, court-approved techniques. As seen in the Thomas case, videotaping allows law enforcement and others to critically review the interrogation and evaluate the reliability of the confession evidence. Such reviews are also an important training tool to help investigators improve their interrogation skills.

While debate still exists over what interrogation tactics may contribute to false confessions, some agreement is beginning among practitioners, instructors, and academics. However, the truth remains that even flawed interrogations, more often than not, can result in obtaining reliable confession evidence. In general, interrogation techniques used in the United States are structured to create a situation where suspects reach a point at which they are convinced that confessing will allow them to escape a real or perceived inevitable circumstance or obtain a real or perceived benefit. This is exactly the same mind-set that innocent suspects have described when they have made false confessions. Therefore, law enforcement officers need the ability to distinguish between a reliable confession and a false one. Videotaping the interrogation from start to finish plays a critical role in fulfilling that need.

### *Confession Reliability Evaluation*

Distinguishing between a reliable confession and a false one is not as easy as it sounds. False confessions, much like reliable ones, often contain numerous details that, as is often testified to by the investigator "only the killer would know." Since an innocent suspect would not have access to such information, it must have somehow been provided to them.

Contamination is a concept well known to law enforcement. Officers wear gloves at crime scenes and separate witnesses so they do not share information. Specially trained personnel interview juvenile witnesses and victims, knowing how suggestible they can be. However, investigators are often not so careful during interrogations. Confession evidence contamination has been identified as the "third step" in obtaining a false confession (the first and second being interrogating an innocent person and using coercive interrogation techniques).<sup>4</sup>

Contamination during an interrogation is seldom, if ever intentional. It's usually found in cases where, due to the investigator's sincere belief in the suspect's guilt, tunnel vision and the accompanying verification bias kicks in. In other words, the interrogator begins to focus on signs of guilt, ignoring or explaining away any evidence to the contrary. This, combined with a poor understanding of how interrogation contamination can occur, is a recipe for disaster.

When it comes to evidence recovery, be it physical evidence, witness evidence, or confession evidence, some contamination is inevitable. Even the best laboratories recognize this and have DNA samples of their personnel on file to help identify contamination when it happens. In verbal exchanges with a suspect, the longer the exchange, the more likely officers or interrogators are to unknowingly reveal information. The critical examination of confession evidence for possible contamination is a major component of evaluating the confession's reliability. But in order to identify it, it needs to be understood how contamination can occur.

## Sources of Confession Contamination

### *Contamination from Outside Sources*

It is standard practice in an investigation to hold back specific details about a crime from those outside the agency (i.e., media, people of interest, general public). This "hold-back" information is intended to be used to corroborate information from informants, witnesses, and suspects as it should not be known to anyone who does not have some inside knowledge of the crime. Unfortunately, what is often thought of as hold-back is not always as secure as believed. For crime details to be truly considered as hold-backs, the investigator must have a thorough knowledge of not only everything that has been in the media, but also the "word on the street." Often, some hold-back information is common knowledge in the neighborhood where the crime occurred. Additionally, some hold-back information may be inferred from the details that are public. An example would be a case where a woman was found murdered in an abandoned building. Based on the sex of the victim and the crime scene location, it may be inferred by residents throughout the neighborhood that a sexual assault had taken place—even if that was a detail that investigators believed they had kept from the public.

If the suspect provides information that they learned from one of these sources, the investigator, overly confident in the security of the hold-back information, may conclude that the only way the suspect could have known that detail was from being present at the crime.

### *Leading Questions*

One of the most common causes of contamination during the interrogation is leading questions. Leading questions can take many forms, but all provide the suspect with information or at least a suggestion as to where the interrogator believes the story should go. Some like "forced choice" or "either/or" questions give the suspect up to a 50/50 chance of a correct guess. In a murder case that started off as a burglary, asking the suspect if he got in through the door or the window significantly increases the innocent suspect's chance of providing the "right" answer, in contrast to the open-ended question of "How did you get in?"

### *The Investigators' Response*

Even the most subtle response from an investigator to a suspect's answer can telegraph a lot of hold-back information to an innocent suspect. In the above example of the burglary gone wrong, if the suspect answers incorrectly (e.g., saying that they got in through the door when the investigator knows that entry was made through a window), the investigator's response of "the door?" tells the suspect that they got it wrong. Often, when the investigator expresses doubt about a response,

the innocent suspect can be seen attempting to change it—trying to make their answer more acceptable to the interrogator.

A more drastic response by the investigator is seen when every time the innocent suspect gets an answer wrong the investigator accuses them of lying, and then agreeing with them when they get it "right." In this way the interrogation resembles the child's game of 20 Questions. The innocent suspect, desperate to escape an inevitable consequence or obtain the perceived benefit collects clues to determine what will finally end up being an acceptable story to the investigator.

### *"Cold Reading" Techniques*

"Cold reading" is a term used to describe some of the techniques used by psychics in order to convince a person that they have supernatural "inside" knowledge about someone or something. Though these techniques can be studied and learned, they are also intuitive and are unconsciously used by people who truly believe that they have psychic abilities. They work well on an investigator who is convinced of the innocent suspect's guilt and is willing to ignore or explain away a suspect's apparent lack of knowledge as evasiveness or an attempt to protect someone else.

One such technique that a suspect may use is providing broad, non-committal answers or statements to hopefully provide the investigator with the information they seek. In the Thomas case, the interrogators asked Thomas to provide details about purchases made at a drugstore with the murder victim's stolen credit card. Thomas answered "Just a lot of stuff...personal stuff," inferring the items that would most likely be purchased from a drugstore. This response, combined with our continued and suggestive questioning, allowed her to move on to use another common cold reading technique—guessing.<sup>5</sup>

A psychic, like the innocent suspect, will make multiple guesses, getting a bit more information even with a wrong guess. Out of 30 guesses, they may get 1 or 2 right or close to right. Verification bias causes one to remember the right answers and not the wrong ones and to "explain away" the wrong answers. Thus, bit by bit, the innocent suspect obtains those hold-back details that will make for a believable but false confession.

### *Revealing Evidence and Crime Scene Photos*

A picture is worth a thousand words, and one crime scene photograph shown to an innocent suspect can provide numerous subtle details that can make a false confession completely believable. Though showing the suspect photos as an interrogation tactic has fallen out of favor, it was recently advocated at a conference on unsolved cases attended by the author. The presenter recommended the creation of a "war room" for the location of the interrogation—complete with crime scene photos posted on the walls.

Contamination through the presentation of evidence is not confined to the use of photographs. While confronting the suspect with evidence information is often necessary when challenging an alibi, it must be used cautiously. Presenting evidence becomes problematic when it is used to "correct" a suspect's account of the crime (such as when the suspect provides the wrong caliber of the gun used in the murder). Although the use of false evidence is generally permitted by the courts, it has frequently been linked to false confessions and, if not used carefully, can contribute to the contamination of confession evidence.<sup>6</sup>

Even when the confession is reliable, the excessive presentation of evidence in an interrogation leaves the confession open to attack by the defense attorney since this form of contamination is one that is most easily understood by juries.

### *Theme Development*

Though called different things by different interrogation instructors, the technique of "the investigator express[ing] a supposition about the reason for the crime's commission" and offering "a possible moral excuse for having committed the crime" is common; however, it can be a source of confession evidence contamination.<sup>7</sup> During the employment of a theme such as self-defense in a murder case, the investigator may unintentionally provide the suspect with information such as weapon type, location of injuries, and other details. Once the theme is accepted by the suspect, the investigator must then challenge the theme, often with evidence that

contradicts the theme in order to get to the "truth." If not done carefully, the challenge can cause additional contamination (e.g. "If you say you shot him in self-defense, then how come he was shot three times in the back?").

In the Thomas case, one of the investigators suggested that Thomas was influenced by others and acted on the spur of the moment. The investigator went on to describe his theory of the case—that there were two others involved, how the victim was first approached, information about the victim's background and so forth—details that were all later incorporated into the false confession.

### *Just Telling the Suspect*

This form of contamination, where the suspect is handed the details of the crime by the investigator, can creep in with the application of some interrogation tactics. If, while using a false evidence ploy of a non-existent eyewitness, the investigator suggests that the witness saw the suspect and two others creep around to the back of the house, they provided information on the number of perpetrators and the location of entry. But often the contamination is blatant, especially in long interrogations where, blinded by tunnel vision and frustrated with the lack of progress, the investigator begins to push the envelope. Sometimes, when attempting to confront the suspect with the strength of the evidence, investigators will begin a statement with "Let me tell you what we know..." and then go on to outline the details of the crime. Like most actions that contribute to contamination, the investigator is usually unaware this is happening and may not realize it even in recollection until confronted with a videotape.

## **Guidelines for the Evaluation of Confession Evidence**

### *Fighting Tunnel Vision*

Confession evidence is like any other evidence in that it should undergo careful scrutiny before it can be accepted as fact. Tunnel vision, combined with those words "I did it," can blind investigators to obvious discrepancies. In many false confession cases, if the same evidence that was provided by a suspect through their confession was provided by a purported witness, the evidence would have been dismissed off-hand by the investigator because it simply did not match the known facts. But, as noted above, many false confession cases are rich in corroborated details.

Since confession evidence can be so powerful, and tunnel vision plays such a strong role in many false confessions, the evaluation should be performed by someone outside the immediate investigation. A "devil's advocate" should be assigned the specific role of challenging any assumptions made by the investigative team and its interpretation of the evidence. They should also be knowledgeable about the causes of false confessions and confession evidence contamination.

The role of a devil's advocate can be a difficult one. Peer pressure and an organizational agenda that pushes for a quick case closure are just two of the obstacles that can diminish the effectiveness of the position. A strong individual with good investigative skills in a supervisory position and with the support of management is needed. Not only are devil's advocates useful in the evaluation of confession evidence, but they are invaluable in keeping investigations on track and identifying loopholes that can later be used by the defense. With the proper encouragement, the devil's advocate approach to testing investigative theories will become part of the normal routine, resulting in better investigators and stronger investigations.

### *Steps in Confession Evidence Evaluation*

First, the devil's advocate should look for evidence that was provided during the confession that was previously unknown to the investigator—facts which could not have been obtained from outside sources or inference and that can be corroborated through independent means. An example of this would be information from a confession that leads the investigators to a previously undiscovered weapon that is confirmed as the murder weapon through forensic examination. Obtaining new and confirmable evidence should be the goal of every investigator during every interrogation.

Secondly, the devil's advocate needs to break down the information provided by the suspect that, although known to the interrogator, is believed to be information that only the true perpetrator could provide (the hold-back information). Does the information provided by the suspect include the hold-back information and, most important, was it provided free from contamination by the investigator during the interrogation? This can be shown by breaking the interrogation down on a spreadsheet and comparing when during the interrogation the details were first provided by the suspect to potential contamination sources. This method allows the devil's advocate to see how the confession developed and determine who is "telling the story"—the suspect or the interrogator.

A leading interrogation school talks about a third form of corroboration—rational corroboration. Acknowledged as the weakest form of corroboration, this is "mundane details or other information that lends credibility to the statement."<sup>8</sup> Such information is usually impossible to independently corroborate. The author has seen such details in his own and numerous other false confession cases and has found that they are often the result of the innocent suspect attempting to make the confession more believable to the investigator. In one case involving a murder and dismemberment, the suspect got every detail wrong—even the tools used to dispose of the body. In defending the "confession," the investigator pointed to the conversation that the suspect said that he had with the victim before he murdered her as something that "only the killer would know," but it was a conversation that in no way could be corroborated.

In both reliable and false confessions details are often provided by the suspect that just don't fit, or the suspect is apparently refusing to admit to known facts. Often this is explained away by investigators by saying that the suspects may be minimizing their involvement or attempting to protect someone else. In a reliable confession, this could be true, especially when (1) there is other evidence that was provided that passes the previous criteria, and (2) the problematic information (or lack of information) points to acts that could increase the suspect's culpability or connect them to other, unknown or unsolved crimes. In a false confession, the details that don't fit may occur because the innocent suspect has been unable to obtain the correct information from the interrogator via contamination.

One red flag to a false confession is when the incorrect information provided by suspects actually increases their culpability, although there is no evidence to suggest that what they are saying is true (such as admitting to a sexual assault during a murder when no such assault took place). Another red flag is when the suspect is unable to provide information that is of a mundane nature, and, since the suspect is admitting to the more horrific details of the crime, should not have any problems providing these mundane details. In the Thomas case, Thomas admitted to participating in the kidnapping and murder of the victim, but could not list the individual items she purchased with the victim's credit card.

## Summary and Recommendations

As can be seen, although a valuable tool, interrogations hold potential dangers as well, including the very real possibility of false confessions. Interrogation schools in the United States have slowly begun to acknowledge these dangers, yet their classroom instruction often deals with it on a superficial level, if at all. This practice is analogous to a doctor receiving instructions in the administration of a drug, with no knowledge of the potential side effects, how to recognize them, or the steps necessary to treat them. The U.S. Department of Justice recently addressed this problem in a consent decree with the New Orleans Police Department where they mandated training for investigators in both the causes of false confessions and "criminal investigative failures" (e.g., tunnel vision).<sup>9</sup>

Along with training in the causes of false confessions, confession contamination, and the critical evaluation of confession evidence, the regular use of devil's advocates would be an invaluable addition to the investigative process. This process for the review of confession evidence can be applied to both witness and informant evidence as well, since both are potentially subject to unintentional contamination. Bad or false information from witnesses and informants has been found to be a major factor in wrongful convictions.

Finally, law enforcement needs to accept the fact that mistakes have been and will continue to be made. However, by studying the mistakes of others and performing regular autopsies of their own missteps, problems can be identified and corrected and the investigative processes strengthened.

By adopting the scientific approach of conducting critical evaluations in order to test theories rather than just working to prove them, the chance of a wrongful conviction will be minimized, and cases against the guilty will be strengthened. ♦

**Notes:**

<sup>1</sup>Everett Doolittle, "The Disease of Certainty," *FBI Law Enforcement Bulletin* (March 2012).

<sup>2</sup>James Trainum and Diana Havlin, "A False Confession to Murder in Washington, DC," in *Criminal Investigate Failures*, ed. D. Kim Rossmo (Boca Raton, Florida: CRC Press, 2009), 205–217.

<sup>3</sup>Brandon L. Garrett, "The Substance of False Confessions," *Stanford Law Review* 62, no. 4 (2010):1,051–1,119, <http://www.stanfordlawreview.org/sites/default/files/articles/Garrett.pdf> (accessed May 20, 2014); Virginia Public Law and Legal Theory Research Paper No. 2010-11, <http://ssrn.com/abstract=1280254> (accessed May 2, 2014).

<sup>4</sup>Richard A. Leo and Steven A. Drizin, "The Three Errors: Pathways to False Confessions," *Police Interrogations and False Confessions*, eds. G. Daniel Lassiter and Christian A. Meisser (Washington, DC: American Psychological Association, 2010).

<sup>5</sup>Interrogation transcript, Metropolitan Police Department.

<sup>6</sup>Saul M. Kassin et al., "Police-induced Confessions: Risk Factors and Recommendations," *Law and Human Behavior* 34 (2010): 3–38, [http://web.williams.edu/Psychology/Faculty/Kassin/files/White%20Paper%20-%20LHB%20\(2010\).pdf](http://web.williams.edu/Psychology/Faculty/Kassin/files/White%20Paper%20-%20LHB%20(2010).pdf) (accessed May 20, 2014).

<sup>7</sup>Fred E. Inbau et al., *Criminal Interrogation and Confessions*, 5th ed. (Burlington, MA: Jones & Bartlett Learning, 2011), 188.

<sup>8</sup>*Ibid.*, 355–356.

<sup>9</sup>*United States vs. City of New Orleans*, Case 2:12-cv-01924, Consent Decree Regarding the New Orleans Police Department (July 24, 2012), 47.

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## The Next Innocence Project: Shaken Baby Syndrome and the Criminal Courts

**Deborah Tuerkheimer**

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August 6, 2009

*Washington University Law Review, Vol. 87, No. 1, 2009*

**Abstract:**

Every year in this country, hundreds of people are convicted of having shaken a baby, most often to death. In a prosecution paradigm without precedent, expert medical testimony is used to establish that a crime occurred, that the defendant caused the infant's death by shaking, and that the shaking was sufficiently forceful to constitute depraved indifference to human life. Shaken Baby Syndrome (SBS) is, in essence, a medical diagnosis of murder, one based solely on the presence of a diagnostic triad: retinal bleeding, bleeding in the protective layer of the brain, and brain swelling.

New scientific research has cast doubt on the forensic significance of this triad, thereby undermining the foundations of thousands of SBS convictions. Outside the United States, this scientific evolution has prompted systemic reevaluations of the prosecutorial paradigm. Most recently, after a seventeen-month investigation costing \$8.3 million, a Canadian commission recommended that all SBS cases be reviewed.

In contrast, our criminal justice system has failed to absorb the latest scientific knowledge. This is beginning to change: for the first time, an SBS conviction was overturned last year because "newly discovered" scientific evidence would likely create a reasonable doubt about the defendant's guilt; also for the first time, a state Supreme Court is considering whether a trial judge erred in excluding as unreliable the prosecution's expert testimony regarding SBS; and the U.S. Supreme Court is now reviewing a petition seeking review of a habeas grant in an SBS case. Yet the response has been halting and inconsistent. To this day, triad-based convictions continue to be affirmed, and new prosecutions commenced, as a matter of course.

These developments have not attracted the attention of legal scholars. In the face of this void, this article identifies a criminal justice crisis and begins a conversation about its proper resolution. The conceptual implications of the inquiry - for scientific engagement in law's shadow, for future systemic reform, and for our understanding of innocence in a post-DNA world - should assist in the task of righting past wrongs and averting further injustice.

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## THE NEXT INNOCENCE PROJECT: SHAKEN BABY SYNDROME AND THE CRIMINAL COURTS

DEBORAH TUERKHEIMER\*

*Every year in this country, hundreds of people are convicted of having shaken a baby, most often to death. In a prosecution paradigm without precedent, expert medical testimony is used to establish that a crime occurred, that the defendant caused the infant's death by shaking, and that the shaking was sufficiently forceful to constitute depraved indifference to human life. Shaken Baby Syndrome (SBS) is, in essence, a medical diagnosis of murder, one based solely on the presence of a diagnostic triad: retinal bleeding, bleeding in the protective layer of the brain, and brain swelling.*

*New scientific research has cast doubt on the forensic significance of this triad, thereby undermining the foundations of thousands of SBS convictions. Outside the United States, this scientific evolution has prompted systemic reevaluations of the prosecutorial paradigm. In contrast, our criminal justice system has failed to absorb the latest scientific knowledge. This is beginning to change, yet the response has been halting and inconsistent. To this day, triad-based convictions continue to be affirmed, and new prosecutions commenced, as a matter of course.*

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*This Article identifies a criminal justice crisis and begins a conversation about its proper resolution. The conceptual implications of the inquiry—for scientific engagement in law's shadow, for future systemic reform, and for our understanding of innocence in a post-DNA world—should assist in the task of righting past wrongs and averting further injustice.*

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#### I. INTRODUCTION

Natalie Beard died on October 16, 1995.<sup>1</sup> That morning, her mother had brought the seven-month-old to the home of her day care provider, Audrey Edmunds.<sup>2</sup> The baby was by all accounts fussy.<sup>3</sup> According to the caregiver's account, shortly after the baby was delivered to her, Edmunds

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1. *State v. Edmunds*, 598 N.W.2d 290, 293 (Wis. Ct. App. 1999).

2. *Id.*

3. *Id.*

propped Natalie in her car seat with a bottle,<sup>4</sup> left the room, and returned a half-hour later to discover her limp.<sup>5</sup> Edmunds—herself a mother—immediately called 911 to report that Natalie appeared to have choked and was unresponsive.<sup>6</sup> Rescue workers responded minutes later and flew the baby to the hospital, where she died that night.<sup>7</sup>

Prosecutors charged Edmunds with murder based on the theory that Natalie had been shaken to death.<sup>8</sup> No witness claimed to have seen the defendant shake the baby.<sup>9</sup> There were no apparent indicia of trauma.<sup>10</sup> Edmunds maintained her innocence throughout.<sup>11</sup> Yet a jury convicted Edmunds on the sole basis of expert testimony that Natalie suffered from Shaken Baby Syndrome (SBS).<sup>12</sup> A court sentenced Edmunds to eighteen years in prison.<sup>13</sup>

In important respects, this case falls squarely within the “shaken baby” prosecution paradigm that developed in the early 1990s. The infant<sup>14</sup> had no external injuries suggestive of abuse.<sup>15</sup> The accused<sup>16</sup> was unable to

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4. Brief of Defendant-Appellant at 4–5, *State v. Edmunds*, 746 N.W.2d 590 (Wis. Ct. App. 2008) (No. 2007AP000933).

5. *Id.*

6. *Id.*

7. *State v. Edmunds*, 598 N.W.2d at 293.

8. Edmunds was charged with reckless homicide in the first degree, *id.*, which required the prosecution to prove that she disregarded an “unreasonable and substantial risk of death or great bodily harm” under circumstances evidencing an “utter disregard for human life,” *id.* at 295.

9. *Id.* at 293–94.

10. *Id.*

11. *Id.* at 293.

12. *Id.*

13. Emphasizing the lack of any evidence that “the severe injuries Natalie sustained could have been the result of an accident, rather than intentional, forceful conduct, directed specifically at Natalie,” the appellate court affirmed Edmunds’s conviction. *Id.* at 294. After exhausting her state remedies, Edmunds petitioned for federal habeas corpus review, which was denied. *Edmunds v. Deppisch*, 313 F.3d 997 (7th Cir. 2002).

14. The average age of infants diagnosed with SBS is between three months and ten months, though children up to three-years-old have been diagnosed. Stephen C. Boos, *Abusive Head Trauma as a Medical Diagnosis*, in *ABUSIVE HEAD TRAUMA IN INFANTS AND CHILDREN: A MEDICAL, LEGAL, AND FORENSIC REFERENCE* 49, 50 (Lori Frasier et al. eds., 2006).

15. In a typical case, an infant “is brought to the emergency room with the sudden onset of unconsciousness and respiratory irregularities or seizure. The given history suggests sudden and unprovoked symptoms . . . [b]ut there is no external evidence to indicate that trauma caused their ailment.” *Id.*

16. The oft-quoted hierarchy of suspected perpetrators of head injury describes fathers as the most likely abusers, followed by mothers’ boyfriends, and unrelated female babysitters. *Id.* at 62. Regarding the social risk factors for child abuse generally, “[y]oung unmarried parents, lack of education, low socioeconomic status, minority status, and many other risk factors have been shown to predict increased child abuse rates. However . . . [a]pplying population variables to individual cases of child abuse may be misleading, and has led to the overassessment of minority populations.” *Id.* at 62.

provide an explanation for the child's condition.<sup>17</sup> The medical evidence against the defendant consisted of the three diagnostic symptoms comprising the classic "triad": retinal hemorrhages (bleeding of the inside surface of the back of the eye); subdural hemorrhages (bleeding between the hard outer layer and the spongy membranes that surround the brain); and cerebral edema (brain swelling).<sup>18</sup> The presence of these three signs was understood to be pathognomic—or exclusively characteristic—of SBS.

At trial, the prosecution's experts testified that "only shaking, possibly accompanied by impact" could explain the injuries.<sup>19</sup> Regarding the force necessary to cause these injuries, jurors heard the explanation typically offered in these cases: the force was equivalent to a fall from a second- or third-story window, or impact by a car moving at twenty-five to thirty miles an hour.<sup>20</sup> The prosecution's experts concluded that the shaking necessarily occurred while the baby was in the defendant's care, since the trauma of the shaking would have caused immediate unconsciousness.<sup>21</sup> The scientific basis for SBS was not challenged by the defense.<sup>22</sup> And

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17. See *infra* notes 181–82 and accompanying text.

18. Brief of Defendant, *supra* note 4, at 5. For discussion of the classic SBS triad, see, for example, Comm. on Child Abuse and Neglect, Am. Acad. of Pediatrics, *Shaken Baby Syndrome: Rotational Cranial Injuries—Technical Report*, 108 PEDIATRICS 206 (2001); Mary E. Case et al., The Nat'l Ass'n of Med. Exam'rs Ad Hoc Comm. on Shaken Baby Syndrome, *Position Paper on Fatal Abusive Head Injuries in Infants and Young Children*, 22 AM. J. FORENSIC MED. & PATHOLOGY 112 (2001). See also Part III.B.1, *infra* notes 60–64 and accompanying text (elaborating on significance of diagnostic triad).

19. Brief of Defendant, *supra* note 4, at 6. See *infra* notes 60–64 and accompanying text (discussing how shaking is thought to cause triad of symptoms).

20. Brief of Defendant, *supra* note 4, at 7. According to the American Academy of Pediatrics, "[t]he act of shaking leading to shaken baby syndrome is so violent that individuals observing it would recognize it as dangerous and likely to kill the child." Am. Acad. of Pediatrics, *supra* note 18, at 206. Prosecution experts have often amplified this type of testimony with in-court demonstrations of the force believed to be necessary to inflict the brain injuries. For a computerized demonstration of this kind see Expert Digital Solutions, Inc., *Shaken Baby*, <http://www.expertdigital.com/shakenbaby.html>. See *infra* note 256 (noting reversal of convictions on this basis). But see *People v. Mora*, 868 N.Y.S.2d 722, 723 (N.Y. App. Div. 2008) (trial court "providently exercised its discretion" in allowing prosecution's expert to "shake his coat in order to demonstrate the amount of force necessary to inflict Shaken Baby Syndrome").

21. Brief of Defendant, *supra* note 4, at 8.

22. "Edmunds presented one medical expert witness who agreed with the State's witnesses that Natalie was violently shaken before her death but who opined that the injury occurred before Natalie was brought to Edmunds's home." *State v. Edmunds*, 2008 WI App 33, ¶ 3, 746 N.W.2d 590, ¶ 3. Edmunds's theory was that one or both of the parents had shaken Natalie the night before her death. *Edmunds v. Deppisch*, 313 F.3d 997, 998 (7th Cir. 2002). This (failure to identify the correct perpetrator) has been a common defense in shaken baby prosecutions, as has the argument that, if the defendant shook the baby, the shaking did not achieve the level of force necessary to sustain a murder conviction. See *infra* note 181 and accompanying text (describing most common caregiver accounts).

indeed, at the time of Edmunds's trial, the medical consensus on this issue was overwhelming.<sup>23</sup>

All of this is standard fare for an SBS prosecution.<sup>24</sup> With rare exception, the case turns on the testimony of medical experts. Unlike any other category of prosecution, all elements of the crime—*mens rea* and *actus reus* (which includes both the act itself and causation of the resulting harm)—are proven by the science. Degree of force testimony not only establishes causation, but also the requisite state of mind.<sup>25</sup> Unequivocal testimony regarding timing—i.e., that symptoms necessarily would appear instantaneously upon the infliction of injury—proves the perpetrator's identity. In its classic formulation, SBS comes as close as one could imagine to a medical diagnosis of murder: prosecutors use it to prove the mechanism of death, the intent to harm, and the identity of the killer.

*Edmunds* is a representative shaken baby case in every respect but one. On January 31, 2008, Audrey Edmunds was granted a new trial on the basis of an evolution in scientific thinking. For the first time, a court examining the foundation of SBS concluded that it had become sufficiently eroded that a new jury probably would have a reasonable doubt as to the defendant's guilt.<sup>26</sup> According to the court, "a shift in mainstream medical opinion"<sup>27</sup> had undermined the basis of the SBS diagnosis, raising the distinct possibility that Edmunds, who was still serving her eighteen-year sentence in Wisconsin, had done nothing whatsoever to harm the child. As is true of an unknown number of

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23. *State v. Edmunds*, No. 96 CF 555, slip op. at 5 (Wis. Cir. Ct. Mar. 29, 2007) ("The medical evidence was largely consistent and unchallenged."). See Brief of Defendant, *supra* note 4, at 9 (discussing unanimity of medical opinions and state's reliance on this in argument to jury).

24. Once a child protection team has made an SBS diagnosis, suspected perpetrators—those with the child when symptoms appeared—are aggressively prosecuted. Each year, an estimated thousand plus defendants are convicted, most of murder, annually. Toni Blake, Jury Consultant, Address at the Forensic Truth Foundation: When Hypothesis and Data Conflict: An Analysis of an Infant Injury Database (May 12–15, 2007) (estimating that 95% of defendants prosecuted in SBS cases are convicted and 90% are serving life sentences).

25. "A key component of any expert testimony on SBS involves translating the mechanism of trauma into constructs . . . which adequately reflect the mens rea requirements for the charge." Brian Holmgren, *Prosecuting the Shaken Infant Case*, in *THE SHAKEN BABY SYNDROME: A MULTIDISCIPLINARY APPROACH* 275, 307 (Stephen Lazoritz & Vincent J. Palusci eds., 2001). As the prosecutor in *Edmunds* argued on summation, "one can only imagine the anger and the intensity of the shaking that goes on and the impact that goes on in these cases." Brief of Defendant, *supra* note 4, at 8. Evidence of force was thus used to establish that the defendant was reckless and exhibited utter disregard for human life.

26. *Edmunds*, 746 N.W.2d at 599.

27. *Id.* at 598–99.

convictions like it,<sup>28</sup> the science upon which the defendant's conviction rested had advanced, raising the specter of innocence.

This Article explores what ensues when medical certainty underlying science-based prosecutions dissipates.<sup>29</sup> It asks how a scientific revolution penetrates the criminal justice system and whether our legal system effectively responds to the inevitable consequences of science outpacing the law. The remarkable transformation of SBS provides a unique vehicle for probing these questions.

This examination begins in Part II, which places SBS prosecution in historical context, exposing the recent and rapid ascendance of a paradigm that, until now, has gone largely unnoticed.<sup>30</sup>

Part III assesses the current scientific controversy. A critical look at the creation of SBS exposes a diagnosis flawed from its inception by a tainted methodological approach, one, in all likelihood, corrupted by a too-close medical-legal nexus.<sup>31</sup> In recent decades, researchers have uncovered these failings, and the diagnosis has evolved accordingly. There is now general agreement among the medical community that the previous incarnation of SBS is invalid.<sup>32</sup> The particulars of this evolution are striking—especially from a criminal justice standpoint. Despite continued controversy around aspects of the diagnosis, Part III identifies a number of key areas where the framework for debate itself has been significantly altered. This discussion reveals that the new SBS is different enough from what came before to raise serious challenges to a substantial number of criminal convictions.

Specifically, these scientific developments have cast into doubt the guilt of an entire category of defendants: those convicted of crimes based on a triad-only SBS diagnosis. While we cannot know how many convictions are “unsafe” without systematic case review, a comparison of the problematic category of SBS convictions to DNA—and other mass

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28. See *infra* Part II.

29. This Article focuses on the criminal justice system's treatment of SBS. It should be noted that SBS's evolution also has powerful family court implications. See, e.g., *In re J.S.*, 785 A.2d 1041 (Pa. Super. Ct. 2001) (affirming removal of two-month-old child and his sibling based on questionable SBS diagnosis).

30. No legal scholar has attended to the proliferation of SBS prosecutions or explored the strange trajectory of SBS in science and law. This project has been given new urgency by mounting challenges to the validity of the science upon which these cases rest. At this moment, when new perspectives on old science are only just beginning to penetrate the criminal justice system, the emergence of a scholarly treatment of SBS and the law is especially critical.

31. See *infra* Part III.A.

32. See *infra* Part III.B.

exonerations—reveals that this injustice is commensurate with any seen in the criminal justice arena to date.<sup>33</sup>

Part IV chronicles the criminal justice system's treatment of the changing science. I do so by surveying the various stages in the criminal process where actors make decisions with the potential to account for—or overlook—scientific developments of the past decade. Police and prosecutors investigate cases and prosecutors decide whether to pursue charges.<sup>34</sup> Defendants and prosecutors make *Daubert* and *Frye* challenges to the admissibility of scientific evidence.<sup>35</sup> Jurors determine whether guilt has been proven beyond a reasonable doubt.<sup>36</sup> Defendants appeal and collaterally attack their convictions based on insufficiency of the evidence.<sup>37</sup> And defendants make motions for post-conviction relief because new evidence has been discovered.<sup>38</sup>

This procedural approach to understanding how the law integrates new scientific knowledge uncovers a response that is halting and inconsistent. I focus my critique on the system's treatment of cases in which SBS diagnoses rest on outmoded medical dogma. What can be discerned about the status quo is alarming. Guilt is being assigned where the best available science creates, at the very least, reasonable doubt. When an outcome reflecting the best available science is generated, it is not because the factual predicate for the prosecution diverges from the typical case but, rather, because the defendant is able to mount an aggressive attack—one that requires resources—on a body of science whose vulnerability is, in theory, equally exposed to all.

In short, prosecutors and courts are differentially absorbing scientific developments, resulting in an arbitrary distribution of justice.<sup>39</sup> Since

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33. See *infra* notes 142–47 and accompanying text.

34. See *infra* Part IV.A. My own intuitions about this phase of the criminal process are informed by my experiences prosecuting child abuse cases as an Assistant District Attorney in the Family Violence Bureau of the New York County District Attorney's Office.

35. See *infra* Part IV.B.

36. See *infra* Part IV.C.

37. See *infra* Part IV.D.

38. See *infra* Part IV.E.

39. The same week *Edmunds* was decided, an appeals court in Arkansas decided the appeal of Samantha Anne Mitchell, an in-home daycare provider for a four-month-old infant. *Mitchell v. State*, No. CACR 07-472, 2008 Ark. App. LEXIS 98, at \*1 (Ark. Ct. App. Feb. 6, 2008). The baby died of what prosecution experts diagnosed as SBS based on the presence of the classic triad of symptoms (again, subdural hemorrhaging, brain swelling, and retinal hemorrhages)—the same triad that convicted Audrey Edmunds. *Id.* at \*5–6. In terms of the medical findings and the prosecution's legal theory, the cases are remarkably similar. Yet the very week that Audrey Edmunds was awarded a new trial, leading prosecutors in Wisconsin ultimately to dismiss the charges against her, Samantha Anne Mitchell's murder conviction was affirmed. *Id.* at \*10.

January 31, 2008, when Edmunds's new trial motion was granted, dozens of convictions based on SBS have been upheld, either on direct appeal or collateral attack. An unknown number of prosecutions have been initiated and an unknown number resulted in convictions.<sup>40</sup> While a portion of these cases rely on corroborating medical evidence of injury beyond the triad,<sup>41</sup> many do not.

The story of our legal system's response to SBS speaks to how crime is constructed and reified. It tells of institutional inertia and a quest for finality<sup>42</sup> that sit uneasily with our commitment to justice. And it demands consideration of where we go from here. By identifying a problem of tragic dimensions, I hope to begin a conversation that seeks solutions and situates itself in the emerging discourse on innocence.<sup>43</sup> The conceptual implications of this inquiry—for scientific engagement in law's shadow, for future systemic reform, and for the notion of innocence in a post-DNA world—should assist in the task of righting past wrongs and averting further injustice.

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40. See, e.g., Shane Anthony, *Nanny Should Get 7 Years in Prison, Jury Says Woman, 22, was Convicted of Assaulting 4-Month-Old Boy*, ST. LOUIS POST-DISPATCH, July 30, 2008, at B1; Rebecca Baker, *Greenburgh Nanny Pleads Guilty in Shaken-Baby Case*, THE JOURNAL NEWS (N.Y.), July 30, 2008, available at <http://m.lohud.com/news.jsp?key=110532>; Sarah Kapis, *Stonewood Father Arrested in Shaken Baby Case*, W. VA. MEDIA, June 23, 2008, [http://www.wboy.com/story.cfm?func=view\\_story&storyid=40376](http://www.wboy.com/story.cfm?func=view_story&storyid=40376); Robert Kerns, *Inquest Jury Rules Infant's Death as Homicide by Shaken Baby Syndrome*, PEKIN DAILY TIMES (Ill.), June 13, 2008, available at <http://www.pekintimes.com/articles/2008/06/13/news5.txt> (on file with author); T.C. Mitchell, *Father Pleads Guilty to Infant Daughter's Killing*, ANCHORAGE DAILY NEWS, Aug. 11, 2008; Molly Montag, *Daycare Provider Faces Charges for Injured Infant*, SIOUX CITY J., July 3, 2008, available at <http://www.siouxcityjournal.com>; Andy Nelesen, *Tot Hit Head in Tub, Murder Suspect Tells Police*, GREEN BAY PRESS GAZETTE, June 20, 2008; Jamaal E. O'Neal, *Man Charged with Felony in Baby's Injury*, LONGVIEW NEWS-JOURNAL (Tex.), Aug. 12, 2008, at 1B; Mona Ridder, *Grand Jury: Neglect Results in Child's Death*, CUMBERLAND TIMES-NEWS, June 25, 2008, available at [http://www.times-news.com/local/local\\_story\\_177093757.html](http://www.times-news.com/local/local_story_177093757.html); Amy Upshaw, *Eudora Foster Mother of Dead Toddler Released on Bond*, ARK. DEMOCRAT GAZETTE, Aug. 13, 2008.

41. By one nationally prominent defense expert's account, one quarter of the cases prosecuted as SBS involve a "battered baby," or a child with substantial medical corroboration of physical abuse. Telephone Interview with John Plunkett, Retired Pathologist (June 20, 2008).

42. This quest is nicely evidenced by a Connecticut trial court's expression of concern in the wake of *Edmunds*: "the *Edmunds* case presents a potential quagmire of epic proportions: the strong likelihood of constant renewed prosecution and relitigation of criminal charges as expert opinion changes and/or evolves over time." *Grant v. Warden*, No. TSRCV03004233S, 2008 WL 2447272, at \*1 n.1 (Conn. Super. Ct. June 4, 2008).

43. See *infra* Part V.

## II. THE AGE OF SBS

The first appeal of an SBS-related conviction was reported in 1984.<sup>44</sup> Based on the presence of bilateral retinal hemorrhages and subdural hematoma, the prosecution's expert concluded that a four-month-old infant had been shaken to death,<sup>45</sup> and the appellate court affirmed the sufficiency of the evidence to convict.<sup>46</sup> Over the next five years, less than fifteen appeals of convictions based on an SBS diagnosis were reported.<sup>47</sup>

Beginning in 1990, however, the number of appeals grew dramatically. In five-year increments, published appellate decisions increased from 74 (January 1, 1990–December 31, 1994), to 160 (January 1, 1995–December 31, 1999), to 315 (January 1, 2000–December 31, 2004).<sup>48</sup> The numbers from the first half of the current five-year period suggest that this trend toward rising SBS appeals is continuing: from January 1, 2005 to June 30, 2008, 259 written opinions in this category were issued.<sup>49</sup>

Appellate case law is admittedly an inadequate measure of prosecutions, both because most convictions do not result in a written appellate decision,<sup>50</sup> and because not all prosecutions result in conviction. Notwithstanding these limitations, the appellate case law can suggest, as it does in this instance, that the total volume of prosecutions has been on a sharply upward trajectory since 1990.

Ascertaining the absolute number of SBS prosecutions is of course far more difficult.<sup>51</sup> Approximately 1500 babies are diagnosed with SBS in

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44. *Ohio v. Schneider*, No. L-84-214, 1984 Ohio App. LEXIS 11988 (Ohio Ct. App. Dec. 21, 1984). For an overview of the diagnostic origins of SBS, see *infra* notes 60–64 and accompanying text.

45. *Schneider*, 1984 Ohio App. LEXIS 11988 at \*3–4. At trial, the defense expert cited disagreement among scientists as to the quantity of force necessary to produce the observed injuries:

There are several articles which suggest that just playing with your child and throwing him up and down in the air when they are small infants, the reason infants are very risky incidences, they have very small bodies and large heads so the head tends to flop back and forth. Many people play with their children and throw up and down in the air and there are several experts suggesting that that definitely should not occur because it can cause small areas of brain damage and therefore injure your child. There really is no real documentation of whether or not a tremendous amount of force or several episodes can severely damage an infant.

*Id.* at \*5. The defendant was convicted by jury of involuntary manslaughter. *Id.* at \*1.

46. *Id.* at \*14.

47. Based on culling results of search of “‘shaken baby’ and convict!”

48. *Id.*

49. *Id.*

50. According to Sam Gross, a leading expert on wrongful convictions, it would be conservative to estimate that, in this context, there are at least twice as many trial convictions as appeals, which would represent a higher incidence of appeals than average. Telephone Interview with Samuel Gross, Thomas and Mabel Long Professor of Law, Univ. of Mich. (July 21, 2008).

51. Media accounts tell of SBS prosecutions commencing daily across the country. See *supra* note 40. Given the number of SBS diagnoses made each year, see text accompanying *infra* note 52,

the United States each year.<sup>52</sup> How many of these cases result in prosecution and conviction is unknown, however, since no comprehensive data on SBS cases has ever been collected.<sup>53</sup> That said, there are a number of ways to estimate the magnitude of defendants potentially impacted by recent scientific developments.<sup>54</sup> One might conservatively assume that the approximately 800 appeals reported since 1990 reflect about 1500 convictions after trial.<sup>55</sup> To focus on more recent figures only, it seems fair to conclude that around 200 defendants a year are being convicted of SBS.<sup>56</sup> Without additional data, we cannot reasonably speculate about the number of defendants who plead guilty to this type of crime,<sup>57</sup> although the estimated 1500 SBS diagnoses a year may provide an outside parameter.

When placed against the backdrop of recent scientific developments, these numbers reflect a crisis in the criminal justice system.

### III. SCIENTIFIC EVOLUTION

As a categorical matter, the science of SBS can no longer support a finding of proof beyond a reasonable doubt in triad-only cases<sup>58</sup>—cases

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this comes as no surprise.

52. Blake, *supra* note 24. See also Nat'l Shaken Baby Coal., *Facts About SBS!!!*, <http://www.shakenbabycoalition.org/facts.htm> (last visited July 13, 2009) ("Experts say 1,000–1,500 cases of SBS occur each year in the United States, but the true number of cases is unknown because of misdiagnoses and underreporting.").

53. This void has allowed the phenomenal aspects of SBS prosecutions to remain largely obscured.

54. See *infra* note 58 (noting that not all SBS convictions have been undermined.); *infra* note 143.

55. See *supra* note 50. But national trial consultant Toni Blake has herself been contacted by 2000 to 3000 lawyers over the past decade regarding assistance with SBS trials and appeals, suggesting that the actual number of trial convictions is significantly higher. Mark Anderson, *Does Shaken Baby Syndrome Really Exist?*, DISCOVER, Dec. 2, 2008, <http://discovermagazine.com/2008/dec/02-does-shaken-baby-syndrome-really-exist>.

56. This estimate is based on the number of reported decisions from January 1, 2005 through June 30, 2008 (259) and a multiplier of two. See *supra* note 50 [Sam Gross's conservative assumption].

57. According to Andrea Lyon, a law professor with experience representing clients in SBS cases, pleas in this type of prosecution are very much the norm given the likelihood that a jury will convict, see *infra* Part IV.C, and the almost certain harshness of a post-trial sentence. Interview with Andrea D. Lyon, Assoc. Dean for Clinical Programs and Clinical Professor of Law, DePaul Univ. Coll. of Law, in Chi., Ill. (Oct. 16, 2008). A similar sentiment was voiced by one public defender, who articulated the dilemma faced by his SBS client: "if he went to trial and lost, [the sentence] was either 20 to 50 years, 20 years to life, or life without parole. Agreeing to confess to shaking the child . . . would considerably reduce any sentence." Anderson, *supra* note 55. See *infra* note 150 (noting Ontario's Goudge Commission recommendations regarding review of guilty pleas).

58. By this, I mean those whose convictions rest exclusively on the presence of retinal hemorrhage and/or subdural hematomas. In contrast, a sizeable number of SBS prosecutions rely on

which represent a significant number of SBS prosecutions. Put simply, here “change has raised the real possibility of past error.”<sup>59</sup>

In the past, the mere presence of retinal hemorrhaging, subdural hematoma, and cerebral edema was taken to mean that a baby had been shaken hard enough to produce what were conceptualized as whiplash forces.<sup>60</sup> According to the conventional understanding of SBS,<sup>61</sup> “[t]he application of rotational acceleration and deceleration forces to the infant’s head causes the brain to rotate in the skull. Abrupt deceleration allows continuing brain rotation until bridging veins are stretched and ruptured, causing a thin layer of subdural haemorrhage on the surface of the brain.”<sup>62</sup> Retinal hemorrhages were thought to result from a similar causal mechanism.<sup>63</sup> Most significantly, the triad of symptoms was believed to be distinctly characteristic—in scientific terms, pathognomonic—of violent shaking.<sup>64</sup>

Despite its lingering presence in the popular imagination, the scientific underpinnings of SBS have crumbled over the past decade<sup>65</sup> as the medical establishment has deliberately discarded a diagnosis defined by shaking.<sup>66</sup> Although no single nomenclature has emerged in its place,<sup>67</sup> doctors are now in widespread agreement that SBS is an unhelpful characterization,<sup>68</sup>

corroborative evidence beyond the triad; convictions which result in these cases are therefore less dramatically undermined by recent scientific developments. See *infra* note 143. It should be noted that what constitutes real, as opposed to apparent, “corroboration” in SBS cases is often a difficult question. See *infra* notes 80–82, 181–90 and accompanying text (challenging validity of perpetrator “confessions”); *infra* note 146 (critiquing United Kingdom Attorney General’s definition of corroboration). See also Stein v. Eberlin, No. 1:07CV3696, 2009 WL 650363 (N.D. Ohio Mar. 10, 2009) (defense expert opined that “parietal cranial irregularities in the victim’s skull likely represent suture variants rather than fractures”); P. Weir et al., *Normal Skull Suture Variant Mimicking Intentional Injury*, 332 BRIT. MED. J. 1020 (2006). Nevertheless, this Article focuses on those cases predicated on the “pure triad,” or triad-only prosecutions.

59. STEPHEN T. GOUDGE, INQUIRY INTO PEDIATRIC FORENSIC PATHOLOGY IN ONTARIO 531 (Ontario Ministry of the Att’y Gen. 2008) (on file with author).

60. See, e.g., John Caffey, *On the Theory and Practice of Shaking Infants*, 124 AM. J. DISEASES CHILDREN 161 (1972); Mary E. Case et al., *supra* note 18.

61. The term “came into general usage in the 1980s.” Robert Reece, *What Are We Trying to Measure: The Problems of Case Ascertainment*, 34 AM. J. PREVENTATIVE MED. S116 (2008).

62. Brian Harding, R. Anthony Risdon, & Henry F. Krous, Letter, *Shaken Baby Syndrome*, 328 BRIT. MED. J. 720, 720 (2004).

63. *Id.*

64. See *infra* Part III.A.

65. See *infra* Part III.B.

66. See *infra* Part III.B.3. This move away from etiological diagnosis toward anatomical diagnosis reflects a key concession to the limits of medical science. Telephone Interview with Stephen Boos, Dep’t of Pediatrics, Armed Forces Ctr. for Child Prot., Nat’l Naval Med. Ctr. (June 17, 2008).

67. Reece, *supra* note 61, at S116 (noting “lack of common nomenclature”).

68. “SBS” has been supplanted by a number of different terms: shaken impact syndrome (SIS); inflicted childhood neurotrauma; abusive head trauma (AHT); inflicted traumatic brain injury (inflicted TBI); and non-accidental head injury (NAHI). Reece, *supra* note 61. Indeed, the Committee

and that the presence of retinal hemorrhages and subdural hematoma cannot conclusively prove that injury was inflicted.<sup>69</sup>

Although it may be tempting to conclude simply that “science evolves,” and leave the inquiry there, the story is more complex; an object lesson in scientific overreaching and the challenge of correction.

#### A. *Flawed Science*

A number of forces coalesced to transform SBS from a certain diagnosis into its current state of flux. Most importantly, in the mid- to late-1990s,<sup>70</sup> medical research, including the SBS literature, became subject to a heightened level of scrutiny. The new “evidence-based medicine” standards required doctors to derive their research from methods that are scientific and statistically rigorous.<sup>71</sup> The change triggered a review of the evidence supporting a number of areas of medicine,<sup>72</sup> and included a comprehensive effort to examine the science underlying SBS.<sup>73</sup>

The application of the evidence-based framework to the SBS literature resulted in a remarkable determination: the medical literature published prior to 1998 contained “inadequate scientific evidence to come to a firm conclusion on most aspects of causation, diagnosis, treatment, or any other matters pertaining to SBS.”<sup>74</sup> More specifically, “[s]erious data gaps, flaws of logic, [and] inconsistency of case definition” meant that “the commonly held opinion that the finding of SDH [subdural hematoma] and RH [retinal

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on Child Abuse and Neglect of the American Academy of Pediatrics (AAP) recently recommended that “[p]ediatricians should use the term ‘abusive head trauma’ rather than a term that implies a single injury mechanism, such as shaken baby syndrome.” Cindy Christian et al., *Abusive Head Trauma in Infants and Children*, 123 PEDIATRICS 1409, 1411 (2009). Notwithstanding this proliferation of alternative diagnostic labels and the AAP’s newly articulated recommendation, both the medical and legal establishments continue to employ the terminology of SBS. For the sake of clarity, I will do so here as well.

69. See *infra* Part III.B.1.

70. “1998/1999 is regarded as the turning point in acceptance of the tenets and practice of EBM.” Mark Donohoe, *Evidence-Based Medicine and Shaken Baby Syndrome: Part I: Literature Review, 1966–1998*, 24 AM. J. FORENSIC MED. & PATHOLOGY 239, 239 (2003).

71. Testimony of Patrick Barnes in Transcript of Evidentiary Hearing (Day One) at 17–19, *State v. Edmunds*, 746 N.W.2d 590 (Wis. Cir. Ct. 2008) (No. 96 DF 555) [hereinafter Barnes testimony, Evidentiary Hearing (Day One)]. See Donohoe, *supra* note 70, at 239 (“In recent years, there has been a clear move toward basing medical practice and opinions on the best available medical and scientific evidence.”).

72. Donohoe, *supra* note 70, at 239.

73. *Id.* at 241.

74. *Id.*

hemorrhage] in an infant was strong evidence of SBS was unsustainable.”<sup>75</sup>

A logical fallacy of profound importance was uncovered by a close examination of the pre-1999 SBS literature: researchers had chosen subjects for study based on the presence of subdural hematomas and retinal hemorrhages and, with little or no investigation into other possible causes of these symptoms, simply concluded that the infants were shaken.<sup>76</sup> Scientists accordingly inferred that subdural hematomas and retinal hemorrhages must necessarily result from shaking.<sup>77</sup> Put differently, researchers “select[ed] cases by the presence of the very clinical findings and test results they [sought] to validate as diagnostic. Not surprisingly, such studies tend[ed] to find their own case selection criteria pathognomonic of SBS.”<sup>78</sup> The circularity of this logic is represented by the following equation: “SBS = SDH + RH [inclusion criteria], therefore SDH + RH = SBS [conclusion].”<sup>79</sup>

Other studies purporting to support the validity of the SBS diagnosis relied on “confessions” to establish the mechanism of injury. Here, too, a number of problems undermined the validity of the research.<sup>80</sup> Putting aside momentarily the possibility that a suspected abuser would be less than candid with doctors and investigators,<sup>81</sup> the classification of an account as a confession in these studies was highly problematic from a

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75. *Id.* As defenders of the scientific research are quick to note, there are obvious “difficulties in performing experiments in this area,” since “[i]t is clearly unethical to intentionally shake infants to induce trauma.” *Id.* at 239.

76. Barnes testimony, Evidentiary Hearing (Day One), *supra* note 71, at 28–29. “The major criticism of those who would indict and convict based on one or two talismanic findings of ‘shaken baby syndrome’ is that the justification for their opinions is based on nothing but circular reasoning.” Thomas L. Bohan, Letter to Editor, *Evaluating Evidence*, CHI. TRIBUNE, June 30, 2005.

77. Barnes testimony, Evidentiary Hearing (Day One), *supra* note 71, at 28–29.

78. Donohoe, *supra* note 70, at 239. As Dr. Patrick Barnes, chief of pediatric neuroradiology at Stanford’s Children’s Hospital and a leading national expert in this area, has explained, “we as a group that wrote those papers assumed what we were concluding.” Barnes testimony, Evidentiary Hearing (Day One), *supra* note 71, at 27–28. According to Dr. Barnes’s testimony, he—along with many other scientists—“told a lie on child abuse based on old diagnostic criteria.” *Id.* at 70–71. He has since made every effort to correct his past mistakes. Interview with Thomas Bohan, President, Am. Acad. of Forensic Scis., in Peaks Island, Me. (June 11, 2008). Telephone Interview with John Plunkett, *supra* note 41.

79. Patrick D. Barnes, *Imaging of the Central Nervous System in Suspected or Alleged Nonaccidental Injury, Including the Mimics*, 18 TOPICS MAGNETIC RESONANCE IMAGING 53, 55 (2007). “The evidence for SBS appears analogous to an inverted pyramid, with a small database (most of it poor-quality original research, retrospective in nature, and without appropriate control groups) spreading to a broad body of somewhat divergent opinions.” Donohoe, *supra* note 70, at 239.

80. Jan E. Leestma, “Shaken Baby Syndrome”: *Do Confessions by Alleged Perpetrators Validate the Concept?*, 11 J. AM. PHYSICIANS & SURGEONS 14 (2006).

81. See *infra* notes 181–90 and accompanying text (discussing perpetrator accounts).

methodological perspective: “where caretakers said that they shook the baby, it was never detailed how much they shook the baby, how long they shook the baby, and did the baby’s symptoms precede the shaking or did they follow the shaking.”<sup>82</sup>

Once the edifice upon which SBS had been constructed cracked, researchers began looking beyond the child abuse literature to the expertise of neurosurgeons, biomechanical engineers,<sup>83</sup> and pathologists.<sup>84</sup> Knowledge gained from these disciplines further eroded confidence in the existence of a pathognomonic relationship between shaking and the SBS triad.<sup>85</sup>

Around the same time, magnetic resonance imaging (MRI) revolutionized the field of radiology and significantly altered the diagnostic universe.<sup>86</sup> Compared to its precursor, computed tomography (CT), MRI enabled a far more detailed assessment of the “pattern, extent, and timing” of central nervous system injuries.<sup>87</sup> New radiological findings challenged what had become akin to scientific gospel,<sup>88</sup> revealing the presence of triad symptoms in the “mimics” of abuse: accidental injury and medical disorders manifesting as SBS.<sup>89</sup> And as technology and scientific methodology advanced, researchers questioning the basis for SBS reached a critical mass.<sup>90</sup>

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82. Barnes testimony, Evidentiary Hearing (Day One), *supra* note 71, at 31. One expert has remarked that it is not surprising that a caregiver would shake a child found unconscious, both because this response is almost instinctual and because the medical establishment once instructed that “if you have an unresponsive child, one of the first things you do is you jiggle or shake them and see if they will respond.” *Id.* See also *infra* notes 181–90 and accompanying text [same as above]. Cf. *Hess v. Tilton*, No. CIV S-07-0909WBSEFBP, 2009 WL 577661 (E.D. Cal. Mar. 5, 2009) (defendant “admitted that he shook [the baby] but insisted it was only in an attempt to clear her throat because she was choking on her own vomit”).

83. Biomechanical research has practical application to “child safety, car seats, [and] playground equipment. . . .” Barnes testimony, Evidentiary Hearing (Day One), *supra* note 71, at 25.

84. *Id.* at 24–25. Although “much of [this] literature was available before 1998, [it] was not widely read or applied by the child protection teams . . . and, particularly, the forensic pediatricians . . .” *Id.* at 25.

85. *Id.* at 24–25.

86. *Id.* at 26, 115.

87. Patrick D. Barnes, *Ethical Issues in Imaging Nonaccidental Injury: Child Abuse*, 13 TOPICS MAGNETIC RESONANCE IMAGING 85, 89 (2002); see also Marguerite M. Caré, *Neuroradiology, in ABUSIVE HEAD TRAUMA IN INFANTS AND CHILDREN: A MEDICAL, LEGAL, AND FORENSIC REFERENCE #*, 89 (Lori Frasier et al. eds., 2006).

88. Barnes testimony, Evidentiary Hearing (Day One), *supra* note 71, at 26.

89. *Id.* at 23, 52–53. See *infra* notes 132–36 and accompanying text (discussing SBS mimics).

90. Interview with Thomas Bohan, *supra* note 78. For an interesting discussion of the “critical role that groups play in social epidemics,” see *Power of Context (Part Two)*, in MALCOLM GLADWELL, *THE TIPPING POINT: HOW LITTLE THINGS CAN MAKE A BIG DIFFERENCE* 169, 171 (Little, Brown and Co. 2000).

This momentum was catalyzed by the high-profile prosecution of British au pair Louise Woodward, which in 1997 brought shaken baby syndrome into the international spotlight.<sup>91</sup> The case was widely perceived as “one of the more intriguing legal dramas of the age—one that [left] unresolved a mystery of sickening fascination to parents everywhere.”<sup>92</sup> In its wake, an already divided scientific community became even more polarized. Physicians felt “compelled to speak out regarding the scientific evidence as portrayed in the trial of Louise Woodward,” contending that “media publicity surrounding the case has led to considerable sentiment that she was convicted despite allegedly irrefutable scientific evidence presented by the defense that the infant’s injuries had occurred days to weeks earlier.”<sup>93</sup> And critics of the SBS diagnosis were galvanized by a legal and symbolic victory that commanded the world’s attention.

In response to these developments, an uneasy equilibrium has been reached. Once considered a “fringe” group, scientists challenging the SBS dogma have emerged as a significant force in terms of numbers as well as influence. Meanwhile, rather than abandon it altogether, defenders of the

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91. Commonwealth v. Woodward, No. CRIM. 97-0433, 1997 WL 694119, at \*1 (Mass. Sup. Ct. Nov. 10, 1997). The defendant called 911 to report that she could not rouse eight-month-old Matthew Eappen from his nap. Debra Rosenberg & Evan Thomas, ‘I Didn’t Do Anything’, NEWSWEEK, Nov. 10, 1997, available at <http://www.newsweek.com/id/97361>. Doctors found massive intracranial bleeding, brain swelling, and a retinal hemorrhage, and Matthew later died. *Nanny Murder Trial—Jury Still Out*, BBC NEWS, Oct. 30, 1997, available at [http://news.bbc.co.uk/1/hi/programmes/from\\_our\\_own\\_correspondent/16726.stm](http://news.bbc.co.uk/1/hi/programmes/from_our_own_correspondent/16726.stm). The prosecution, as is typical in SBS cases, rested almost entirely on medical evidence. Experts testified that “‘there was no doubt . . . that this infant was a victim of shaken baby syndrome;” and that this was “‘a classic picture of acute shaken baby injury.”’ *Id.*

The defense challenged the science more aggressively—and far more publicly—than had ever been done before. *See id.* (describing “clash of the medical men” in which “[b]oth teams produced ‘the world’s leading experts’ to make their own case”). Woodward was represented by Barry Scheck, one of the nation’s preeminent defense attorneys, whose advocacy proved the difference that resources can make. *See Rosenberg & Thomas, supra* (“Scheck and his team hired medical experts (at the cost of thousands of dollars a day) who testified that Matthew’s skull fracture had occurred about three weeks before he died, and that the fatal bleeding could have been unleashed by just a slight jar.”). The defense presented a number of experts to testify to an alternative theory of Matthew’s death. According to this testimony, the fatal hemorrhage was caused by a “re-bleed” of a chronic brain clot resulting from an undetected injury. *Woodward*, 1997 WL 694119, at \*1. *See infra* note 194 (citing supporting re-bleed theory). The trial “roil[ed] two nations.” Rosenberg & Thomas, *supra*. After a jury convicted the defendant of murder, the trial judge reduced the verdict to involuntary manslaughter and sentenced Woodward to time already served. Commonwealth v. Woodward, 694 N.E.2d 1277, 1281 (Mass. 1998). In his order, the judge articulated one rational view of the evidence which would constitute manslaughter: the baby had a chronic blood clot which re-bled upon “rough” handling by Woodward. *Id.* at 1287.

92. Rosenberg & Thomas, *supra* note 91.

93. David L. Chadwick et al., Letter to the Editor, *Shaken Baby Syndrome—A Forensic Pediatric Response*, 101 PEDIATRICS 321, 321 (1998).

validity of the diagnosis have adapted it in subtle but important ways: SBS has been reincarnated to reflect a shifted consensus.<sup>94</sup>

### *B. Shifted Consensus*

Since the mid-1990s, the science surrounding SBS has undergone a striking transformation. With little attention outside of the medical community, universally held tenets have been undermined, leading a segment of the scientific establishment—including some formerly prominent supporters of its validity—to perceive the diagnosis as illegitimate. Others, equally distinguished in their respective fields, have responded to the new research by defending SBS against attack.<sup>95</sup> Thus, despite the progression of scientific discourse, the current debate about shaken baby syndrome is remarkably polarized.<sup>96</sup> Scientists on each side of the controversy espouse their respective views with a passion and certainty matched in intensity by that of their opponents.<sup>97</sup>

This polarization, and the bitterness that accompanies it, can tend to obscure a significant area of consensus that has developed around the invalidity of previously accepted dogma. Doctors who defend the legitimacy of SBS and dismiss many of its critics' attacks are willing to concede that the science has evolved—and that even mainstream thinking has changed in a number of areas. The testimony of prosecution experts marks this movement.<sup>98</sup>

The movement is subtle, but undeniable. Its significance may depend upon the context in which it is being evaluated. From the perspective of “pure” science, the similarities between the two factions may be overshadowed by their unresolved differences;<sup>99</sup> but in the criminal justice

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94. Defenders of the new SBS adhere to the view that the cluster of triad symptoms, while not *pathognomonic* of abuse, are *generally indicative* of violent shaking and/or impact. See *infra* notes 107–09 and accompanying text.

95. Defenders of the validity of the diagnosis fall along a spectrum. For instance, without rejecting the construct in its entirety, many physicians have revised their thinking about the original or “strong” version of SBS—i.e., the syndrome defined by a triad of symptoms understood to be pathognomonic of shaking. See *infra* Part III.B.1.

96. See *infra* notes 109, 113, 123, 128–29 and accompanying text.

97. *Id.*

98. See, e.g., Testimony of William Perloff in Transcript of Evidentiary Hearing (Day Four) at 11–12, *State v. Edmunds*, 746 N.W.2d 590 (2008) (No. 96 CF 555); Testimony of Betty Spivak in Transcript of Evidentiary Hearing (Day Three) at 12–14, *State v. Edmunds*, 746 N.W.2d 590 (2008) (No. 96 CF 555) [hereinafter Spivak testimony, Evidentiary Hearing (Day Three)].

99. Evaluating this claim is complicated, given that the notion of “pure science” in the domain of SBS may well be a fiction.

setting, the new common ground should be of critical importance. A brief overview of what has become uncontroversial reveals why.

### 1. *The Myth of Pathognomony*

An emerging body of research has undermined the scientific basis for defining the triad of SBS symptoms as exclusively diagnostic of abuse.<sup>100</sup> No longer are physicians willing to state with certainty that the constellation of symptoms that once characterized SBS individually<sup>101</sup> and collectively<sup>102</sup> must in every case indicate that a child was abused.<sup>103</sup> In particular, as scientific study has generated new explanations for the presence of subdural hematomas<sup>104</sup> and retinal hemorrhages,<sup>105</sup> doctors have become increasingly reluctant to use the word pathognomonic when discussing these symptoms.<sup>106</sup> While many disagree vehemently with the contention that shaking alone cannot possibly cause the diagnostic triad,<sup>107</sup> they have conceded that the triad is not *necessarily* induced by shaking,

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100. See, e.g., J. Plunkett and J.F. Geddes, Letter, *The Evidence Base for Shaken Baby Syndrome*, 328 BRIT. MED. J. 719, 720 (2004) (urging “reconsider[ation of] the diagnostic criteria, if not the existence, of shaken baby syndrome”).

101. In cases, the presence of subdural hematoma or retinal hemorrhage alone has provided the basis for an SBS diagnosis. *Id.* at 719. See *infra* note 280 and accompanying text (describing prosecutions of this kind).

102. See Clinical Statement of American Academy of Ophthalmology, [http://one.aao.org/CE/PracticeGuidelines/ClinicalStatements\\_Content.aspx?cid=c379ec3e-8251-48e6-a88e-fb6f37954b14](http://one.aao.org/CE/PracticeGuidelines/ClinicalStatements_Content.aspx?cid=c379ec3e-8251-48e6-a88e-fb6f37954b14) (last visited July 20, 2009).

103. See *supra* notes 60–64 and accompanying text.

104. See, e.g., Marta C. Cohen & Irene Scheimberg, *Evidence of Occurrence of Intradural and Subdural Hemorrhage in the Perinatal and Neonatal Period in the Context of Hypoxic Ischemic Encephalopathy*, 12 PEDIATRIC DEVELOPMENTAL PATHOLOGY 169 (2009); Julie Mack et al., *Anatomy and Development of the Meninges: Implications for Subdural Collections and CSF Circulation*, 39 PEDIATRIC RADIOLOGY 200 (2009) (on file with author); Eva Lai Wah Fung et al., *Unexplained Subdural Hematoma in Young Children: Is it Always Child Abuse?*, 44 PEDIATRICS INT’L 37 (2002); V.J. Rooks et al., *Prevalence and Evolution of Intracranial Hemorrhage in Asymptomatic Term Infants*, 29 AM. J. NEURORADIOLOGY 1082 (2008).

105. See, e.g., P.E. Lantz et al., *Perimacular Retinal Folds from Childhood Head Trauma*, 328 BRIT. MED. J. 754 (2004); Gregg T. Leuder et al., *Perimacular Retinal Folds Simulating Nonaccidental Injury in an Infant*, 124 ARCHIVES OPHTHAMOLOGY 1782 (2006).

106. There has been widespread acknowledgment that what one researcher has called “the proposed pathognomonic association between unexplained subdural hematoma/retinal hemorrhages and child abuse” may be suspect. Fung et al., *supra* note 104, at 37 (adopting a cross-cultural perspective and concluding that the diagnosis may be a “self-fulfilling prophecy”). This concession has been articulated by even those physicians who maintain the validity of the diagnosis. Interview with Lawrence Ricci, Dir., Spurwink Child Abuse Program, in Portland, Me. (June 12, 2008); Telephone Interview with Stephen Boos, *supra* note 66. See also C. Smith & J. Bell, *Shaken Baby Syndrome: Evidence and Experts*, 50 DEVELOPMENTAL MED. & CHILD NEUROLOGY 6, 7 (2008) (arguing that “trauma remains the most likely cause of SDH [subdural hemorrhage] in infancy” while “stress[ing] that the triad is not pathognomonic of inflicted injury”).

107. See *infra* Part III.B.3.

and that a differential diagnosis must be considered.<sup>108</sup> This represents a dramatic evolution in mainstream scientific thinking.

Critics of the new research argue that shaking is still the most likely explanation for retinal hemorrhaging and subdural hematoma.<sup>109</sup> Nevertheless, given that the diagnostic paradigm rests fully on the triad, the move away from pathognomy inevitably reframes ongoing debate.

## 2. *Lucid Intervals*

In the past, defendants prosecuted for SBS were identified by the science—that is, by the certainty of doctors that the perpetrator of abuse was necessarily the person with the infant immediately prior to the loss of consciousness. However, studies have since shown that children suffering fatal head injury may be lucid for more than seventy-two hours before death.<sup>110</sup> Because the prospect of a lucid interval lessens the ability to pinpoint when an injury was inflicted, this research dramatically alters the forensic landscape. Without other evidence, the identity of a perpetrator—assuming a crime has occurred—simply cannot be established.<sup>111</sup>

Similarly, whereas before, doctors effectively foreclosed the possibility that prior accidental injury caused an infant's later symptoms, lucid interval studies support the notion of a lag time.<sup>112</sup>

Those who dispute the importance of this research note that the concept of lucidity is ambiguous and argue that, even in an interval classified as lucid, an infant suffering from fatal head trauma would show signs of severe neurological damage.<sup>113</sup> At least one documented case—where a hospitalized child was observed by medical personnel in a “clingy, but

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108. In SBS cases, the differential diagnosis is a list of possible causes of the infant's symptoms. It results from a methodology that seeks to eliminate those factors that cannot have contributed to the injuries. Barnes testimony, Evidentiary Hearing (Day One), *supra* note 71, at 12, 32. For further discussion of the differential diagnosis, see *infra* notes 134–36 and accompanying text.

109. This perspective was articulated repeatedly in my conversations with physicians. It is also represented in the scientific literature. See, e.g., David L. Chadwick et al., *Annual Risk of Death Resulting from Short Falls Among Young Children: Less than 1 in 1 Million*, 121 PEDIATRICS 1213 (2008).

110. See, e.g., M.G.F. Gilliland, *Interval Duration Between Injury and Severe Symptoms in Nonaccidental Head Trauma in Infants and Young Children*, 43 J. FORENSIC SCI. 723 (1998); Kristy B. Arbogast et al., In Reply to Letter to Editor, *Initial Neurologic Presentation in Young Children Sustaining Inflicted and Unintentional Fatal Head Injuries*, 116 PEDIATRICS 1608 (2005).

111. See *infra* note 250 (noting, among others, cases where identity is in dispute).

112. See *supra* note 110.

113. Interview with Lawrence Ricci, *supra* note 106; Spivak testimony, Evidentiary Hearing (Day Three), *supra* note 98, at 94–102.

perfectly responsive” state for sixteen hours before her death<sup>114</sup>—has proven otherwise.<sup>115</sup>

But here, again, the emerging consensus dwarfs the continuing disagreement.<sup>116</sup> A period of time can exist where a child is impaired but functioning,<sup>117</sup> making the lucid interval “a distinct discomfoting but real possibility.”<sup>118</sup> In the past, caregiver accounts of seemingly unprecipitated neurological crises were dismissed or even deemed inculpatory.<sup>119</sup> These accounts must now be evaluated with the possibility of a lucid interval in mind.

### 3. Removing the Shaking from the Syndrome

New debate has emerged regarding whether shaking can generate the force levels sufficient to cause the injuries associated with SBS. Those who believe it cannot point to a number of biomechanical studies, as well as research using animal and computer models.<sup>120</sup> Many of these scientists assume *arguendo* that rotational acceleration-deceleration forces can, in theory, cause retinal hemorrhage and subdural hematoma, but contend that shaking an infant with sufficient force to do so would necessarily damage

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114. Testimony of Robert Huntington in Transcript of Evidentiary Hearing (Day Two) at 36, *State v. Edmunds*, 746 N.W.2d 590 (2008) (No. 96 CF 555) [hereinafter Huntington testimony, Evidentiary Hearing (Day Two)].

115. See Robert Huntington, Letter, *Symptoms Following Head Injury*, 23 AM. J. FORENSIC MED. & PATHOLOGY 105 (2002) (describing case study in which infant was observed by hospital personnel in prolonged lucid state before dying from injuries associated with SBS). This case (“Hernandez”) had a transformative effect on Dr. Huntington, the pathologist who performed the autopsy in *Edmunds*. At trial, Dr. Huntington testified that it was “highly probable” that Natalie had been injured within two hours of being seen by medical personnel. Huntington testimony, Evidentiary Hearing (Day Two), *supra* note 114, at 33. Based on his subsequent involvement with the Hernandez case, Dr. Huntington testified on behalf of Edmunds at her 2007 post-conviction evidentiary hearing that he had “changed [his] opinion about whether there could be a significant lucid interval after injury[.]” *Id.* at 34. See *infra* Part IV.E.1. Although Hernandez is factually *sui generis*, “everybody agrees that the single incident, the single validated case can falsify a theory. That’s what’s significant about them.” Attorney for the Defense in Transcript of Oral Argument (Day 5) at 132–33, *State v. Edmunds*, 746 N.W.2d 590 (Wis. Cir. Ct. Mar. 8, 2007) (No. 96 CF 555).

116. There seems to be general agreement in the medical community that, in nonlethal cases, where a child typically presents as lucid, the science can even less readily identify a perpetrator. Interview with Ricci, *supra* note 106; Telephone Interview with Stephen Boos, *supra* note 66.

117. Experts may debate whether the exhibiting signs were so severe that medical professionals would have been aware of a problem, but this does not equate to what a nonmedical person would necessarily conclude—which, for purposes of evaluating a caregiver history, would seem to be the relevant inquiry.

118. Huntington testimony, Evidentiary Hearing (Day Two), *supra* note 114, at 44.

119. See *infra* notes 80–82 and accompanying text. See also Part IV.A.2.

120. See, e.g., A.C. Duhaime et al., *The Shaken Baby Syndrome: A Clinical, Pathological, and Biomechanical Study*, 66 J. NEUROSURGERY 409 (1987); A.K. Ommaya et al., *Biomechanics and Neuropathology of Adult and Paediatric Head Injury*, 16 BRIT. J. NEUROSURGERY 220 (2002).

the neck and cervical spinal cord or column. Since most infants diagnosed with SBS do not present this type of injury,<sup>121</sup> they could not have been simply shaken.<sup>122</sup>

This perspective remains subject to considerable criticism within the medical establishment.<sup>123</sup> But even those who vehemently dispute the conclusion that shaking alone cannot cause the triad have revised their thinking. No longer is shaking advanced as an exclusive etiology.<sup>124</sup> Instead, the current position of this group of physicians with respect to nonnatural forces (i.e., intentional or accidental trauma) is that either shaking *or impact* may cause the classic triad.<sup>125</sup> More important is the widespread recognition that the two possible mechanisms cannot be clinically differentiated. Thus, the most committed defenders of the validity of the SBS diagnosis now allow that impact cannot be eliminated as a potential causal mechanism.

Once this fact is acknowledged, the question of how much force is required to generate the types of injury associated with SBS becomes critical to whether trauma was inflicted, accidental, or undeterminable.

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121. "As forensic pathologists are keenly aware, neck injuries in a 'shaken' child are a rarity, not a commonality." Kimberley Molina, *Neck Injuries and Shaken Baby Syndrome*, 30 AM. J. FORENSIC MED. & PATHOLOGY 89 (2009) (citing data presented at Annual Meeting of the National Association of Medical Examiners indicating 0% incidence of neck injuries in seventy-nine potential "shaking" cases).

122. See, e.g., Faris A. Bandak, *Shaken Baby Syndrome: A Biomechanics Analysis of Injury Mechanisms*, 151 FORENSIC SCI. INT'L 71 (2005).

123. Among those who believe that shaking *can* cause the constellation of SBS injuries, some are willing to concede that this has not been scientifically proven. These physicians posit that the absence of proof is a reflection of poor modeling, rather than anatomical impossibility. They also note that researchers are obviously unable to shake live babies (and ethical considerations prevent this kind of experiment on animals that would be useful for comparison). According to those who adhere to the notion that shaking may result in the diagnostic triad, these realities make it extremely difficult to prove the causal mechanism involved in SBS. Telephone Interview with Stephen Boos, *supra* note 66; Interview with Lawrence Ricci, *supra* note 106.

Along these same lines, in the past, doctors were certain, not only that shaking was the mechanism at issue, but also that the shaking necessary to cause the triad of symptoms associated with SBS was of such an extremely forceful nature that the causal act could not be anything other than abuse. To illustrate the point, doctors compared the hypothesized forces at issue to known causes of subdural hematoma and retinal hemorrhage—i.e., falls off of multi-story buildings and car crashes—and they modeled this violent shaking with baby dolls. See *supra* notes 19–20 and accompanying text. Today, confronting the absence of a solid scientific basis for these claims, and in recognition of the logic that such extreme force might be expected to cause neck and cervical cord injury, the conventional wisdom regarding degree of force has been disavowed. Telephone Interview with Stephen Boos, *supra* note 66; Interview with Lawrence Ricci, *supra* note 106. Disagreement continues, however, regarding whether this type of injury is always clinically discernable.

124. See *supra* notes 60–64 and accompanying text (describing original formulation of SBS diagnosis).

125. Telephone Interview with Stephen Boos, *supra* note 66; Interview with Lawrence Ricci, *supra* note 106. See also Duhaimé, *supra* note 120.

The latest thinking about force thresholds complicates this inquiry. New research shows that relatively short-distance falls may cause fatal head injury that looks much like the injury previously diagnosed as SBS.<sup>126</sup> Moreover, these signs and symptoms may not appear immediately.<sup>127</sup>

While the “short-fall” literature continues to be a source of debate<sup>128</sup> and its scientific significance minimized by some,<sup>129</sup> the potential impact of these findings on criminal prosecutions is enormous.<sup>130</sup> Where doctors would previously have been certain that an infant was shaken, in many cases<sup>131</sup> a fall must now be entertained as an explanation for injuries.<sup>132</sup> Once the threshold of force sufficient to cause the injuries at issue has been cast into doubt, scientific identification of a causal mechanism that is

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126. “The injury may be associated with bilateral retinal hemorrhage, and an associated subdural hematoma. . . .” John Plunkett, *Fatal Pediatric Head Injuries Caused by Short-Distance Falls*, 22 AM. J. FORENSIC MED. & PATHOLOGY 1, 10 (2001). See generally Scott Denton, *Delayed Sudden Death in an Infant Following an Accidental Fall: A Report with Review in the Literature*, 24 AM. J. FORENSIC MED. & PATHOLOGY 239 (2003).

127. *Id.* See *infra* Part III.B.2.

128. See, e.g., Robert M. Reece, Letter, *The Evidence Base for Shaken Baby Syndrome: Response to Editorial from 106 Doctors*, 328 BRIT. MED. J. 1316 (2004).

129. See, e.g., Testimony of Jeffrey Jentzen, in Transcript of Evidentiary Hearing (Day Three) at 30–35, *State v. Edmunds*, 746 N.W.2d 590 (2008) (No. 96 CF 555). Other physicians, even those who generally testify on behalf of the prosecution in SBS cases, have conceded the importance of the short-falls findings. See, e.g., Testimony of Alex Levin in Transcript of Evidentiary Hearing (Day Four) at 133, *State v. Edmunds*, 746 N.W.2d 590 (Wis. Cir. Ct. 2008) (No. 96 CF 555) (characterizing this research as “valuable addition to the literature”).

130. The implications of this research extend beyond traditional SBS prosecutions. For instance, in Texas, one death row inmate, Cathy Lynn Henderson, was recently granted a stay of execution and a hearing on her habeas motion based on newly available scientific evidence regarding the effects of short falls on pediatric head trauma. *Ex parte Henderson*, 246 S.W.3d 690 (Tex. Crim. App. 2007). At her trial in 1995, Henderson claimed that she had accidentally dropped the infant from her arms—a contention effectively rebutted by the testimony of prosecution experts, who unanimously concluded that the infant’s extensive brain injuries must necessarily have been caused by intentionally slamming of the head against a hard surface. *Id.* at 691. The certainty attending this conclusion has since been undermined by the short-fall literature, as evidenced by the affidavits and reports submitted by the defendant in support of her motion for habeas relief. *Id.* Most notably, the medical examiner who testified for the prosecution “in essence, recant[ed] his trial-time conclusive opinion” as a result of the “new scientific information” not available when Henderson was convicted of capital murder. *Id.* at 692. As this Article goes to print, the trial court has not yet ruled on an evidentiary hearing held earlier this year.

131. To be clear, falls are not the only alternative explanation for the SBS triad. See *infra* notes 134–36 and accompanying text (discussing natural causes). Depending on the case—in particular, the available physical/forensic evidence (or lack thereof) and the caregiver’s account—a fall may be more or less likely than other possible causes of injury.

132. Infants’ heads may encounter impact in a variety of ways: babies fall from high chairs, beds and stairs; babies are accidentally dropped. “A history by the caretaker that the child may have fallen cannot be dismissed.” Plunkett, *supra* note 126, at 10. Given the frequency with which caregivers offer a fall as explanation for the child’s injuries, see *infra* note 181, this scientific development has real criminal justice significance.

abusive<sup>133</sup> becomes problematic. Put differently, the medical testimony can no longer do the work of establishing *mens rea*.

Just as researchers have identified the possibility of accidental trauma as a cause of the SBS triad, so, too, has increasing attention been given to of a number of nontraumatic causes of symptoms previously assumed to be pathognomonic of shaking.<sup>134</sup> A “number of medical disorders documented in the medical peer-reviewed literature . . . can mimic [abusive head trauma],” including congenital malformations, metabolic disorders, hematological diseases, infectious diseases and autoimmune conditions.<sup>135</sup> In sum, depending upon the clinical picture presented, the differential diagnosis for symptoms previously associated exclusively with SBS now contemplates a wide range of nontraumatic possibilities: medical or surgical interventions; prenatal, perinatal and pregnancy-related conditions; birth effects; infections; diseases; disorders; malformations; post-vaccinal conditions; re-bleeds; and hypoxia (lack of oxygen to the brain).<sup>136</sup>

Notwithstanding these rather seismic shifts in medical thinking, the criminal justice system has—with only rare and recent exception—been unyielding to new thinking about a diagnosis that proves a crime.

#### IV. SBS AND THE LAW

Given the scientific developments described, we may surmise that a sizeable portion of the universe of defendants convicted of SBS-based crimes is, in all likelihood, factually innocent. Even more certainly, a far greater number of defendants among this group were wrongfully convicted. The distinction is an important one:

The expression “wrongful conviction” is not a legal term of art and it has no settled meaning. Plainly the expression includes the conviction of those who are innocent of the crime of which they have been convicted. But in ordinary parlance the expression would, I think, be

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133. The use of “abusive” in this context is meant to convey a mental state beyond negligence, which accords with the vast majority of SBS-based criminal prosecutions. See *infra* note 248 (elaborating on requisite *mens rea*).

134. See *supra* note 108 (defining “differential diagnosis”).

135. Andrew P. Sirotnak, *Medical Disorders that Mimic Abusive Head Trauma*, in *ABUSIVE HEAD TRAUMA IN INFANTS AND CHILDREN: A MEDICAL, LEGAL, AND FORENSIC REFERENCE* 191 (Lori Frasier et al. eds., 2006). See also Barnes, *supra* note 79.

136. See generally K. Hymel et al., *Intracranial Hemorrhage and Rebleeding in Suspected Victims of Abusive Head Trauma: Addressing the Forensic Controversies*, 7 *CHILD MALTREATMENT* 329 (2002); Barnes, *supra* note 87; see also *supra* notes 104–05.

extended to those who, whether guilty or not, should clearly not have been convicted at their trials . . . . In cases of this kind,<sup>137</sup> it may, or more often may not, be possible to say that a defendant is innocent, but it is possible to say that he has been wrongly convicted. The common factor in such cases is that something has gone seriously wrong in the investigation of the offence or the conduct of the trial, resulting in the conviction of someone who should not have been convicted.<sup>138</sup>

In SBS cases, identifying the factually innocent is complicated by two related propositions. First, no crime whatsoever may have occurred, thus eliminating the opportunity to establish someone else's culpability.<sup>139</sup> Second, at least to date, science has not definitively established an alternative explanation for the injuries associated with SBS.<sup>140</sup> What this means is that a significant number of people convicted in triad-only prosecutions<sup>141</sup> are likely innocent of wrongdoing, but others are not, and we have no way of differentiating between these groups.<sup>142</sup> Accordingly, we may rightly be troubled by the convictions of those whose factual innocence is unproven.

The criminal justice implications of all of this are staggering.<sup>143</sup> To put the scope of the problem in a more familiar framework, it is helpful to

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137. Cases in which "flawed expert evidence was relied on to secure conviction" are specifically referenced. *Infra* note 138.

138. This passage is taken from a speech of Lord Bingham, the senior law lord in the United Kingdom until his retirement, in *R (on the application of Mullen) v. Secretary of State for the Home Department* [2005] 1 AC 1, 4, cited in Stephanie Roberts & Lynne Weathered, *Assisting the Factually Innocent: The Contradictions and Compatibility of Innocence Projects and the Criminal Cases Review Commission*, 29 OXFORD J. LEGAL STUD. 43, 50 (2009).

139. "Proving that someone else committed the crime is by far the most common method of achieving an exoneration, but it is unavailable if there was no crime at all." Samuel R. Gross, *Convicting the Innocent*, 4 ANN. REV. L. & SOC. SCI. 173, 183 (2008).

140. See *infra* notes 233–45 and accompanying text (discussing the challenges associated with the differential diagnosis).

141. See *supra* note 58 (defining term). For the moment, I put aside cases in which a suspect's seemingly incriminatory account was used—in retrospect, incorrectly—to corroborate the prosecutor's case. See *infra* notes 183–90 and accompanying text.

142. My thanks to Robert Mosteller for helping me to arrive at this formulation. E-mail from Robert Mosteller, Harry R. Chadwick Sr. Professor of Law, Duke University, to Deborah Tuerkheimer, Professor, University of Maine School of Law (Aug. 29, 2008, 15:46 EST) (on file with author).

143. In the estimation of one forensic medical expert, SBS cases may be divided into four groups. One includes those where injury is clearly inflicted, in all likelihood, by impact. Although, in this group, the causal mechanism may not be shaking, medical evidence apart from the triad indicates to a reasonable degree of scientific certainty that the baby was abused. In these cases, a finding of guilt seems just. The three remaining groups of cases involve evidence that, from a criminal justice stance, tends to negate proof beyond a reasonable doubt of a defendant's guilt: evidence of natural disease, the

consider the number of known exonerations in the United States over the past thirty years. From 1989 through 2007, there were 210 DNA exonerations, mostly for rape.<sup>144</sup> It is reasonable to suspect that this number of SBS-based convictions after trial occurred in the past year alone.<sup>145</sup> Additional (non-DNA) exonerations include those of 111 inmates on death row, 135 other individuals, and perhaps another 200 or so defendants whose convictions were overturned based on a “mass” scandal implicating widespread systemic corruption.<sup>146</sup> Unlike SBS cases, none of these exonerations involve a set of paradigmatic facts later determined to be a faulty basis for prosecution.<sup>147</sup>

Despite the large numbers of potentially impacted cases—or perhaps, because of them—our criminal justice system has yet to respond to new scientific realities.<sup>148</sup> Its failure to do so stands in marked contrast to other nations’ recognition of the problematic nature of pure-triad prosecutions. The emphatic institutional responses of the United Kingdom<sup>149</sup> and

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presence of chronic hematomas, and those in which no likely mechanism presents itself. Telephone Interview with John Plunkett, *supra* note 41.

144. Gross, *supra* note 139, at 175. Of course, DNA has uncovered only a fraction of the cases in which an innocent person was convicted. For a comprehensive examination of what is known—and all that we have yet to learn—about false convictions over the past thirty years, see Gross, *supra* note 139.

145. See *supra* note 56 and accompanying text. To be clear, I do not mean to suggest that every one of these post-trial convictions would, upon review, be found wrongful. See *supra* notes 58, 143 (refining subset of problematic cases). That said, a fair accounting of the number of defendants whose convictions have been undermined by scientific developments must also contemplate the possibility that some defendants who pleaded guilty before trial were innocent. See *supra* note 57; Gross, *supra* note 139, at 180–81 (generally discussing the difficulty of assessing how many innocent defendants plead guilty). Moreover, any inquiry aimed at quantitative measure should also acknowledge that triad-only prosecutions continue to this day; therefore, a true reckoning of the magnitude of injustice implicates a somewhat prospective outlook.

146. Gross, *supra* note 139, at 175–76.

147. As Sam Gross suggested to me, arson cases may provide the closest analogy, albeit an imperfect one, to the problem that I am describing. Telephone Interview with Samuel Gross, *supra* note 50. In 1992, the National Fire Protection Association “issued new guidelines that for the first time applied scientific principles to the analysis of the remains of suspicious fires, and revealed that the expert evidence of arson in [one death row inmate’s] case, and many others, had no scientific basis.” Gross, *supra* note 139, at 183.

148. As a general proposition, the U.S. criminal justice system—in contrast to those of many other nations—does not respond to extra-legal developments in a monolithic manner. Our system is atomized by its federalist, multi-state nature and by the multiplicity of actors involved in decision making throughout the criminal process. To explicate how scientific developments around SBS have penetrated the justice system, is, therefore, a formidable challenge. This difficulty is compounded by the extent to which SBS prosecutions, as a phenomenon of increasing importance, have gone largely unnoticed and data related to them correspondingly uncollected. Despite this, a procedural analysis of the various stages at which legal standards guide the exercise of discretion follows. It provides a holistic perspective on a system that has not widely absorbed new scientific realities.

149. In 2005–2006, the Attorney General, Lord Goldsmith, conducted a seven-month review of eighty-eight SBS cases, including guilty verdicts and pleas. (SBS convictions are significantly less commonplace in the United Kingdom than in the States.) Lord Goldsmith’s investigation was triggered

Canada<sup>150</sup> are particularly instructive. Just as our criminal justice system has seemed to operate within a time bubble, largely untouched by scientific evolution, so, too, it remains insulated from unmistakable signs

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by a 2005 Court of Appeal decision, now the governing case law, which concluded that “[i]n cases where the triad alone is present . . . the triad alone ‘cannot automatically or necessarily’ lead to a conclusion that the infant has been shaken.” THE RT HON THE LORD GOLDSMITH QC, THE REVIEW OF INFANT DEATH CASES: ADDENDUM TO REPORT SHAKEN BABY SYNDROME at 9–10 (2006). The Attorney General’s review methodology is vulnerable to criticism, particularly because among the evidence considered “to support the finding of SBS” was a defendant’s “[a]dmissions to shaking” and the presence of chronic subdural hematomas, *id.* at 12, each of which may be of limited corroborative value, *see infra* notes 104, 183–90 and accompanying text. This may explain why only three of the cases reviewed—a not insubstantial false conviction rate of 3.4%, but fewer than what many had expected—were identified as “giving rise to concern” and referred to the Criminal Court of Appeal. Goldsmith, *supra*, at 14. Irrespective of methodological shortcomings, however, Lord Goldsmith’s systemic review and the Court of Appeal decision that preceded it have appreciably altered the course of SBS prosecutions. As one commentator has suggested, “in [the] future there will be demands for each case to be assessed individually, on the evidence available, rather than on a formula which has now been proved to have weaknesses.” Sam Lister, *Q&A: Shaken Baby Syndrome*, TIMES ONLINE, Feb. 14, 2006, [www.timesonline.co.uk/tol/news/uk/article546383.ece](http://www.timesonline.co.uk/tol/news/uk/article546383.ece).

150. On April 25, 2007, the Province of Ontario established an inquiry into pediatric forensic pathology and appointed Justice Stephen Goudge of the Court of Appeal its Commissioner. Seventeen months and \$8.3 million later, Justice Goudge issued a 1000 page report which told what he called a “tragic story of pediatric forensic pathology in Ontario from 1981 to 2001. . . .” COMMISSIONER’S STATEMENT ON RELEASE OF THE REPORT, Oct. 1, 2008. Many of the Commission’s findings related specifically to the mistakes of one particular forensic pathologist and a failed oversight mechanism. But apart from the work of any individual, the report expressed deep concerns about the legitimacy of triad-based SBS prosecutions, concluding that in this set of cases, “a further review is warranted as part of restoring public confidence.” *Id.* See Goudge, *supra* note 59, at 531 (“[O]ur systemic examination has identified this particular area of forensic pathology as one where change has raised the real possibility of past error.”). In light of his doubts regarding “convictions based on the pure ‘triad,’ where no other pathology evidence is identified, and possibly in other SBS cases,” *id.* at 528, Justice Goudge recommended that a review be conducted with the objective of “identify[ing] those cases in which the pathology opinion can be said to be unreasonable in light of the understandings of today and in which the pathologists’ opinions were sufficiently important to the case to raise significant concerns that the convictions were potentially wrongful,” *id.* at 531. Because many of the convicted parties are now claiming that their pleas were “induced by various factors, including the serious consequences of potentially being convicted of murder charges and the acknowledged difficulties in challenging [the state’s forensic pathologist’s] opinions,” the report emphasized that “cases should not be excluded from review only because an accused pleaded guilty.” *Id.* at 532–33. Justice Goudge’s findings and conclusions are detailed extensively in his full report, *supra* note 59.

Upon issuance of the Goudge Commission Report, the Ontario coroner’s office quickly identified 220 cases where a determination was made that an infant died after being shaken. Antonella Artuso, *Shaken Baby Doubts Surface*, OTTAWA SUN, Oct. 2, 2008, at 7. Under the auspices of the Attorney General, 142 of these cases are being reviewed by a team which includes the province’s former associate chief justice, its chief forensic pathologist, a regional supervising coroner, a senior defense counsel, and a senior Crown attorney. Theresa Boyle, *Team Selected to Probe 142 Shaken Baby Cases*, THE TORONTO STAR, Dec. 2, 2008, [available at thestar.com](http://www.thestar.com). On November 6, 2008, Anna Sokoynyuk was the first person to have a case dismissed based on the Attorney General’s review. She had been charged with murder for the death of her three-month-old daughter. *Mom of Dead Baby Walks Free After Charges Against Her Withdrawn in Court*, TORONTO CITY NEWS, Nov. 6, 2008, [http://www.citynews.ca/news/news\\_28894.aspx](http://www.citynews.ca/news/news_28894.aspx).

that, elsewhere in the world,<sup>151</sup> other legal systems are assimilating new scientific understandings and adapting accordingly. When viewed in a global perspective, our continued adherence to a prosecution template that rests on discredited science is particularly jarring.

What follows is an account of how we have arrived at this place.

### *A. Investigation and Prosecution*

In the United States, unlike the United Kingdom and Canada, the SBS prosecution paradigm that ascended in the 1990s has remained largely untouched by scientific developments of the past decade.<sup>152</sup> This systemic failure should not be equated with the prosecutorial pursuit of charges against defendants believed to be innocent of wrongdoing.<sup>153</sup> Rather, SBS cases are going forward because law enforcement officers genuinely believe in the validity of the diagnostic triad that has fallen from scientific grace.<sup>154</sup> But this explanation, while more benign than its alternative, begs the question of why the triad continues to exert an almost talismanic effect.<sup>155</sup>

151. Apart from the institutional review mechanisms instituted by the United Kingdom and Canada, it is worth noting that Australia's criminal justice system has also begun to absorb new scientific understandings. In 2003, the Supreme Court of Western Australia issued an important decision in an SBS case. *R. v. Court* (2003) 308 WASC 1. At a bench trial for murder, the defendant was acquitted by a judge of all charges in a prosecution based on the presence of retinal hemorrhages and subdural hematoma, as well as spinal injury. *Id.* ¶¶ 1, 9. Central to the verdict was the court's reliance on the testimony of a prominent forensic pathologist, who testified that it was "not tenable" that the only possible cause of death was violent shaking. *Id.* ¶ 5. According to the trial judge,

[a]s I understand [the defense expert's] evidence, he was suggesting that unless a witness had seen the deceased being shaken or unless there was some medical evidence consistent with the child having been shaken, such as bruising or other external injury, or acceptable admissions, then to conclude that the deceased had died by being shaken in a prolonged or violent way was, as he expressed it, "highly suspect."

*Id.* The Supreme Court affirmed the reasonableness of this verdict. *Id.* ¶¶ 76, 95.

152. See *supra* notes 52–57 and accompanying text (discussing quantitative measures). Qualitative data also supports this proposition. Telephone Interview with Toni Blake, Jury Consultant, 2nd Chair Servs. (June 17, 2008); Telephone Interview with Brian Holmgren, Assistant Dist. Attorney, Davidson County Dist. Attorney Gen.'s Office, Child Abuse Unit (July 1, 2008).

153. While it is easy, and even fashionable, to vilify prosecutors, they are typically motivated by a desire to hold the guilty responsible for their actions. Many child abuse prosecutors seem almost missionary about their task, but this may come with the territory.

154. According to the database maintained by Toni Blake, see *supra* note 24, the vast majority of prosecutions go forward based solely on the presence of one or more triad symptoms. Telephone Interview with Toni Blake, *supra* note 152.

155. Apart from the dynamics discussed in the remainder of this Part, it must be noted that the death of an infant—the embodiment of innocence—inevitably provokes an intense emotional response among participants in the criminal process. It is quite reasonable that those affected would experience what Susan Bandes has insightfully described as an "urge to find an event blameworthy [in order] to

It is worth noting the considerable deference given to child-abuse doctors<sup>156</sup>—who, as a general rule, remain believers in the diagnosis.<sup>157</sup> Accordingly, prosecutors may exhibit a disinclination to interrogate the science upon which these physicians' opinions rest. There is nothing novel about the observation that prosecutors tend to defer to their experts; but, in this context, the relationship between the prosecutor and the allied medical professionals is a particularly close one.<sup>158</sup> In the typical SBS case, the expert *is* the case: there is no victim who can provide an account, no eyewitness, no corroborative physical evidence, and no apparent motive to kill.<sup>159</sup> Doctors identify both the occurrence of a crime and its perpetrator, and their assurance regarding each is essential for a conviction.<sup>160</sup> These dynamics may well contribute to a prosecutorial reluctance to challenge the validity of an SBS diagnosis. But they do not fully explain a continued willingness to pursue charges in cases built entirely on contested expert testimony.<sup>161</sup>

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convert a loss into a crime." Interview with Susan A. Bandes, Distinguished Research Professor of Law, DePaul Univ. Coll. of Law, in Chi., Ill. (Oct. 16, 2008).

156. In 2006, "the American Board of Pediatrics approved a petition for subspecialty certification in child abuse pediatrics." Kent P. Hymel & Karen Seaver Hill, *Child Advocacy: New Board Specialty Signals Positive Change in Child Abuse Pediatrics*, CHILDREN'S HOSPITALS TODAY (2007), available at <http://www.childrenshospitals.net/AM/Template.cfm?Section=Archives&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=31157> (last visited May 6, 2009). The first board certification examination will take place in the fall of 2009. *Id.*

157. See Robert Parrish, *Prosecuting a Case, in ABUSIVE HEAD TRAUMA: A MEDICAL, LEGAL, AND FORENSIC REFERENCE* 393, 396–97 (Lori Frasier et al. eds., 2006) (noting that American Prosecutors Research Institute and other prosecutors are a good source of referral to experts in area).

158. In many cases, this relationship has been formalized in a manner unique to the child-abuse setting. As described by one leading expert on nationwide prosecutorial practices: Many local prosecutors across the country have formed or participate in interdisciplinary teams intended to bring together child protective service (CPS) workers, law enforcement investigators, medical professionals, mental health providers, educators, and others who play a role in ensuring that justice is appropriately sought for severely abused children. *Id.* at 395; see also Holmgren, *supra* note 25, at 276.

159. The hypothesis generally advanced by pediatricians and prosecutors is that shaking "results from tension and frustration generated by a baby's crying or irritability . . ." Am. Acad. of Pediatrics, *supra* note 18, at 206. See also Holmgren, *supra* note 25, at 289–90 ("Prosecutors will often not be able to point to a traditional 'motive' (e.g., hatred, jealousy, vengeance, greed) to explain the caretaker's conduct. Rather, they must reorient jurors to think about motive in a unique context—one that does not reflect a purposeful mental state but instead a risk factor, stressor or catalyst that prompts the caretaker's reactive and abusive conduct . . . . The most common motive in SBS cases is anger or frustration resulting from the infant's crying.").

160. The dominance of the "team approach to investigation," erodes a sharp differentiation between the roles of prosecutor and physician. Parrish, *supra* note 157, at 395–96. I found this to be true when, as a prosecutor, I participated in a medical grand rounds regarding a case that was the subject of one of my investigations.

161. Cognitive biases on the part of jurors, *infra* notes 243–47 and accompanying text, may also affect prosecutors.

To complete the account, it is helpful to consider first, how prosecutors are trained in the science of SBS; second, how prosecutors perceive the accounts of those suspected of abuse; and, third, how prosecutors are influenced by the systemic nature of SBS convictions.

### 1. Prosecutorial Training

Training is especially critical in this area, where a complex and evolving body of science is outcome determinative.<sup>162</sup> As one prominent instructor recently urged, “investigators and prosecutors should obtain a basic education on medical issues common to all of these cases.”<sup>163</sup> Since most prosecutors encounter SBS cases infrequently, few become experts in the issues they raise.<sup>164</sup> It is unsurprising, then, that a nationwide training apparatus has developed to disseminate information about the basic structure of an SBS prosecution. For instance, the American Prosecutors Research Institute of the National District Attorneys Association<sup>165</sup> transmits newsletters,<sup>166</sup> organizes conferences,<sup>167</sup> and

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162. Parrish, *supra* note 157, at 395–96.

163. *Id.* at 395. “A fundamental understanding of the medical knowledge concerning AHT committed against children is absolutely essential to a prosecutor’s success in refuting commonly offered defenses, clarifying and dispelling myths introduced by opposing expert witnesses, and providing juries with sufficient information to reach a just decision.” *Id.* at 396.

164. “It is rare for a particular prosecuting attorney to handle multiple cases involving AHT [abusive head trauma] in child victims unless the prosecutor works in a specialized team assigned to handle physical abuse and child homicide.” *Id.* at 396. Even those prosecutors who do develop an expertise in this type of case “must be ever mindful that science is an ongoing process and medical research can quickly become dated . . . . Without a full understanding of the medical research that underlies an expert’s opinion, the prosecutor can neither make full use of the physician’s expertise, nor adequately cross-examine the opposing expert.” Holmgren, *supra* note 25, at 305.

165.

The mission of the American Prosecutors Research Institute is to provide state and local prosecutors knowledge, skills and support to ensure that justice is done and the public safety rights of all persons are safeguarded. To accomplish this mission, APRI serves as a nationwide, interdisciplinary resource center for research and development, technical assistance, training and publications reflecting the highest standards and cutting-edge practices of the prosecutorial profession.

American Prosecutors Research Institute, <http://www.ndaa.org/apri/index.html> (last visited July 21, 2009).

166. See, e.g., Erin O’Keefe, *Shaken Baby Syndrome: Overcoming Untrue Defenses*, 10 UPDATE 11 (1997), available at [http://www.ndaa.org/publications/newsletters/update\\_index.html](http://www.ndaa.org/publications/newsletters/update_index.html); Devon Lee et al., *Tips for Investigating Child Fatalities*, 13 UPDATE 1 (2000), available at [http://www.ndaa.org/publications/newsletters/update\\_index.html](http://www.ndaa.org/publications/newsletters/update_index.html); Victor I. Vieth, *Tips for Medical Professionals Called as Witnesses*, 13 UPDATE 7 (2000), available at [http://ndaa.org/publications/newsletters/update\\_index.html](http://ndaa.org/publications/newsletters/update_index.html).

167. Most recently, in July 2008, the National District Attorneys Association convened a conference on the “Investigation and Prosecution of Child Fatalities and Physical Abuse,” which

provides other support for prosecuting the SBS case.<sup>168</sup> The National Center on Shaken Baby Syndrome, an organization dedicated in part to training law enforcement officers,<sup>169</sup> has hosted and collaborated on nine conferences since 2000.<sup>170</sup> And prosecutors who have become leaders in the field have published book chapters with instruction in handling SBS cases from investigation through trial.<sup>171</sup>

These training materials present a view of the science refracted through an advocate's lens. For instance, a 2001 publication asserts: "the [prosecution] expert can testify that the forces the child experiences are the equivalent of a 50–60 m.p.h. unrestrained motor vehicle accident, or a fall from 3–4 stories on a hard surface;"<sup>172</sup> and "current research and professional consensus within the medical literature clearly supports the conclusion that . . . there is no lucid interval."<sup>173</sup> Similarly, from a chapter published in 2006: "there is emerging consensus among credible medical experts that when children have suffered serious or potentially fatal head injuries, they will start to experience symptoms almost immediately after injury;"<sup>174</sup> "[t]he collection of ocular damage, subdural or subarachnoid bleeding over the brain, axonal damage, and severe brain swelling is not seen in the same patterns in any forms of accidental trauma, but is seen in cases involving severe and violent shaking;"<sup>175</sup> and "the medical field has reached substantial consensus concerning many of the issues pertinent to criminal [SBS] cases."<sup>176</sup>

While it should be expected that materials used to educate prosecutors would be strategically focused with respect to trial, this same orientation with respect to case investigation is more problematic. And while we might also anticipate that the most extreme critiques of the science underlying SBS convictions would be soundly—and passionately—attacked, many of these materials fail to acknowledge the shifting of the

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included discussion of Abusive Head Trauma. More information may be found at [http://www.ndaa.org/education/apri/investigation\\_child\\_fatalities\\_abuse\\_2008.html](http://www.ndaa.org/education/apri/investigation_child_fatalities_abuse_2008.html) (last visited July 21, 2009).

168. See Parrish, *supra* note 157, at 396.

169. National Center on Shaken Baby Syndrome, About the Center, <http://www.dontshake.org/sbs.php?topNavID=2&subNavID=10> (last visited July 21, 2009).

170. National Center on Shaken Baby Syndrome, Conferences, <http://www.dontshake.org/sbs.php?topNavID=5&subNavID=38> (last visited May 6, 2009).

171. See generally Holmgren, *supra* note 25; Parrish, *supra* note 157.

172. Holmgren, *supra* note 25, at 307.

173. *Id.* at 305. See *id.* at 307 (stating that "the onset of symptoms is virtually contemporaneous with the abusive act").

174. Parrish, *supra* note 157, at 398.

175. *Id.* at 405.

176. *Id.* at 395.

center. In defending the science of old,<sup>177</sup> the authors tend to obscure the changed consensus around fundamental aspects of the SBS diagnosis.<sup>178</sup> At the same time, significant challenges to the conventional medical wisdom are ignored.<sup>179</sup> Nomenclature aside,<sup>180</sup> few concessions to developments in research have been made. The digested science describes a diagnosis upon which prosecutors can securely rely.

## 2. Caregiver Accounts

Prosecutorial confidence in guilt is augmented by statements on the part of SBS suspects—statements which are inevitably perceived as incriminatory. The three accounts most often offered to explain an infant's loss of consciousness or other obviously severe neurological symptoms are that: (i) their onset was unprovoked/without explanation, (ii) the infant fell from a short distance, and (iii) the infant was shaken playfully or in the course of revival efforts.<sup>181</sup> Research over the past decade has made each of these explanations newly plausible.<sup>182</sup> But because law enforcement officers interrogating the SBS suspect “know” that the infant's injuries were caused by violent shaking—the science is believed to prove this definitively—the narratives are all perceived as false and, therefore, incriminating.<sup>183</sup>

Moreover, if the suspect's story changes in response to familiar interrogation techniques,<sup>184</sup> this fact itself is used to support an SBS

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177. See *supra* notes 172–76. Support for the assertions made in recent publications is often found in sources from the past that have since been challenged. For instance, a 2001 publication asserts that “the expert can testify that the forces the child experiences are the equivalent of a 50–60 m.p.h. unrestrained motor vehicle accident, or a fall from 3–4 stories on a hard surface” and cites evidence from the records of cases ranging from 1986–1994. Holmgren, *supra* note 25, at 307. In the same publication, the claim that “the onset of symptoms is virtually contemporaneous with the abusive act” is bolstered by studies from the 1990s. *Id.* See also *supra* note 173.

178. See *supra* notes 174–76 and accompanying text.

179. See *supra* notes 173–76 and accompanying text.

180. See *supra* notes 67–68 and accompanying text (discussing new diagnostic labels). Most notable, pathognomony as the defining feature of SBS has been supplanted by the more ambiguous claim that “retinal hemorrhages, bilateral subdural hematoma, and diffuse axonal injury are highly specific for SBS as a mechanism.” Holmgren, *supra* note 25, at 306.

181. Boos, *supra* note 14, at 50.

182. See *supra* Part III.B.3.

183. Holmgren, *supra* note 25, at 276 (“[T]he initial history provided by the caretaker is false in the vast majority of abuse cases and frequently evolves or changes over time as the caretaker is confronted with medical findings.”) (citations to scientific literature omitted).

184. See Leestma, *supra* note 80, at 14 (noting that the “interrogator may communicate to the accused that ‘if you could tell us exactly what happened and if you shook the baby, we could do something for the baby and maybe save its life.’”). While the particular tactics employed in the SBS context may be unique, the underlying techniques are not. See Richard A. Leo et al., *Bringing*

diagnosis.<sup>185</sup> The ensuing interrogation confirms the suspect's guilt, as this veteran SBS prosecutor's characterization suggests: Each of the three most common histories, and others, may be combined in patterns of changing histories as guilty adults attempt to fabricate new explanations to respond to the probing or suggestive questions of one or multiple interviews.<sup>186</sup>

But even if the caregiver's story remains constant, it too may be used as evidence of guilt.<sup>187</sup> The "discrepant history"—"when the history does not match the physical condition in front of you"—is also seen as proof that the infant was shaken.<sup>188</sup> Whatever contradicts the scientific "givens" is deemed "discrepant" and a confession.

In sum, law enforcement officers confirm their suspicions of SBS whenever a suspect provides "a false, discrepant, evolving *or* absent history."<sup>189</sup> The suspect cannot avoid self-incrimination; the investigator's certainty of guilt can only be reinforced.<sup>190</sup>

*Reliability Back In: False Confessions and Legal Safeguards in the Twenty-First Century*, 2006 WIS. L. REV. 479, 512–20 (2006) (surveying empirical evidence on false confessions).

185. See, e.g., Carole Jenny et al., *Analysis of Missed Cases of Abusive Head Trauma*, 282 JAMA 621 (1999); Robert Reece, *Medical Evidence in the Context of Child Abuse Litigation*, NEW ENG. L. REV. 607, 610 (2002) ("[T]he history does not match the physical condition in front of you . . . Does the history fit what you see? If it does not, then you must question how such an injury could have occurred."). See also Anderson, *supra* note 55 (citing a nationally prominent pediatrician's observation, based on his consulting experience, that "[i]f a parent does not know exactly what's happening, very frequently the first conclusion is that they're trying to hide something. And sometimes parents are racking their brains, coming up with one or two possibilities. Then it looks like they're changing their stories. That can be used to damn them.").

186. See Boos, *supra* note 14, at 50 ("[W]hose story has evolved or changed to fit new information revealed by medical reports, medical personnel, or investigators?"); Parrish, *supra* note 157, at 416.

187. A model prosecutorial summation makes this point as follows: "it just couldn't happen the way the defendant says—not unless the laws of physics and gravity are different in the defendant's house. These doctors tell us that the defendant is a liar . . . A defendant who lies to protect himself points the finger of guilt upon himself." Holmgren, *supra* note 25, at 325.

188. Reece, *supra* note 61, at 610. Put differently, "[t]he false histories help identify the likely individual who caused the child's injuries by providing compelling evidence of the abuser's consciousness of guilt." Holmgren, *supra* note 25, at 277.

189. Holmgren, *supra* note 25, at 277.

190. Consider the dynamics reflected in the following interrogation of a day care provider suspected (based on the presence of the triad) of shaking a six-month-old infant to death. According to the caregiver's initial account, after leaving the children unattended for a short time, she returned to find a toddler sitting on the neck of the baby, who was having trouble breathing. After waiving her *Miranda* warnings, the caregiver (Rogers) was told by the interrogating officer (Wheeler) that: according to a "panel of doctors," a child "could not have caused" the baby's injuries; that "anyone could have been pushed 'over the top' by all of the children in Rogers's care," and "if Rogers was just overwhelmed, then that was 'explainable'"; that Wheeler "already knew something 'aggressive' happened, but now she just needed to know why;" that "only an adult could have inflicted the force necessary to hurt [the baby] in this manner and that the injury occurred close to the time that [the baby] began seizing," when only Rogers was present; that "if [police] could not go to the doctors with a logical explanation for what happened, then it looked 'very, very bad' for Rogers; and that Rogers's

### 3. Reification

Finally, prosecutorial thinking about these cases is pervaded by an echo of the methodological fallacy of the early SBS literature.<sup>191</sup> If, across the country over the years, defendants have been proven guilty of shaking babies to death based on the presence of retinal hemorrhages, subdural hematomas and cerebral edemas, then the presence of these symptoms must mean that someone is guilty of shaking a baby to death. All that remains is to identify the last person with the conscious child. That person becomes the suspect, who can then be confidently pursued. In this manner, the triad-based crime constructed by the medical establishment<sup>192</sup> has been reified—its existence affirmed—by the systematic conviction of its apparent perpetrators.<sup>193</sup>

#### B. Evidentiary Challenges

Defense motions to exclude expert testimony regarding SBS have, almost without exception, proven unsuccessful.<sup>194</sup> Despite new challenges to the scientific underpinnings of the diagnosis, the admission of SBS testimony is facilitated by its once-uncontroversial nature. Even recently, and in cases involving triad symptoms alone, courts in both *Daubert* and

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story “had to match the medical evidence.” Two hours after the interview began, Rogers confessed to shaking the baby and (“she thought”) repeatedly slamming his head on the floor. She was arrested, charged and convicted of intentional child abuse resulting in death, and sentenced to life imprisonment.

In an extraordinary decision, the Nebraska Supreme Court reversed the defendant’s conviction due to a violation of her Fifth Amendment right against self-incrimination. Specifically, the court held that Rogers had invoked her right to silence, and that this invocation was not scrupulously honored by the police. The case will be tried later this year. Telephone Interview with Tim Burns, Douglas County Pub. Defender’s Office (June 10, 2009).

191. The cognitive dissonance resulting from having prosecuted people whose guilt has now been scientifically undermined should not be discounted. But here I am identifying a dynamic that is more systemic.

192. See *supra* Part III.A.

193. This dynamic has likely been perpetuated by media coverage of always sensational “baby-killing” cases. See *supra* note 40. See also Vanessa Bauza, *Abusive Shaking Top Killer of Babies: Police Say Infant Latest Area Victim*, SUN SENTINEL (Fort Lauderdale, Fla.), Oct. 4, 1999.

194. In the course of my research, I have not been made aware of any case in which the testimony of defense experts challenging the basis for an SBS diagnosis was excluded on *Daubert* or *Frye* grounds. See *infra* note 195 for a summary of the *Daubert* and *Frye* standards. Prosecutors are either declining to make these challenges or are making them unsuccessfully. See Holmgren, *supra* note 25, at 316 (“There is no scientific research which supports the re-bleed theory of causation in very young children. . . . Accordingly, the application of this theory to infants should be challenged on *Frye* and *Daubert* grounds.”).

*Frye* jurisdictions<sup>195</sup> have rejected arguments that SBS is not generally accepted in the medical community<sup>196</sup> and that it is not based on reliable scientific methods.<sup>197</sup>

Given the importance placed on the criterion of general acceptance within the “relevant” scientific community—even in *Daubert* jurisdictions, where it is not dispositive—the consensus among pediatricians has been given particular emphasis by admitting trial judges.<sup>198</sup> In the absence of legally binding precedent, judges are well aware that “for some time, courts in other states have found shaken baby syndrome to be a generally accepted diagnosis in the medical community.”<sup>199</sup> Judges have also noted that research into SBS has been peer reviewed, and that there has been “considerable literature put out by professional scientific organizations that substantiate the findings.”<sup>200</sup> While at least one court has explicitly recognized “[t]he absence of a

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Two approaches [to the admissibility of scientific testimony] are dominant—general acceptance [*Frye*] and scientific soundness [*Daubert*]. Under the former, the proponent must show that the scientific community agrees that the principles or techniques on which the expert relies are capable of producing accurate information and conclusions. Under the latter standard, general acceptance remains an important consideration, but the court must consider other factors to decide for itself whether the expert’s methodology is scientifically valid.

CHARLES MCCORMICK ET AL., MCCORMICK ON EVIDENCE 335 (Kenneth S. Brown et al. eds., 6th ed. 2006).

196. See, e.g., *Middleton v. State*, 980 So. 2d 351, 353 (Miss. Ct. App. 2008) (defendant contended that “Shaken Baby Syndrome is not a condition or theory that is generally accepted in the medical community”).

197. See, e.g., *State v. Leibhart*, 662 N.W.2d 618, 623 (Neb. 2003) (defendant argued “that the theory of shaken baby syndrome as a cause of certain injuries was not supported by reliable scientific authority, data, or research”).

198. See, e.g., *id.* at 627–28 (SBS “is generally accepted within the scientific medical community of pediatrics”) (internal quotations omitted). The *Leibhart* court concluded that

[w]ith respect to general causation, the district court did not abuse its discretion in concluding on this record that the reasoning or methodology underlying testimony regarding shaken baby syndrome was valid, and with respect to specific causation, the district court did not abuse its discretion in concluding that such reasoning or methodology properly could be applied to the facts in issue in this case.

*Id.* at 628.

199. *Id.* at 628 (citing *State v. Lopez*, 412 S.E.2d 390 (S.C. 1991); *State v. McClary*, 541 A.2d 96 (Conn. 1988); *In re Lou R.*, 499 N.Y.S.2d 846 (N.Y. Fam. Ct. 1986)). See also *State v. Vandemark*, No. 04-01-0225, 2004 Del. Super. LEXIS 376, at \*8–9 (Del. Super. Ct. 2004) (“[I]t seems that the science behind Shaken Baby Impact Syndrome has been accepted in Delaware and just about every other jurisdiction.”). See Holmgren, *supra* note 25, at 306 (“Expert testimony involving a diagnosis of SBS is well recognized and does not need to satisfy the *Daubert* or *Frye* Standards governing the admissibility of expert testimony or novel scientific evidence.”).

200. *Leibhart*, 662 N.W.2d. at 627 (internal quotation omitted).

known rate of error,” this void was dismissed as merely “reflect[ing] the limitations of the subject matter.”<sup>201</sup>

The standards for determining the admissibility of scientific evidence in effect privilege the institutionalized theoretical framework—even despite serious doubts about the validity of underlying methodologies. Perhaps judicial reluctance to keep testimony regarding SBS from the jury derives from faulty evaluations of the science, or from an overly deferential respect for the establishment that recommends it. But it is also quite likely that judges are allowing this type of testimony because our justice system is structured in a way that makes its admission the default. “[T]he standard for admissibility is relevance and reliability, not certainty,” as courts often remark when allowing SBS testimony.<sup>202</sup>

As is widely recognized, the law of evidence is fundamentally premised on the functioning of our adversary system. As the United States Supreme Court emphasized in *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, “[v]igorous cross-examination, presentation of contrary evidence, and careful instruction on the burden of proof are the traditional and appropriate means of attacking shaky but admissible evidence.”<sup>203</sup> Courts often justify the admission of SBS testimony by reference to this foundational principle. For instance: “The ‘gate-keeping function of the court was never meant to supplant the adversarial trial process. The fact that experts disagree as to methodologies and conclusions is not grounds for excluding relevant testimony;”<sup>204</sup> “[a] party confronted with an adverse expert witness who has sufficient, though perhaps not overwhelming, facts and assumptions as the basis for his opinion can highlight those weaknesses through effective cross-examination.”<sup>205</sup>

Admissibility determinations are also grounded in the proper allocation of decision-making authority between judge and juror. In a recent reversal on interlocutory appeal of a trial judge’s order excluding the prosecution’s

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201. *Vandemark*, 2004 Del. Super. LEXIS 376, at \*16–17. Discussing a particular study where the rate of false positives (i.e., cases incorrectly diagnosed as abuse) was admittedly unknown, the trial judge noted that “no suggestion was made about how to structure [a more rigorous] analysis.” *Id.* at \*16. In *Leibhart*, the court made a similar observation regarding the limits of the science proffered by the prosecution: “it [has] been clinically tested as the best it can.” *Leibhart*, 662 N.W.2d at 627.

202. *See, e.g.,* *People v. Martinez*, 74 P.3d 316, 322 (Colo. 2003).

203. *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579, 596 (1993).

204. *Commonwealth v. Martin*, Nos. 2006-CA-002236-MR, 2006-CA-002237-MR, 2008 WL 2388382, at \*7 (Ky. Ct. App. June 13, 2008) (quoting *LP Matthews LLC v. Bath & Body Works, Inc.*, 458 F. Supp. 2d 198, 210 (D. Del. 2006)).

205. *Id.* at \*8 (quoting *Stecyk v. Bell Helicopter Textron, Inc.*, 295 F.3d 408, 414 (3d Cir. 2002)).

SBS testimony, this consideration was explicitly invoked.<sup>206</sup> “The gatekeeping function of the trial court is restricted to keeping out unreliable expert testimony, not to assessing the weight of the testimony. This latter role is assigned to the jury.”<sup>207</sup> Even more emphatically, “[t]he court is *only* a gatekeeper, and a gatekeeper alone does not protect the castle . . . .”<sup>208</sup>

Systemic factors construct a presumption of admissibility: if the evidence is not “pseudoscientific” or “junk science,”<sup>209</sup> it comes in. This presumption is overcome only rarely by still-evolving research.<sup>210</sup> In recent years, testimony regarding SBS has been excluded only twice.<sup>211</sup> In Kentucky, after hearing from experts on both sides, a trial court concluded that the diagnosis “presupposes the cause.”<sup>212</sup> The court’s order continued: “To allow a physician to diagnose SBS with only the two classical markers, and no other evidence of manifest injuries, is to allow a physician to diagnose a legal conclusion.”<sup>213</sup> Accordingly, the judge precluded the state from presenting expert testimony regarding SBS based exclusively on subdural hematoma and retinal hemorrhage and in the absence of “any other indicia of abuse.”<sup>214</sup> As noted, this order was subsequently

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206. According to the appellate court, the trial judge’s order

was an abuse of discretion, because it was founded on the unsupported legal conclusion that because there was dispute amongst the experts as to the possible cause of the infants’ injuries, it was the court’s role to choose the side it found more convincing and exclude the side it found less convincing, based in part on giving greater weight to “scientific” as opposed to “clinical” studies.

*Id.* at \*7. For further discussion of the evidentiary ruling in *Martin*, see *infra* notes 212–16 and accompanying text.

207. *Martin*, 2008 WL 2388382, at \*7.

208. *Id.* at \*8 (quoting *United States v. Mitchell*, 365 F.3d 215, 245 (3d Cir. 2004)).

209. *Id.* at \*7 (noting that testimony of prosecution experts, “even accepting . . . its flaws” cannot be so described).

210. *State v. Leibhart*, 662 N.W.2d 618, 628 (Neb. 2003) (reexamination under *Daubert* appropriate “where recent developments raise doubts about the validity of previously relied-upon theories”) (citation omitted).

211. This conclusion is based on searches of the LEXIS database and the web, as well as my conversations with the likely participants in these litigation efforts. Telephone Interview with John Plunkett, *supra* note 41; Telephone Interview with Toni Blake, *supra* note 152; Telephone Interview with Brian Holmgren, *supra* note 152. In addition to the two admissibility decisions discussed above, a few trial courts have disallowed experts from using the SBS terminology. For instance, a judge in Ohio precluded reference to SBS, concluding that testimony to this effect would improperly usurp the role of the jury. The prosecution expert was, however, allowed to testify “as to the characteristics of the injuries suffered by a child believed to have been subjected to rotational acceleration/deceleration.” Renee Brown, *Judge Denies Reference to Syndrome During Trial*, TIMES REPORTER (New Phila., Ohio) (on file with author).

212. Order and Opinion Re: Daubert Hearing, *Kentucky v. Davis*, Case No. 04-CR-205 at \*21 (Ky. Cir. Ct. Apr. 17, 2006).

213. *Id.* at \*23.

214. *Id.*

reversed.<sup>215</sup> The defendant has appealed the decision to the state supreme court.<sup>216</sup>

The other court to exclude SBS evidence did so in a case also involving a diagnosis based on retinal hemorrhage and subdural hematoma.<sup>217</sup> After hearing testimony from experts on both sides, the Missouri trial judge determined that the SBS diagnosis “appears to have gained considerable acceptance . . . among pediatricians. However, there is substantial, persistent and continuing criticism of this diagnosis among many in the medical and scientific research communities.”<sup>218</sup> In its unpublished order, the court concluded that the state had failed to meet its burden of establishing that SBS is generally accepted in the scientific and medical communities.<sup>219</sup> The state was thus precluded from offering testimony that the infant was a victim of violent shaking based on the diagnostic triad alone.<sup>220</sup> This ruling was not appealed.<sup>221</sup>

Although the two trial court decisions to exclude testimony about SBS are outliers, they foretell more aggressive defense challenges to the

215. *Commonwealth v. Martin*, Nos. 2006-CA-002236-MR, 2006-CA-002237-MR, 2008 WL 2388382, at \*9 (Ky. Ct. App. June 13, 2008).

216. The appeal to the Kentucky Supreme Court was filed on July 14, 2008 and is pending as the Article goes to print. The “CaseInfo” sheet for *Martin* is available at [http://apps.kycourts.net/coa\\_public/CaseInfo.aspx?Case=2006CA002236](http://apps.kycourts.net/coa_public/CaseInfo.aspx?Case=2006CA002236).

217. Order, *State v. Hyatt*, No. 06M7-CR00016-02 (Mo. Cir. Ct. Nov. 6, 2007). In *Hyatt*, the one-year-old who was being cared for by the defendant was released from the hospital without lasting injury. The caregiver has been charged with abuse of a child for “knowingly inflict[ing] cruel and inhuman punishment upon [the baby] by shaking her, and in the course thereof . . . caus[ing] serious emotional injury. . . .” The felony is punishable by five to fifteen years in prison. Felony Complaint, *State v. Hyatt*, No. 06M7-CR00016-02 (on file with author).

218. Order, *supra* note 217. The court further noted: “The critics contend that subdural hematoma and retinal bleeding can have many other causes and that the diagnosis of shaken baby syndrome is merely a ‘default’ diagnosis, one which pediatricians use when they have no other explanation for the cause of the child’s injuries.” *Id.*

219. *Id.* Missouri is a *Frye* jurisdiction. Request for ‘Frye’ Hearing and Brief in Support of Request, *State v. Hyatt*, No. 06M7-CR00016-02 (Mo. Cir. Ct.) (on file with author).

220.

The Court therefore finds that in the absence of some other evidence or indicia of abuse besides subdural hematoma, retinal bleeding and absence of cranial trauma, neither party may call a witness to give an expert opinion that the child was the victim of violent shaking; the Court further finds that an expert may not opine that a (small) subdural hematoma and retinal bleeding in an infant can only be caused by manual shaking.

Order, *supra* note 217.

221. Nevertheless, the state attempted to proceed on the theory that previously occurring injuries (i.e., a small bruise and scrape) constituted “other indicia of abuse.” Telephone Interview with Kirk Zwink, Esq., Sole Practitioner, Karl Zwink Law Office (July 21, 2008). According to Kirk Zwink, who represented Kathy Hyatt, the state’s evidence at trial included claimed inconsistencies in the defendant’s account, as well as the expert testimony of two pediatricians. *Id.* The defendant testified and presented an expert pathologist on her behalf. After a three-day trial in January 2009, the jury returned its verdict within a half hour: not guilty. *Id.*

admissibility of the science, as well as greater pressure on judges to restrict the scope of expert testimony. If research in this area continues to erode the foundations of the diagnosis, evidentiary rulings will evolve accordingly—but only after a lag guaranteed by judicial deference to precedent, to physicians, and to the workings of the adversary system. For now, with few exceptions, if an SBS case goes to trial, juries will decide the worth of the science and the fate of the accused.

### C. Jury Verdicts

Little is known about the operation of juries in shaken baby cases.<sup>222</sup> One national trial consultant who assists the defense in this area has estimated a conviction rate of 95%;<sup>223</sup> a prosecutor widely recognized as a national authority on SBS has suggested that the figure is closer to 50%;<sup>224</sup> and a forensic pathologist who has consulted on many hundreds of cases for the defense places the figure somewhere between the two.<sup>225</sup> In the absence of meaningful empirical documentation,<sup>226</sup> the impressionistic data of those who see the largest number of these cases—and have done so for at least a decade—becomes a helpful source of information.

Such experts in SBS trial outcomes seem to agree upon certain basic propositions. Juries continue to convict based on medical testimony about the triad of symptoms.<sup>227</sup> They are, however, acquitting more frequently today than ever before.<sup>228</sup> Although the most important predictor of an

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222. “Typically, a jury verdict in a criminal case is inscrutable; the jury performs its paradigmatic function as fact finder shrouded in secrecy, and it is impossible to say why or how the jury convicted or acquitted in any given case.” Julie A. Seaman, *Black Boxes*, 58 EMORY L.J. 427, 432 (2008). For reasons already discussed, the “black box” nature of the jury may well be compounded in the SBS context. See *supra* note 148 (observing that ascendance of the prosecution paradigm has gone largely unnoticed and remarking on a corresponding failure to collect data).

223. Telephone Interview with Toni Blake, *supra* note 152. As a basis for comparison, for an analysis of overall conviction rates, see Andrew D. Leipold, *Why are Federal Judges so Acquittal Prone?*, 83 WASH. U. L.Q. 151 (2005). See also Daniel Givelber, *Lost Innocence: Speculation and Data about the Acquitted*, 42 AM. CRIM. L. REV. 1167 (2005).

224. Telephone Interview with Brian Holmgren, *supra* note 152.

225. Telephone Interview with John Plunkett, *supra* note 41 (estimating conviction rate of 1/2 to 2/3 of cases tried).

226. The National Center on Shaken Baby Syndrome keeps no centralized database, and no other organization tracks prosecutions. The largest database containing this type of information belongs to Toni Blake, the leading trial consultant in this area. Blake’s database contains over 500 SBS cases from 1997–2007. Telephone Interview with Toni Blake, *supra* note 152.

227. Where there is medical corroboration of abuse beyond the triad—e.g., rib fractures, grip marks, long bone fractures, and evidence of injuries in various stages of healing—the case is often resolved by a guilty plea before trial. See *supra* note 41.

228. Telephone Interview with Toni Blake, *supra* note 152; Telephone Interview with Brian Holmgren, *supra* note 152; Telephone Interview with John Plunkett, *supra* note 41. For an account of

acquittal is the defense presentation of nationally prominent experts who challenge the science,<sup>229</sup> the presentation of this type of evidence still results in conviction more often than acquittal.<sup>230</sup> Therefore, while an increasing reliance on defense experts<sup>231</sup> and a growing population of such experts for defendants to draw on<sup>232</sup> should be expected to result in a greater number of acquittals proportionally, there is every reason to believe that SBS-based convictions will persist.

In prosecutions that rely on science to prove causation, *mens rea* and identity, how can jurors faced with genuine scientific debate as to each of these elements be convinced of guilt beyond a reasonable doubt? To make sense of this question, consider how the prosecution's burden of proof may be effectively eased, first, by the skepticism that greets the "differential diagnosis" offered by the defense experts<sup>233</sup> and, second, by the sheer inertial force of SBS.

The current state of the science does not typically allow the defense to identify one cause with certainty. Instead, experts provide a complex forensic analysis. From the defendant's perspective, the differential diagnosis is strategically important because it provides an alternative version of events—albeit a less definitive one—that gives jurors a different way of thinking about what happened. But the differential diagnosis is also dangerous, as it tends to functionally shift the prosecutor's burden of proving its theory of the case onto the defense.<sup>234</sup>

The state's winning argument to juries is this: *the defendant has not established what caused the child's death while the prosecution experts are in full agreement regarding their diagnosis. They told you what the three presenting symptoms mean—how they are caused, how much force is*

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one recent acquittal, see Wendy Davis, *Danforth Woman Found Not Guilty of First Degree Murder*, WATSEKA TIMES REPUBLIC, Mar. 3, 2009.

229. Toni Blake has also suggested that mothers are convicted at the highest rates. Telephone Interview with Toni Blake, *supra* note 152.

230. *Id.*; Telephone Interview with Brian Holmgren, *supra* note 152; Telephone Interview with John Plunkett, *supra* note 41.

231. As noted by the expert who is widely credited (or, depending on perspective, maligned) for spearheading the movement of SBS skeptics, the more doctors a defendant can afford, the greater the likelihood of an acquittal. Telephone Interview with John Plunkett, *supra* note 41. While the equity concerns raised by SBS cases are not unique to this context, they may be particularly acute where, as here, the science dictates outcomes.

232. The minority view is becoming more prevalent. Barnes testimony, Evidentiary Hearing (Day One), *supra* note 71, at 70; Testimony of George R. Nichols in Transcript of Evidentiary Hearing (Day One) at 170, *State v. Edmunds*, 746 N.W.2d 590 (Wis. Cir. Ct. 2008) (No. 96 CF 555); Telephone Interview with John Plunkett, *supra* note 41; Interview with Thomas Bohan, *supra* note 78.

233. See *supra* notes 132–36 and accompanying text.

234. A specifically crafted jury instruction could explain the interplay between defense evidence of a differential diagnosis and the prosecution's burden of proof.

required, and how soon after the trauma the baby would have lost consciousness. The defense experts gave you a list of various possibilities, but admitted that they could not be sure about what happened here. And, indeed, they did not even agree amongst themselves regarding this child's death.<sup>235</sup>

In the *Edmunds* post-conviction hearing, where the determination for a judge was whether new scientific research would probably result in a different outcome at trial,<sup>236</sup> the prosecutor made this appeal: "The primary flaw [in the defendant's theory of post-conviction relief] is the fact—and it's not an opinion; it is a fact—that no one on this defense team could agree on the cause of death in this case."<sup>237</sup> Indeed, no defense expert testified to certainty regarding any particular theory of death.<sup>238</sup>

This reasoning would seem to have considerable traction with jurors.<sup>239</sup> Indeed, the differential diagnosis—or, from the perspective of the prosecution, "a veritable laundry list of alternative medical possibilities which are commonly proffered" by the defense<sup>240</sup>—has become a critical area of contention in SBS trials.<sup>241</sup>

The defense must concede that it cannot definitively prove a mechanism of injury.<sup>242</sup> According to the accused in an SBS case, testimony regarding other plausible diagnoses is important not because it definitively establishes the occurrence of a scenario other than the one

235. For sample prosecutorial closing argument in SBS case, see Holmgren, *supra* note 25, at 324–27. See also Attorney for the State in Transcript of Oral Argument at 89–90, *State v. Edmunds*, 746 N.W.2d 590 (Wis. Cir. Ct. 2008) (No. 96 CF 555) ("It might be interesting, it might be fun for the defendant to have the jury speculate, but that's not what we do in courts of law.").

236. More precisely, the court must determine "whether a reasonable probability exists that a different result would be reached at trial." *Edmunds*, 2008 WI App 33, ¶ 13, 746 N.W.2d 590, ¶ 13 (citation omitted). See *infra* Part IV.E.1.

237. Attorney for the State in Transcript of Oral Argument, *supra* note 235, at 75–76. The prosecutor reiterated this point later in the argument: "the mud balls; throw, throw, see if something sticks. Differential Diagnosis." *Id.* at 87–88.

238. See, e.g., Barnes testimony, Evidentiary Hearing (Day One), *supra* note 71, at 71.

239. As one prosecutor has instructed, "[d]efenses are frequently focused on other possible medical explanation for the injuries. A responsive theme might be that 'arguments derived from possibilities are idle.'" Holmgren, *supra* note 25, at 288.

240. *Id.* at 314. See *id.* at 319 ("The expert who acknowledges the classic findings of SBS include subdural hematoma, retinal hemorrhage and edema, but chooses to ignore this constellation of findings in favor of an alternative hypothesis will appear foolish."); *id.* at 312–19 (discussion of "meeting untrue defenses and cross-examination of defense experts").

241. See Parrish, *supra* note 157, at 410 (suggesting prosecutorial strategy for dealing with defense experts' testimony regarding differential diagnosis).

242. *Edmunds* acknowledged as much in her post-conviction relief hearing, but argued that this burden was not properly hers: "The state says in terms of differential diagnosis, bring it home . . . [p]rove your other causes. Well, this . . . puts the burden backwards. We don't have a burden of proving some alternative cause." Attorney for the Defense in Transcript of Oral Argument, *supra* note 115, at 141. See *id.* at 138.

hypothesized by the prosecution, but because it casts doubt on the claim that no other scenario *could* explain the symptoms.

This mode of argument tends to be deeply unsatisfying to the human psyche and, as a consequence, problematic for jury decision making. It is widely recognized that “fact finders look for stories, not just discrete nuggets of fact to fit into a set of legal rules.”<sup>243</sup> Burdens of proof notwithstanding, a consensus that identifies a single narrative will almost invariably trump an amalgam of possibilities that challenge it.<sup>244</sup> In SBS cases, what the defense asks the jury to do is surmount this psychological barrier<sup>245</sup> and acquit.

The likelihood of this occurring is diminished by the context in which the medical dispute is presented to jurors. In a typical SBS case, as a matter of law, the prosecution must establish that the presence of retinal hemorrhages, subdural hematoma, and cerebral edema proves beyond a reasonable doubt that the defendant on trial shook the baby to death. If the science cannot bear this burden, the jury must acquit—even in the absence of a known cause.<sup>246</sup> The reality is quite different on the ground, where, to prevail at trial, a defendant must disprove the validity of a medical diagnosis with impressive establishment *bona fides*.

Until only recently, SBS had been embraced nearly unanimously by the scientific community, and it still commands the faithful adherence of a majority of physicians. To the general public, the diagnosis has come to be understood as a meaningful marker of criminality. Substance aside, these measures of acceptance serve as powerful proxies for truth, enabling jurors to discount the insights of the skeptics and the challenges raised by their research.

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243. Mary I. Coombs, *Telling the Victim's Story*, 2 TEX. J. WOMEN & L. 277, 288 (1993).

244. I have previously observed that “verdicts reflect which narrative was more persuasive to the jury.” Deborah Tuerkheimer, *Recognizing and Remediating the Harm of Battering: A Call to Criminalize Domestic Violence*, 94 J. CRIM. L. & CRIMINOLOGY 959, 981 (2004).

245. This type of reasoning is “speculative,” *see supra* note 235, insofar as it requires jurors to reach a verdict in the absence of a proven causal mechanism. But thus defined, where the prosecution’s version of events has not been adequately established, a speculative verdict is completely appropriate, and indeed dictated by the presumption of innocence. Put differently, SBS defendants who challenge the science do not advance any particular explanation as the definitive cause of death, but, rather, insist that since a number of possibilities could have been causal, the prosecution cannot satisfy its burden of proof. The jury need not speculate that any one of the alternatives is in fact *the cause*; the very existence of alternatives negates proof of inflicted injury beyond a reasonable doubt.

246. As Edmunds’s attorney argued in her post-conviction relief hearing, the “evidence is now there that undermines the state’s ability to prove the mechanism and timing of death.” Attorney for the Defense in Transcript of Oral Argument, *supra* note 115, at 138.

#### D. Insufficiency Claims

Defendants challenging the sufficiency of the evidence against them in SBS cases<sup>247</sup> focus on two areas of arguably deficient proof: mens rea,<sup>248</sup> and causation/identity.<sup>249</sup> While many prosecutions involve physical evidence of other abuse (i.e., beyond shaking) apart from the triad,<sup>250</sup> a substantial number rests solely on the presence of retinal hemorrhaging and subdural hematoma.<sup>251</sup> Even in this latter subcategory, courts are invariably affirming convictions.<sup>252</sup>

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247. Defendants may move for a judgment of acquittal based on an insufficiency of the evidence at the conclusion of the prosecution's case, after the defense has rested, and again after the jury has returned its verdict. A denial of this motion is given considerable deference, but is reviewable on direct appeal or on collateral attack. While the applicable legal standards differ, claims that a conviction rests on insufficient evidence raise similar issues across jurisdictional and procedural contexts.

248. See Charles A. Phipps, *Responding to Child Homicide: A Statutory Proposal*, 89 J. CRIM. L. & CRIMINOLOGY 535, 551–74 (1999) (discussing mental states associated with traditional homicide statutes used to prosecute defendants under SBS theory). For a sampling of cases from just this past year, see, e.g., *Mitchell v. State*, No. CACR 07-472, 2008 Ark. App. LEXIS 98 (Ark. Ct. App. Feb. 6, 2008); *People v. Lemons*, No. 273058, 2008 Mich. App. LEXIS 387 (Mich. Ct. App. Feb. 26, 2008); *State v. Gilbert*, No. M2007-00260-CCA-R3-DC, 2008 Tenn. Crim. App. LEXIS 326 (Tenn. Crim. App. Apr. 8, 2008).

249. See, e.g., *U.S. v. Dimberio*, 56 M.J. 20 (C.A.A.F. 2001); *State v. Cort*, 766 A.2d 260 (N.H. 2000). See also *infra* notes 257–68.

250. See, e.g., *People v. Frank*, No. A109619, 2007 Cal. App. Unpub. LEXIS 3777 (Cal. Ct. App. May 10, 2007); *People v. Heredia*, No. A112828, 2007 Cal. App. Unpub. LEXIS 9537 (Cal. Ct. App. Nov. 28, 2007); *Moore v. State*, 656 S.E.2d 796 (Ga. 2008); *State v. Hollins*, 981 So. 2d 819 (La. Ct. App. 2008); *State v. Hill*, 250 S.W.3d 855 (Mo. Ct. App. 2008); *State v. Batich*, No. 2006-A-0031, 2007 Ohio App. LEXIS 2127 (Ohio Ct. App. May 11, 2007); *Commonwealth v. Hardy*, 918 A.2d 766 (Pa. Super. Ct. 2007); *State v. Sweet*, No. E2007-OD202-CCA-R3-PC, 2008 Tenn. Crim. App. LEXIS 280 (Tenn. Crim. App. Apr. 15, 2008); *Hammond v. State*, No. 2-06-417-CR, 2008 Tex. App. LEXIS 969 (Tex. Ct. App. Feb. 7, 2008).

While this Article is largely concerned with triad-based SBS prosecutions, it bears mentioning that even cases involving proof apart from the triad may be problematic. Some physical evidence is of questionable corroborative value. See, e.g., *People v. Montgomery*, No. 269957, 2007 Mich. App. LEXIS 2412 (Mich. Ct. App. Oct. 23, 2007) (bruise on right temple). Moreover, even where the physical evidence clearly indicates abuse, the identity of the perpetrator may be disputed. See, e.g., *People v. Garcia*, No. H023327, 2003 Cal. App. Unpub. LEXIS 3479 (Cal. Ct. App. Apr. 7, 2003). In *Garcia*, the defense expert testified to preexisting injuries unrelated to head trauma. *Id.* at \*10. He “agreed that [the baby] was a battered child, that his injuries were nonaccidental, and that his death was a homicide. But he believed that it was impossible to determine with medical certainty whether the injuries that caused his death occurred shortly before the time of death or whether death resulted from complications from earlier patterns of injuries.” *Id.* Finally, reliance on perpetrator “confessions” to prove guilt may be misplaced. See *supra* Part IV.A.2

251. See, e.g., *People v. Jackson*, No. D049865, 2007 Cal. App. Unpub. LEXIS 9866 (Cal. Ct. App. Dec. 6, 2007); *Middleton v. State*, 980 So. 2d 351 (Miss. Ct. App. 2008).

252. In the past year, the only court to reverse an SBS conviction did so because the defendant was denied effective assistance of counsel. In *Schoonmaker*, the New Mexico Supreme Court noted that “[e]xpert testimony was critical to the defense to call into question the State’s expert opinions that [the child’s] injuries could only have been caused by shaking of a violent nature.” *State v. Schoonmaker*, 176 P.3d 1105, 1113 (N.M. 2008). Based on the testimony of defense experts in other

Deference to the fact-finding functions of juries translates into a legal regime generally hostile to insufficiency arguments.<sup>253</sup> In the evidentiary context, this judicial deference is exercised at the front-end of the trial process; here it comes at the back-end, after the prosecution has rested, after the defense has rested, and/or after the jury has returned its guilty verdict.<sup>254</sup> The governing standard on appeal is “whether, considering the evidence in a light most favorable to the prosecution, *any* rational trier of fact could have found the essential elements of the offense charged beyond a reasonable doubt.”<sup>255</sup> It is thus to be expected that defendants rarely persuade courts to overturn SBS-based convictions on sufficiency grounds.<sup>256</sup>

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cases and published scientific research, the court found that “disagreement exists in the medical community as to the amount of time between when injuries occur and when the child becomes symptomatic, and whether injuries like [the child’s] can be caused by short-distance falls. . . .” *Id.* at 1114. It was clear, therefore, that the defendant’s failure to call experts to testify on his behalf was due not to the absence of supporting science, but to poverty. *Id.* at 1113–16. In a remarkable opinion, the court concluded that because of the trial courts’ role in “deny[ing] counsel access to the necessary funding,” the defendant was entitled to a new trial. *Id.* at 1114.

In another appeal based on ineffective assistance, the Utah Supreme Court in 2007 reversed a murder conviction based on defense counsel’s failure to retain a qualified expert to examine CT scans of the infant’s injuries. *State v. Hales*, 152 P.3d 321 (Utah 2007). In *Hales*, SBS was diagnosed based on brain swelling and retinal hemorrhages. *Id.* at 326. According to the State’s expert, these injuries could only have been caused by violent shaking which would have caused immediate unconsciousness with no possibility of a lucid interval. *Id.* at 329. In support of his motion, the defendant submitted the affidavit of a pediatric neuroradiologist stating that, based upon his (post-conviction) review of the CT scan, it would have been impossible for trauma to have occurred during the time period in which the defendant was with the baby. *Id.* In response to the court’s ruling, the state determined that there was insufficient evidence to proceed with further prosecution. Stephen Hunt, *New Evidence Frees Inmate in Murder Case*, SALT LAKE TRIBUNE, June 16, 2007.

253. “The basic problem seems to be that judges do not want to look as though they are abrogating the role of the jury as trier of fact. The legal sufficiency of evidence is, technically, a question of law, but it looks and sounds like a judgment on the weight of the evidence—it is a judgment on the weight of the evidence, only an extreme one.” Samuel R. Gross, *Substance & Form in Scientific Evidence: What Daubert Didn’t Do*, in *REFORMING THE CIVIL JUSTICE SYSTEM* 234, 252 (Larry Kramer ed., 1996).

254. See *supra* note 247 (detailing procedural postures of various types of sufficiency challenges).

255. *State v. Gilbert*, No. M2007-00260-CCA-R3-CD, 2008 Tenn. Crim. App. LEXIS 326 (Tenn. Crim. App. Apr. 8, 2008) (citations omitted).

256. In the rare instance where an appellate court has reversed a SBS conviction, it has done so on other grounds. See, e.g., *United States v. Gaskell*, 985 F.2d 1056 (11th Cir. 1993) (prejudicial in-court shaking demonstration with baby doll); *People v. Basuta*, 94 Cal. App. 4th 370 (Cal. Ct. App. 2001) (evidentiary); *Andrews v. State*, 811 A.2d 282 (Md. 2002) (same); *State v. Maze*, No. M2004-02091-CCA-R3-CD, 2006 WL 1132083 (Tenn. Crim. App. Aug. 28, 2006) (failure to instruct on lesser-included charges); *Schoonmaker*, 176 P.3d 1105 (ineffective assistance of counsel); *Caban v. State*, No. 5D08-279, 2009 WL 722049 (Fla. Dist. Ct. App. Mar. 20, 2009) (improper impeachment of defense expert).

Shirley Ree Smith may be the only defendant to succeed in doing so.<sup>257</sup> Her case is extraordinary, particularly because the procedural context in which the claim arose—an appeal of a denial of Smith’s federal habeas petition—makes the result exceedingly unlikely.

In certain respects, the facts of *Smith* diverge from the paradigmatic SBS pattern. The defendant was the child’s grandmother.<sup>258</sup> The medical evidence showed an absence of retinal bleeding.<sup>259</sup> Most significantly, pathologists found “no swelling, and only a small, non-fatal amount” of subdural and subarachnoid bleeding.<sup>260</sup>

But in other ways, the facts share important similarities with the typical triad-only SBS prosecution. No bruises on the body, fractures, or grip marks were present.<sup>261</sup> The accused claimed to have discovered the infant in a nonresponsive state.<sup>262</sup> The “discrepant history” was considered evidence of guilt.<sup>263</sup> The prosecution experts’ testimony was “absolutely critical to its case.”<sup>264</sup>

Even under the highly deferential standard mandated on federal habeas review,<sup>265</sup> a three-judge panel of the Ninth Circuit concluded that this evidence was insufficient to sustain a guilty verdict: “There was simply no

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257. I reach this conclusion based on a thorough search of the LEXIS database and my conversations with leaders on both sides of nationwide litigation efforts.

258. As the court remarked,

[t]his is not the typical shaken baby case. Grandmothers, especially those not serving as the primary caretakers, are not the typical perpetrators. Further, Petitioner was helping her daughter raise her other children (a 2-year-old and a 14-month-old) and there was no hint of Petitioner abusing or neglecting these other children, who were in the room with [the baby] when he died.

*Smith v. Mitchell*, 437 F.3d 884, 889 (9th Cir. 2006).

259. *Smith*, 437 F.3d at 887. Notwithstanding this observation, it is important to note that SBS-based convictions in the absence of retinal hemorrhages are routinely affirmed on appeal. *See, e.g.*, *People v. Jackson*, No. D049865, 2007 Cal. App. Unpub. LEXIS 9866 (Cal. Ct. App. Dec. 6, 2007); *State v. Humphries*, No. 06CA00156, 2008 Ohio App. LEXIS 315 (Ohio Ct. App. Feb. 4, 2008).

260. *Smith*, 437 F.3d at 887.

261. The only external injury was “recent small abrasion, approximately 1/16 by 3/16 of an inch, on the lower skull, upper neck region, and a recent bruise beneath this abrasion.” *Id.*

262. *Id.* at 886.

263. Smith apparently told police that she had given the baby a “jostle” to rouse him and responded, “Oh my God, Did I do it?” to a social worker when informed that the baby had died of shaking. *Id.* at 889 n.11.

264. *Id.* at 890.

265. *Jackson v. Virginia*, requires courts to determine whether “after viewing the evidence in the light most favorable to the prosecution, any rational trier of fact could have found the essential elements of the crime beyond a reasonable doubt.” *Jackson v. Virginia*, 443 U.S. 307, 319. The Antiterrorism and Effective Death Penalty Act (AEDPA) even more “severely restricts” the scope of review of state court decisions, as it “mandates that [courts] apply the standards of *Jackson* with an additional layer of deference . . . and only grant habeas relief where the state court’s adjudication of a *Jackson* claim is objectively unreasonable.” *Smith v. Mitchell*, 453 F.3d 1203, 1203–06 (9th Cir. 2006) (Bea, J., dissenting) (internal citation omitted).

demonstrable support for shaking as the cause of death . . . . [T]here has very likely been a miscarriage of justice in this case.”<sup>266</sup>

The court’s reasoning in this regard is instructive on when a deficiency in proof rises to the level requiring reversal:

All of the prosecution witnesses based their opinion of Shaken Baby Syndrome on their hypothesis that violent shaking had torn or sheared the brain stem in an undetectable way<sup>[267]</sup> . . . . [A]nd they reached this conclusion because *there was no evidence in the brain itself of the cause of death*. Thus . . . the tearing might have occurred or it might not have occurred; there simply was no evidence to permit an expert conclusion one way or the other on the point. This is simply not the stuff from which guilt beyond a reasonable doubt can be established . . . .<sup>268</sup>

The improbability of a court substituting its view of the sufficiency of the evidence for the jury’s in this manner—and of that ruling being left intact—is indicated by *Smith*’s highly unusual procedural path. The defendant’s conviction was affirmed by the state appellate court.<sup>269</sup> The California Supreme Court denied review.<sup>270</sup> The federal magistrate judge recommended that the habeas petition be denied and the district court denied the petition.<sup>271</sup> After the three-judge panel reversed this denial and the full court voted to deny a petition for rehearing en banc, a number of

266. *Smith*, 437 F.3d at 890. “With all due respect to the California Court of Appeal, and even with the additional layer of deference mandated by AEDPA, we conclude that the Court of Appeal unreasonably applied *Jackson* when it held the evidence to be sufficient to convict Smith of causing [the child’s] death.” *Id.*

267. See *infra* note 268 (further discussing disputed significance of lack of visible shearing in brain stem).

268. *Smith*, 437 F.3d at 890. A number of Ninth Circuit judges criticized the panel for “adopt[ing] the defense experts’ view of what physical evidence is necessary to support a valid diagnosis of shaken baby syndrome.” *Smith*, 453 F.3d at 1207 (Bea, J., dissenting). The judges who would have affirmed Smith’s conviction had a very different view of the evidence against her:

The physicians called by the prosecution reached their conclusion *despite* the lack of visible shearing, not because of it, and explained why. Indeed, what provided the basis for the doctors’ opinions was the evidence of recent trauma to [the child’s] brain: (1) the subdural hemorrhaging; (2) the subarachnoid hemorrhaging; (3) the hemorrhaging around the optic nerves; (4) the blood clot between the hemispheres of [the child’s] brain; and (5) the bruise and abrasion at the lower back of [the child’s] head. The prosecution’s experts considered and rejected other causes of [the child’s] death . . . . Since none of these alternate theories explained [the child’s] death, the prosecution’s doctors opined that [he] died from violent shaking, as evidenced by the trauma.

*Id.* at 1206.

269. *Id.*

270. *Id.*

271. *Id.*

judges wrote to dissent bitterly.<sup>272</sup> The United States Supreme Court then granted *certiorari*, vacated the judgment, and remanded the case for further consideration<sup>273</sup> in light of a recent decision elaborating on the standard applicable to federal habeas review of a state court affirmation of conviction.<sup>274</sup> After the Ninth Circuit reinstated its earlier judgment and opinion,<sup>275</sup> the state once again petitioned the Supreme Court for review.<sup>276</sup> This petition is currently pending as this Article goes to print.<sup>277</sup>

Now compare *Smith* to the far more typical case of Drancy Deshann Jackson, whose conviction was recently affirmed on direct appeal by a California court.<sup>278</sup> Jackson is currently serving a prison term of thirteen years for felony child abuse.<sup>279</sup> The medical evidence consisted of subdural hemorrhaging and diffuse brain swelling—no retinal hemorrhages, no other injuries—which prosecution experts diagnosed as

272. *Id.* (“[T]he opinion is inaccurate.”); *id.* at 1207–08 (“Under our court’s approach, a federal court of appeals may, effectively, set aside an expert opinion where it conflicts with the views of the other side’s experts.”).

273. *Patrick v. Smith*, 550 U.S. 915 (2007).

274. *Carey v. Musladin*, 549 U.S. 70 (2006).

275. *Smith v. Patrick*, 508 F.3d 1256 (9th Cir. 2007). The court’s rationale for reinstating the opinion is emphatic:

Nothing in the State’s failure of evidence takes this case out of the class of cases subject to the test of *Jackson*. Unlike *Musladin* . . . this case presents merely one more instance where the evidence presented by a state is wholly insufficient to permit a constitutional conviction. *Jackson* makes clear that such cases cannot constitutionally stand if the evidence was insufficient “to convince a trier of fact beyond a reasonable doubt of the existence of every element of the offense.” . . . *Jackson* makes clear that a conviction is unconstitutional even if there is *some* evidence of guilt when all of the evidence, viewed in the light most favorable to the prosecution, does not permit any rational fact-finder to find guilt beyond a reasonable doubt. *Smith*’s case accordingly falls squarely within *Jackson*. Moreover, the prosecution’s evidence falls so far short that it was unreasonable for the state appellate court to conclude that it met the *Jackson* standard.

*Id.* at 1258–59 (citations omitted).

276. Petition for Writ of *Certiorari*, *Patrick v. Smith*, No. 07-1483 (9th Cir. May 27, 2008).

277. Whether the Court decides to review the case may depend on its assessment of the following reasoning advanced by the Ninth Circuit:

It is true, of course, that the Supreme Court has never had a case where the issue was whether the evidence, expert and otherwise, was constitutionally sufficient to establish beyond a reasonable doubt that a defendant had shaken an infant to death. But there are an infinite number of potential factual scenarios in which the evidence may be insufficient to meet constitutional standards. Each scenario theoretically could be construed artfully to constitute a class of one. If there is to be any federal habeas review of constitutional sufficiency of the evidence as required by *Jackson*, however, [AEPDA] cannot be interpreted to require a Supreme Court decision to be factually identical to the case in issue before habeas can be granted on the ground of unreasonable application of Supreme Court precedent. The Supreme Court does not interpret AEDPA in such a constrained manner.

*Smith v. Patrick*, 508 F.3d at 1259.

278. *People v. Jackson*, No. D049865, 2007 Cal. App. Unpub. LEXIS 9866 (Cal. Ct. App. Dec. 6, 2007).

279. *Id.* at \*1.

SBS.<sup>280</sup> The defendant's account—that the baby fell from the couch where he had been propped with a bottle—was dismissed as “inconsistent” with the observed symptoms.<sup>281</sup>

The defense presented evidence that Jackson was an “excellent parent who never abused or hit his children or any other child for whom [he] was the caretaker.”<sup>282</sup> The baby's pediatrician testified that “there was no evidence [the baby] had been abused” prior to the incident in question.<sup>283</sup> The sole defense expert, a biomechanical engineer, questioned the scientific basis for SBS.<sup>284</sup> Citing research showing that short-distance falls can cause subdural hematomas, he also noted “that it was an open question whether an earlier injury could make the child more susceptible to injury from a second fall.”<sup>285</sup>

Applying the familiar standard of review,<sup>286</sup> the appellate court determined that:

[t]he conflict among the experts' opinions . . . did not render the evidence insufficient. . . . In finding [against the defendant], the jury necessarily rejected his experts' contention . . . . The credibility and weight of the expert testimony was for the jury to determine, and it is not up to us to reevaluate it. The jury could reasonably believe the evidence of the prosecution witnesses and reject that of the defense witness.<sup>287</sup>

280. *Id.* at \*4–5. Other prosecutions have gone forward on the basis of subdural hematomas alone. *See, e.g.,* *People v. Collier*, No. A120808, 2009 WL 389721 (Cal. Ct. App. Feb. 18, 2009) (affirming conviction). Prosecutors have also proceeded on the basis of retinal hemorrhages (without subdural hematoma). *See, e.g.,* *Hess v. Tilton*, No. CIV S-07-0909, 2009 WL 577661 (E.D. Cal., Mar. 5, 2009) (affirming conviction).

281. *Jackson*, 2007 Cal. App. Unpub. LEXIS 9866, at \*13.

282. *Id.* at \*8.

283. *Id.*

284. *Id.* at \*5–6.

285. *Id.* at \*6.

286. The standard was described in *Jackson* as follows:

When reviewing a claim attacking the sufficiency of the evidence to support a conviction, the question we ask is “whether, after viewing the evidence in the light most favorable to the prosecution, any rational trier of fact could have found the essential elements of the crime beyond a reasonable doubt.” As an appellate court, we “must view the evidence in a light most favorable to respondent and presume in support of the judgment the existence of every fact the trier could reasonably deduce from the evidence.” . . . A conviction will not be reversed for insufficient evidence unless it appears “that upon no hypothesis whatever is there sufficient substantial evidence to support [the conviction].” . . . “If the circumstances reasonably justify the trier of fact's findings, the opinion of the reviewing court that the circumstances might also be reasonably reconciled with a contrary finding does not warrant a reversal of the judgment.”

*Id.* at \*9–10 (citations omitted).

287. *Id.* at \*13 (citations omitted).

As the reasoning of the *Jackson* court evinces, the legal framework governing sufficiency challenges seems to virtually preordain this result.<sup>288</sup> Credibility determinations are within the province of the jury; when the testimony of defense experts is rejected, that rejection must be afforded deference by the appeals court. Provided that the prosecution experts testify in a manner that reasonably justifies a finding of guilt, the conviction is affirmed.<sup>289</sup>

In short, a conflict in expert opinions is functionally irrelevant to the disposition of sufficiency challenges. Given this, the legal landscape will not be appreciably altered by a louder chorus of SBS skeptics, but by continued movement in this direction on the part of the SBS faithful. If the testimony of *prosecution* experts comes to reflect the scientific limitations of a triad-based diagnosis of abuse, a court may well conclude that evidence of SBS is “not the stuff from which guilt beyond a reasonable doubt can be established. . . .”<sup>290</sup>

Even in the midst of continued scientific controversy, this judicial shift may yet occur.<sup>291</sup> Despite deep tensions within the competing opinions,<sup>292</sup> *Smith* suggests that the trial record must contain evidence of a sufficient quantum and caliber. According to the Ninth Circuit, habeas relief was warranted because “[a]n expert’s testimony as to a *theoretical conclusion or inference* does not rescue a case that suffers from an underlying

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288. For a recent example of this phenomenon, see *Thomas v. State*, No. 03-07-00646-CR, 2009 WL 1364348, at \*7 (Tex. App. May 14, 2009) (“Sharply conflicting evidence was presented regarding the scientific basis of shaken baby syndrome and, consequently, the diagnosis of the State’s witnesses . . . . Once admitted, this conflicting evidence presents an issue for the jury to resolve.”). The same is true of manifest weight challenges. See *State v. Humphries*, No. 06CA0015b, 2008 Ohio App LEXIS 315, at \*23–24 (Ohio Ct. App. Feb. 4, 2008) (“[A] conviction is not against the manifest weight of the evidence solely because the jury heard inconsistent testimony.”) (internal quotations omitted). In *Humphries*, the court affirmed the child endangerment conviction of Latasha Humphries for the death of her child, whose SBS diagnosis was based on subdural hematoma and cerebral edema alone. *Id.* at \*12. Humphries was identified as the perpetrator based on a perceived impossibility of a lucid interval, as well as the defendant’s “fail[ure] to provide a reasonable explanation for [the child’s] injuries. . . .” *Id.* at \*22. Only one expert testified on behalf of the defendant. *Id.* at \*2. See *supra* note 231 (noting significance of presenting more than one expert). The opinion references marijuana use, *Humphries*, 2008 Ohio App. Lexis, at \*5, the defendant’s status as an unmarried mother, and the impoverished environment in which the child was being raised (e.g., “dingy one piece pajamas,” crib missing one side, *id.* at \*9–10)—factors which may well have disadvantaged Humphries at trial and on appeal.

289. As Samuel Gross has observed in the civil context, “traditionally courts have held that the testimony of any qualified expert is sufficient to sustain a verdict on any issue on which she testified.” Gross, *supra* note 253, at 252.

290. *Smith v. Mitchell*, 437 F.3d 884, 890 (9th Cir. 2006).

291. In what may indicate an overall trend in this direction, trial consultant Toni Blake noted that, in 2007, “we saw one of these cases overturned about once a month.” Anderson, *supra* note 55.

292. See *supra* notes 268, 272 and accompanying text.

insufficiency of evidence to convict beyond a reasonable doubt.”<sup>293</sup> But the “absence of evidence”<sup>294</sup> cited by the court—an absence which “cannot constitute proof beyond a reasonable doubt”<sup>295</sup>—is, more precisely, an absence of evidence worthy of conviction. Identifying the qualitative judgment embodied in this determination is not to indict it. After all, even the “rational trier of fact” to whom courts are deferring must have certain standards.<sup>296</sup> In triad-only SBS cases, judges willing to assess the value of the state’s evidence, as the court did in *Smith*, may conclude that an absence of evidence has convicted others.

#### *E. Post-Conviction Proceedings*

##### *1. Edmunds*

In early 2007, the judge who presided over Audrey Edmunds’s trial over a decade earlier conducted a five-day evidentiary hearing in support of her motion for a new trial based on newly discovered evidence. The defense experts<sup>297</sup> testified that, since the mid-1990s, “significant research has undermined the scientific foundations for SBS, creating substantial challenges to matters that were nearly universally accepted in the medical community at the time of Edmunds’s trial.”<sup>298</sup>

According to the defense experts, a still-emerging body of literature had cast new doubt on previously accepted medical dogma.<sup>299</sup> Now in dispute: whether shaking alone can cause the constellation of injuries associated with SBS;<sup>300</sup> whether a specific mechanism for the injuries (i.e., shaking) can be accurately identified;<sup>301</sup> whether considerable force, as opposed to a minor impact, is necessary to cause the injuries associated with the syndrome;<sup>302</sup> whether previously unrecognized mimics of child abuse can cause the triad of symptoms said to be pathognomonic of

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293. *Smith*, 437 F.3d at 890 (emphasis added).

294. *Id.*

295. *Id.*

296. *Id.* at 885.

297. The following physicians testified as experts for the defense: the chief of pediatric neuroradiology at Stanford’s Children’s Hospital; the former Chief Medical Examiner for Kentucky; a forensic pathologist; a pediatrician; an ophthalmologist; and the autopsy pathologist who testified at Edmunds’s trial as a prosecution witness. Transcript of Evidentiary Hearing (Days One and Two), *State v. Edmunds*, 746 N.W.2d 590 (2008) (No. 96 CF 555).

298. Brief of Defendant, *supra* note 4, at 11.

299. *Id.* at 3 (“[T]he science that sent Audrey Edmunds to prison did not stand still.”).

300. *Id.* at 13–16.

301. *Id.*

302. *Id.* at 20.

abusive head trauma,<sup>303</sup> and whether the occurrence of the type of head trauma leading to serious brain damage inevitably causes immediate unconsciousness.<sup>304</sup>

The defense experts testified that “in 1996 they themselves would have testified as the State’s experts had at Edmunds’s trial,”<sup>305</sup> but the evolving science had changed their opinions as to the likely cause of death.<sup>306</sup> In short, the scientific foundation for concluding beyond a reasonable doubt that Edmunds had shaken Natalie Beard to death was no longer intact.<sup>307</sup> The near unanimity that once characterized the medical establishment’s understanding of SBS had been shattered.<sup>308</sup> Yet no new medical accord had been reconstituted in its place.<sup>309</sup> Against this disquieting backdrop, Audrey Edmunds’s new trial motion was decided.

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303. *Id.* at 16–20.

304. *Id.* at 20–23.

305. *Id.* at 11.

306. Regarding the particular circumstances of Natalie’s death, the defense experts testified that the evidence upon which Edmunds was convicted had been undermined by a number of scientific developments: studies using biomechanical models, animal models, and computer simulations suggested that Natalie’s brain injuries could not have been caused by shaking alone; even if Natalie’s death were caused by trauma (i.e., impact), considerably less force than previously suspected could have caused her injuries; new research had uncovered a number of causes of the retinal hemorrhages which, at trial, were said to conclusively prove that Natalie had been shaken; emerging science revealed that chronic subdural hematomas—like the one discovered at Natalie’s autopsy—may re-bleed with little precipitation, causing further brain injury; the differential diagnosis (a range of possible explanations for Natalie’s injuries other than abusive head trauma) had evolved considerably in recent years; and, finally, the evidence thought to be dispositive on the timing of injuries was contradicted by a number of “lucid interval” studies, undermining past certainty that Natalie was injured during the hour that she was in Edmunds’ care. *Id.* at 14–23.

307. The appellate court summarized the evidentiary record of the post-conviction hearing as follows:

Edmunds presented evidence that was not discovered until after her conviction, in the form of expert medical testimony, that a significant and legitimate debate in the medical community has developed in the past ten years over whether infants can be fatally injured through shaking alone, whether an infant may suffer head trauma and yet experience a significant lucid interval prior to death, and whether other causes may mimic the symptoms traditionally viewed as indicating shaken baby or shaken impact syndrome. Edmunds could not have been negligent in seeking this evidence, as the record demonstrates that the bulk of the medical research and literature supporting the defense position, and the emergence of the defense theory as a legitimate position in the medical community, only emerged in the ten years following her trial.

*State v. Edmunds*, 2008 WI App 33, ¶ 15, 746 N.W.2d 590, ¶ 15.

308. Even the state’s experts acknowledged, to varying degrees, that scientific consensus about SBS had changed since the mid-1990s. *See State v. Edmunds*, No. 96 CF 555, slip op. at 7 (Wis. Cir. Ct. Mar. 29, 2007) (“Expert witnesses on both sides now indicate that research about Shaken Baby Syndrome has evolved . . .”); *supra* Part III.B.

309. The defense experts maintained that Natalie’s death was caused by some combination of violent shaking and impact, and that this trauma could only have been inflicted immediately prior to the onset of unmistakable and severe neurological damage. Brief Plaintiff-Respondent at 35–37, *State v. Edmunds*, 746 N.W. 2d 590 (Wis. Ct. App. 2008) (No. 2007AP000933) [hereinafter “State’s brief”].

While expressly acknowledging that “[s]tanding alone and unchallenged, the defense witnesses provide[d] a sufficient evidentiary basis to order a new trial based upon newly discovered medical evidence,”<sup>310</sup> the trial judge denied the motion. But an appellate court reversed this decision and concluded that there was a reasonable likelihood that a different result would be reached at a new trial.<sup>311</sup>

In a remarkable opinion without judicial precedent, the court noted the “shift in mainstream medical opinion since the time of Edmunds’s trial.”<sup>312</sup> While there were “now competing medical opinions as to how Natalie’s injuries arose and . . . the new evidence does not completely dispel the old evidence,”<sup>313</sup> the court was persuaded that “the emergence of a legitimate and significant dispute within the medical community as to the cause of those injuries that constitutes newly discovered evidence.”<sup>314</sup> According to the appeals court,

[at trial,] the State was able to easily overcome Edmunds’s argument that she did not cause Natalie’s injuries by pointing out that the jury would have to disbelieve the medical experts in order to have a reasonable doubt as to Edmunds’s guilt. Now, a jury would be faced with competing credible medical opinions in determining whether there is a reasonable doubt as to Edmunds’s guilt. Thus, we conclude

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310. *Edmunds*, No. 96 CF 555, slip op. at 6 (Wis. Cir. Ct. Mar. 29, 2007). Nevertheless, the court engaged in a deliberate balancing of the defense evidence against the evidence offered by the state in rebuttal. After having “look[ed] at all the evidence from the trial as well as the evidence presented by both sides on defendant’s motion for a new trial,” it concluded that “[t]he newly discovered evidence presented by the defense is significantly outweighed by the evidence presented by the prosecution.” *Id.* at \*10–11.

311. The appellate court held that the trial judge had incorrectly applied the law, and that this error constituted an abuse of discretion:

After determining that both parties presented credible evidence, it was not the court’s role to weigh the evidence. Instead, once the circuit court found that Edmunds’s newly discovered medical evidence was credible, it was required to determine whether there was a reasonable probability that a jury, hearing all the medical evidence, would have a reasonable doubt as to Edmunds’s guilt. This question is not answered by a determination that the State’s evidence was stronger. . . . [A] jury could have a reasonable doubt as to a defendant’s guilt even if the State’s evidence is stronger.

*Edmunds*, 2008 WI App 33, ¶ 18, 746 N.W. 2d 590, ¶ 18. Noting that the trial judge had already made its credibility determinations, the appeals court proceeded to apply the correct legal standard itself rather than remand the case. *Id.* ¶ 19. On April 14, 2008, Wisconsin Supreme Court denied the petition for review. *State v. Edmunds*, 749 N.W.2d 663 (Wis. 2008).

312. *Edmunds*, 2008 WI App 33, ¶ 23, 746 N.W.2d 590, ¶ 23.

313. *Id.* “Indeed, the debate between the defense and State experts reveals a fierce disagreement between forensic pathologists, who now question whether the symptoms Natalie displayed indicate intentional head trauma, and pediatricians, who largely adhere to the science as presented at Edmunds’s trial.” *Id.*

314. *Id.*

that the record establishes that there is a reasonable probability that a jury, looking at both the new medical testimony and the old medical testimony, would have a reasonable doubt as to Edmunds's guilt.<sup>315</sup>

Audrey Edmunds was granted a new trial.<sup>316</sup> Months later, all charges against her were dismissed.<sup>317</sup>

## 2. *Beyond Edmunds*

Enormous procedural and substantive hurdles confront defendants at the post-conviction stage.<sup>318</sup> Although the law differs depending on jurisdiction, a number of generalizations can be made about the SBS defendant's burden of proof. Put simply, there are tensions between the governing framework for collateral relief and the issues presented by SBS cases.<sup>319</sup> These strains were nicely illustrated by the state's arguments against post-conviction relief in *Edmunds*.

First, the evidence presented at the post-conviction stage must be deemed new, or "discovered" after the trial.<sup>320</sup> One problem for the

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315. *Id.*

316. *Id.*

317. On July 11, 2008, the state announced its decision to dismiss charges against Edmunds. Ed Trevelen, *Citing Wishes of Baby's Parents, Prosecutors Won't Retry Edmunds*, WIS. STATE J., July 11, 2008.

318. This discussion is confined to newly discovered evidence claims, which are most relevant to SBS cases given the trajectory of the underlying science. "[E]very state currently permits at least some form of post-trial relief on the basis of newly discovered evidence." Daniel S. Medwed, *Up the River Without a Procedure: Innocent Prisoners and Newly Discovered Non-DNA Evidence in State Courts*, 47 ARIZ. L. REV. 655, 659 (2005) (citing 1 Donald E. Wilkes, Jr., *State Postconviction Remedies and Relief: With Forms*, 1-13, at 55-58 (2001) (all states provide a direct remedy in the form of a new trial motion based on newly discovered evidence). Newly discovered evidence "represents a ground for relief through the principal state post-conviction remedies in thirty-two states." *Id.* at 682.

Apart from *Edmunds*, I am aware of only two SBS cases where post-conviction relief was granted. In each, murder charges were ultimately dismissed, albeit on somewhat different grounds. One defendant's conviction was overturned in 2004 based on the discovery of flaws in the autopsy. *Dad Freed from Life Sentence in Son's Death*, ORLANDO SENTINEL (Fla.), Aug. 28, 2004, at A1, available at <http://articles.mercola.com/sites/articles/archive/2004/09/18/yurko-case.aspx>. That same year, charges against another defendant were dismissed by a newly elected District Attorney after an extensive review of "new evidence that point[ed] to reasonable doubt." Maura Dolan, *Fatal Abuse or Tragedy Compounded?*, L.A. TIMES, June 16, 2006, at A1.

319. I focus here on the legal standards applicable to these claims, as opposed to the formidable procedural barriers to collateral relief. These barriers have been criticized by Professor Daniel Medwed, who has proposed reforms targeted at greater systemic embrace of newly discovered non-DNA evidence, including abolishing statute of limitations, allowing innocence claims to be heard by a new judge, and creating a de novo standard of appellate review for summary dismissals of newly discovered evidence motions. Medwed, *supra* note 318, at 686-715.

320. *Edmunds*, 2008 WI App 33, ¶ 13, 746 N.W.2d 590, ¶ 13. Related to this is the requirement that the defendant's failure to discover the evidence is not the result of negligence, which raises issues

defense is that the proffered evidence is less definitive than past “scientific improvement[s]”<sup>321</sup>—DNA typing, primarily.<sup>322</sup> In *Edmunds*, the prosecutor underscored this point: the defense could offer no “bone test . . . [that] would tell us whether that infant was . . . the subject of [shaking-inflicted] brain injury.”<sup>323</sup> Instead, the evidence was described as “an academic debate among medical experts,”<sup>324</sup> and one the prosecution characterized as ongoing at the time of the trial in order to negate a showing of “newness.”<sup>325</sup> For instance, the article widely recognized as the “classic that really set this all in motion about doubting shaking,”<sup>326</sup> was published in 1987,<sup>327</sup> and a small number of scientists were already questioning the basis for SBS in the early 1990s.<sup>328</sup> The state thus argued that “[t]he debate . . . was fully engaged” at the time of trial.<sup>329</sup> Although the court rejected this characterization,<sup>330</sup> future defendants collaterally attacking their convictions may have greater difficulty satisfying the “newly discovered” requirement if the evidence offered as “new” at the post-conviction stage was more fully developed when the trial occurred.<sup>331</sup>

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similar to those presented by the “newly discovered” standard. *Id.* See *infra* notes 323–33 and accompanying text.

321. Attorney for State in Transcript of Oral Arguments (Day 5) at 69, *State v. Edmunds*, 746 N.W.2d 590 (Wis. Cir. Ct. Mar. 8, 2007) (No. 96 CF 555).

322. Defendants making newly discovered evidence motions face impediments to relief that are very much situated against the backdrop of DNA exonerations. See *infra* notes 343–50 and accompanying text (DNA as paradigm of newly discovered evidence).

323. Attorney for State in Transcript of Oral Arguments, *supra* note 321, at 69.

324. State’s brief, *supra* note 309, at 17. Compare *id.* at 17 (“Edmunds’ newly discovered evidence claim is a ‘non-starter’ because, despite two days of expert testimony, she failed to present clear and convincing evidence of anything ‘new’ here.”) with Defendant’s brief, *supra* note 4, at 35–36 (“The new evidence demonstrates that the scientific basis for SBS theory is under serious challenge.”).

325. State’s brief, *supra* note 306, at 18–22.

326. Barnes testimony, Evidentiary Hearing (Day One), *supra* note 71, at 97 (referencing Duhaime study, *supra* note 120).

327. Duhaime, *supra* note 120.

328. At least one physician, Dr. John Plunkett, has been doing so for decades. Telephone Interview with John Plunkett, *supra* note 41; Interview with Thomas Bohan, *supra* note 78.

329. State’s brief, *supra* note 309, at 21.

330. “While there may have been strands of disagreement about Shaken Baby Syndrome present in 1996, studies, research, debate and articles about the concept have grown exponentially since the trial . . . . All the defense experts indicated they would have agreed with the prosecution’s theory if they had been testifying in 1996.” *State v. Edmunds*, No. 96 CF 555, slip op. at 6 (Wis. Cir. Ct. Mar. 29, 2007). The appellate court affirmed this aspect of the ruling. See *supra* note 307.

331. Edmunds, unlike most defendants requesting post-conviction relief, was also able to point to the fact that the autopsy pathologist retracted important portions of his trial testimony. See Defendant’s brief, *supra* note 4, at 24 (“Perhaps most significantly, Dr. Huntington retracted key parts of his 1996 testimony—both on the certainty that Natalie was shaken, and the assessment that there could have been no significant lucid interval.”); *supra* note 115 (explaining basis for Huntington’s conversion).

Second, the evidence must be material to the case and not merely cumulative.<sup>332</sup> The prosecution in *Edmunds* asserted that the “academic debate” about SBS was “beside the point”:<sup>333</sup> theoretical disagreements about whether shaking alone could cause death and whether the triad alone was pathognomonic of abuse were irrelevant to Edmunds’s conviction, given the severity of the infant’s injuries.<sup>334</sup> The court could dispense with this argument in short order,<sup>335</sup> given that the prosecution fell squarely within the SBS paradigm—the cause of death was said to be forceful shaking, the diagnosis was made on the basis of the classic triad,<sup>336</sup> and the perpetrator was identified based on the impossibility of a lucid interval.<sup>337</sup> But given the current state of scientific research, which (unlike DNA<sup>338</sup>) cannot conclusively establish a defendant’s innocence, deviations from this prototypical fact pattern will tend to undermine the defendant’s materiality claim.

Finally, the evidence must probably have resulted in a different verdict at trial.<sup>339</sup> This is the most difficult burden for the defense,<sup>340</sup> and was predictably the greatest area of contention in the *Edmunds* post-conviction relief proceedings.<sup>341</sup> The defense argued to the court that, at trial,

[t]he jury never had any reason to doubt that diagnosis of shaking, with or without impact, and nearly immediate collapse was unassailable as medical evidence. This is simply no longer true . . . .  
[T]his new evidence of evolving science that rigorously challenges

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332. *Edmunds*, 2008 WI App 33, ¶ 13, 746 N.W.2d 590, ¶ 13.

333. State’s brief, *supra* note 309, at 33.

334. “The severity of the injuries sustained by Natalie takes this case out of the classic ‘triad’ mold. Not only did Natalie sustain retinal bleeding, she sustained retinal folds and retinoschisis.” *Id.* at 27.

335. “The evidence is material to an issue in the case because the main issue at trial was the cause of Natalie’s injuries, and the new medical testimony presents an alternate theory for the source of those injuries.” *Edmunds*, 2008 WI App 33, ¶ 15, 746 N.W.2d 590, ¶ 15.

336. According to prosecution experts, differences between retinal hemorrhages—in terms of extent, location, and pattern—are significant. *See, e.g.*, Testimony of Alex Levin in Transcript of Evidentiary Hearing (Day Four), *supra* note 129, at 99–101.

337. Defendant’s brief, *supra* note 4, at 40 (“[T]he science was the whole case, and new research seriously challenges the foundations of the scientific case”).

338. *See infra* notes 343–51 and accompanying text (discussing DNA as “new evidence” paradigm).

339. *Edmunds*, 2008 WI App 33, ¶ 13, 746 N.W.2d 590, ¶ 13.

340. *See* State’s brief, *supra* note 309, at 16 (“[T]he hardest requirement to meet is that the offered evidence in view of the other evidence would have probably resulted in an acquittal.” (quoting *Lock v. State*, 142 N.W.2d 183 (Wis. 1966))).

341. “The real crux of the dispute in this case is whether the new expert medical testimony Edmunds offers establishes a reasonable probability that a different result would be reached in a new trial.” *Edmunds*, 2008 WI App 33, ¶ 16, 746 N.W.2d 590, ¶ 16. Here the trial judge sided with the state. *See supra* note 310.

and refutes long-presumed hypotheses . . . very well could change the outcome. . . .<sup>342</sup>

In refuting this notion, the prosecutor explicitly juxtaposed the scientific attacks on SBS with the certainty of DNA exonerations. Unlike the new debate offered by the defense, DNA was “real science” that established innocence “to an astronomical degree of science (sic) or statistical probability.”<sup>343</sup> DNA did not “dispute a theory or demonstrate a rift or a contention in the scientific community. It didn’t provide for alternative hypotheses.”<sup>344</sup> In contrast to defense evidence substantiating the existence of lucid intervals, DNA samples “exclude[d] the defendant from the world of possible perpetrators.”<sup>345</sup> And unlike testimony regarding possible alternative causes of death in *Edmunds*, DNA provided definitive answers.<sup>346</sup>

As the *Edmunds* arguments show, DNA has implicitly been positioned as the paradigm of newly discovered evidence. Although the appeals court ultimately rejected the prosecutor’s arguments, DNA’s reign as the “poster child of newly discovered evidence” motions<sup>347</sup> must be reckoned with. The level of certitude DNA provides has become a *de facto* “benchmark,”<sup>348</sup> and the actual innocence it establishes is a touchstone for post-conviction relief.<sup>349</sup> As a consequence, legal standards may be formulated and applied in ways that tend to disadvantage other types of proof. As a matter of law, DNA is not the benchmark<sup>350</sup> and actual

342. Attorney for the Defense in Transcript of Oral Argument, *supra* note 115, at 58.

343. Attorney for the Prosecution in Transcript of Oral Argument, *supra* note 321, at 65.

344. *Id.*

345. *Id.* at 105.

346. The prosecutor in *Edmunds* argued this point as follows: “Is there an enzyme that still exists in the bones of this deceased child that will tell us if she was the subject of rotational acceleration-deceleration injury that killed her? No.” Attorney for the Defense in Transcript of Oral Argument, *supra* note 115, at 88.

347. Attorney for the Prosecution in Transcript of Oral Argument, *supra* note 321, at 64–65.

348. *Id.* at 88.

349. An emerging scholarly literature explores the post-DNA meanings of “actual innocence” and “wrongful conviction” and considers the conceptual, strategic, and practical implications that follow. See generally Gross, *supra* note 139; Susan A. Bandes, *Framing Wrongful Convictions*, 2008 UTAH L. REV. 5 (2008); Richard A. Rosen, *Reflections on Innocence*, 2006 WIS. L. REV. 237 (2006); Carol S. Steiker & Jordan M. Steiker, *The Seduction of Innocence: The Attraction and Limitations of the Focus on Innocence in Capital Punishment Law and Advocacy*, 95 J. CRIM. L. & CRIMINOLOGY 587 (2005); Andrew M. Siegel, *Moving Down the Wedge of Injustice: A Proposal for a Third Generation of Wrongful Convictions Scholarship and Advocacy*, 42 AM. CRIM. L. REV. 1219 (2005); Margaret Raymond, *The Problem With Innocence*, 49 CLEV. ST. L. REV. 449 (2001).

350. Edmunds’s attorney emphasized this:

Yes, the DNA evidence can absolutely prove that somebody did not commit a crime and can absolutely prove somebody else did commit the crime, but that is not to say that that’s what you

innocence is not the *sine qua non* of a new trial. But the subjectivity inherent in predicting the effect of new evidence on a jury's deliberations<sup>351</sup> means that the litigation of post-conviction relief motions will continue to take place in the shadow of DNA.

Given these formidable obstacles, the trial court's denial of Edmunds's motion<sup>352</sup> was to be expected. In the decision, we may rightly discern that similarly situated defendants will have difficulty prevailing in the future.<sup>353</sup> Perhaps more surprising is that the trial court's decision was overturned on appeal.<sup>354</sup> This development portends hope for those seeking new trials in SBS cases.

Even so, the promise of *Edmunds* is closely circumscribed by its limited precedential effect.<sup>355</sup> Beyond onerous post-conviction relief standards,<sup>356</sup> defendants seeking collateral relief in SBS cases confront the likelihood that, in coming years, the current scientific controversy will be suspended in a kind of equilibrium. At some point, unless a revolutionary breakthrough fatally undermines SBS, defendants convicted in this era of uncertainty will be hard-pressed to claim that evidence of the diagnosis's

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have to have in order to create a reasonable probability of a different outcome. That's a real red herring here. That's a much higher standard than the clearly established legal standard under the case law.

Attorney for the Defense in Transcript of Oral Argument, *supra* note 115, at 135.

351. Daniel Medwed has observed generally that

non-DNA cases are difficult for defendants to overturn . . . given the subjectivity involved in assessing most forms of new evidence and the absence of a method to prove innocence to a scientific certainty. This inherent difficulty in litigating innocence claims predicated on newly discovered non-DNA evidence is exacerbated by the structural design of most state post-conviction regimes . . . .

Medwed, *supra* note 318, at 658. Professor Medwed helpfully summarizes these collateral relief regimes. *Id.* at 681–86.

352. See *supra* notes 310–11 and accompanying text.

353. Edmunds was represented by Professor Keith Findley and the Wisconsin Innocence Project, a clinical program of the University of Wisconsin Law School whose mission is described at <http://www.law.wisc.edu/fjr/clinicals/ip/index.html>. It is worth noting that the Innocence Project, like others of its kind, has more resources, greater access to experts, and more extensive research capabilities than what is available to most defendants seeking post-conviction relief.

354. See *supra* notes 311–16 and accompanying text. Although he denied the defendant's motion, the trial judge's factual findings were particularly helpful to Edmunds on appeal. *Id.*

355. This is an inevitable feature of federalized system of justice. Where *Edmunds* is controlling, however, its impact may prove significant. See *Shaken-Baby Ruling Worries Prosecutor*, WIS. STATE J., Feb. 29, 2008, at C3 (“[A] prosecutor says it will be virtually impossible to convict anyone who shakes a baby to death in Wisconsin if a recent court ruling stands.”).

356. One response to these realities is resort to a review commission, which may be the most efficient way of dealing with the systemic nature of triad-based SBS convictions and their potential failings. See *supra* notes 149–50 and accompanying text (describing approaches of United Kingdom and Canada).

invalidity is new. Newly discovered evidence motions will be effectively foreclosed without ever having become truly viable.<sup>357</sup>

This prospect would be somewhat less problematic if, throughout the criminal process, a systemic assimilation of the evolved science was underway. As we have seen, however, it is not.

## V. CONCLUSION

SBS is a case study in the intersection of science and law, and the distorting influence that each may have on the other.

The construction and persistence of SBS raises the distinct possibility that our adversarial system of criminal justice may be corrupting science. It may do so by placing pressure on scientists to articulate opinions more extreme—and certainly with more confidence—than those they actually hold.<sup>358</sup> And it may do so by raising the stakes for those who have testified in court, under oath, to their version of scientific reality.

The natural course of scientific evolution has resolved many past medical conflicts. In the case of SBS, as well, ongoing research could ultimately answer the open questions.<sup>359</sup> New technological developments

357. As the evolutionary trajectory of the science progresses and newly discovered evidence motions become obsolete, defendants whose trial lawyers failed to mount a substantial challenge to now-suspect medical orthodoxy will assert that their representation was ineffective. Keith Findley has articulated this point as follows:

where the medical evidence is 'new' in the ordinary sense—that is, the jury at trial never heard the medical evidence—but not new in the legal sense—it existed and could have been presented at trial—the defendant's claim will likely shift to a claim of ineffective assistance of counsel based on counsel's failure to marshal the available scientific evidence.

E-mail from Keith Findley, Clinical Professor and Co-Director, Wisconsin Innocence Project, University of Wisconsin Law School to Deborah Tuerkheimer, Professor, University of Maine School of Law (Dec. 10, 2008, 17:52) (on file with author).

358. One pediatrician with whom I spoke elaborated on this point:

the fact that we interact with lawyers and the court makes things worse. When you swear to tell the truth and nothing but the truth, are you swearing to speak only the truth, or to convey only the truth. Let's assume you believe you know the truth in the first place. You can only communicate in court through the artifices of the court by answering lawyers' questions that are purposely configured to structure and manipulate the truth. Within this venue, how do you deliver the "proper" concept into the minds of the jury, to whom you are trying to convey the truth. Some would assert that you should not reflect on uncertainties that you feel do not influence your ultimate opinion. You need to polarize your position, so that after cross and opposing witnesses, the jury lands in the middle where they belong.

This pediatrician, who asked not to be named, later added: "the urge to polarize your opinion significantly increase[s] when you are facing opposing 'expert' opinion, which you consider to be hyper-polarized, incompletely reflective of the clinical case, scientifically incorrect or outright disingenuous."

359. My conversations with advocates on both sides of this debate can be generalized as follows. Those who believe that SBS is an invalid diagnosis cite ongoing research into the previously

would facilitate this process. But SBS, from inception to current iteration, is fully embedded in the domain of law. This reality creates a special kind of urgency: around the country, murder convictions are resulting weekly from evidence that is a source of significant scientific controversy. Even if it were possible for research to progress on this front “naturally”—a dubious proposition given what has come before<sup>360</sup>—organic processes take time, which, here, is of the essence.

Even more untenable is the suggestion that this scientific dispute be decided in the courts. As the cautionary tale of SBS demonstrates, our adversarial, atomized system of justice, with its need for finality, is a poor forum for this debate. The institutional norms of science and law often collide; in this case, with tragic results. Without proper differentiation of their respective functions, both scientific certainty and individualized justice suffer.

To the greatest extent possible, then, a comprehensive inquiry must take place apart from the fray.<sup>361</sup> Perhaps only the National Academy of Sciences (NAS)<sup>362</sup>—or, even more fittingly, a similar undertaking by a newly created National Institute of Forensic Sciences<sup>363</sup>—can provide this space.

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undetected prevalence of retinal hemorrhages (by Patrick Lantz, among others) and subdural hemorrhages (by Ronnie Rooks, among others) as critical to resolving the debate. Defenders of the diagnosis point to better modeling and the possibility of capturing a shaking episode on film as the impetus for resolution. *But see*, <http://www.youtube.com/watch?v=jBsXA4H5Dzw> (last visited July 23, 2009) (shaking of an infant recorded on a “nanny-cam;” baby was not injured). Of course if, in the future, shaking resulting in the classic SBS symptoms is recorded on video, this may tend to establish that shaking alone can cause the triad, but it will not prove a pathognomic relationship between shaking and the triad. Put differently, proof that A can cause B does not equate with proof that B is necessarily caused by A.

360. *See supra* Part III.A.

361. Others within the scientific community have been agitating for a neutral body to undertake a thorough study of the basis for SBS. *See, e.g.*, Bohan, *supra* note 76 (calling this “long past the time that persons capable of scientifically examining [the controversy surrounding the diagnosis] be called on to do so as part of an independent broad-based team under the auspices of the National Academies of Science;” Interview with Thomas Bohan, *supra* note 78. Even outside the SBS context, one commentator has recently argued that greater “institutionalized oversight of forensic sciences, by scientists, is needed to compensate for the inadequacies of adversary adjudication.” Keith A. Findley, *Innocents at Risk: Adversary Imbalance, Forensic Science, and the Search for Truth*, 38 SETON HALL L. REV. 893, 955 (2008).

362. According to its own assessment, “[t]he reports of the National Academies are viewed as being valuable and credible because of the Institution’s reputation for providing independent, objective, and non-partisan advice with high standards of scientific and technical quality.” From National Academies: Our Study Process, <http://www.nationalacademies.org/studycommitteprocess.pdf> (last visited July 23, 2009). Within the scientific community, this seems to be a generally accepted characterization. A NAS study requires a federal agency as its primary financial sponsor, implicating the willingness of Congress to authorize funds for the endeavor. *Id.*

363. In February 2009, the National Research Council of the National Academies issued its much heralded report, *Strengthening Forensic Science in the United States: A Path Forward*, available at

In the meantime, until scientific consensus has been achieved, the criminal justice system must find its own solutions to the problem of a diagnosis already morphed and still in transition.

To date, our system has failed. In place of adaptation, we have seen massive institutional inertia. Once the SBS prosecution paradigm became entrenched, the crime became reified. Deferential review standards and a quest for finality perpetuated the system's course. How expeditiously, and how deliberately, this course is righted will inform the meaning of justice.<sup>364</sup>

Complicating the endeavor, SBS prosecutions raise discomfiting possibilities that diverge from those presented by the innocence archetype. Here, no other perpetrator can be held accountable; indeed, no crime at all may have occurred. The problem is not individual, but systemic, and its source is error, not corruption. Responsibility is diffuse: prosecutors and scientists may each legitimately point fingers. Most fundamentally, scientific developments have cast new doubt without yet creating certainty in its place. The story of SBS thus challenges current notions of wrongful convictions. Underlying conceptual frameworks must evolve accordingly.

For now, we find ourselves situated in an extraordinary moment; one which tests our commitment to innocence that is not proven, but presumed.

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[http://www.nap.edu/catalog.php?record\\_id=12589](http://www.nap.edu/catalog.php?record_id=12589) (last visited July 23, 2009). Although the NRC Report did not specifically address the problem of SBS, it did catalogue a wide range of ways in which "substantive information and testimony based on faulty forensic science analyses may have contributed to wrongful convictions of innocent people." *Id.* at S-3. Perhaps most importantly, the Report recommended creation of a new independent federal agency, the National Institute of Forensic Science (NIFS), whose mission would encompass "establishing and enforcing best practices for forensic science professionals;" "developing a strategy to improve forensic science research and educational programs, including forensic pathology;" and "promoting scholarly, competitive peer-reviewed research . . . in the forensic science disciplines and forensic medicine." *Id.* at S-14.

364. I pursue the question of reform in a future Article.



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## Flawed Convictions: 'Shaken Baby Syndrome' and the Inertia of Injustice: Introduction

Deborah Tuerkheimer

Northwestern University - School of Law; DePaul University - College of Law

March 2, 2014

*Oxford University Press, April 2014, Forthcoming*

### Abstract:

The emergence of "Shaken Baby Syndrome" presents an object lesson in the dangers that lie at the intersection of science and criminal law. As often occurs in the context of scientific knowledge, understandings of SBS have evolved. We now know that the diagnostic triad — the three neurological symptoms once equated with guilt — does not itself prove beyond a reasonable doubt that an infant was abused nor that the last person with the baby was responsible for the baby's condition. Nevertheless, our legal system has failed to absorb this new consensus. As a result, innocent parents and caregivers remain incarcerated and, perhaps more perplexingly, triad-based prosecutions continue even to this day.

This is the CONTENTS and INTRODUCTION to "Flawed Convictions: 'Shaken Baby Syndrome' and the Inertia of Injustice" (Oxford University Press, April 2014). "Flawed Convictions" surveys the scientific, cultural, and legal history of SBS from inception to formal dissolution, exposing extraordinary failings in the criminal justice system's treatment of what is, in essence, a medical diagnosis of murder. The story of SBS highlights fundamental inadequacies in the legal response to science-dependent prosecution. "Flawed Convictions" proposes a restructuring of the law that confronts the uncertainty of scientific knowledge.

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# Flawed Convictions

“Shaken Baby Syndrome” and  
the Inertia of Injustice

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# FLAWED CONVICTIONS

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For my parents, Barbara and Frank

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## INTRODUCTION

### con·vic·tion\*

/kən'vikSHən/

Noun

1. A formal declaration that someone is guilty of a criminal offense, made by the verdict of a jury or the decision of a judge in a court of law;
2. A firmly held belief or opinion.

A woman who spent over a decade in prison for shaking a baby to death, all the while proclaiming her innocence, watched her conviction at last unravel. The science thought to prove guilt had advanced, said an appeals court, raising doubts about whether the woman, Audrey Edmunds, had done anything whatsoever to harm the baby. It was 2008 when she was freed.

In their standard formulation, Shaken Baby Syndrome (SBS) prosecutions rested entirely on the claims of science—which meant, as a practical matter, that they depended on the testimony of medical experts. Doctors came to court and explained that, notwithstanding the absence of any other signs of abuse, shaking could be proved by three neurological symptoms: bleeding beneath the outer layer of membranes surrounding the brain, bleeding in the retina, and brain swelling. The relationship between these three symptoms—“the triad”—and shaking was described as pathognomic, meaning that shaking was the only causal explanation possible. The science could also rule out an accidental jostle, given how forceful the shaking must have been to generate these injuries. The science could even identify a perpetrator—the caregiver last with the lucid baby—since the infant’s loss of consciousness would necessarily have been immediate. Remarkably, the

state could present the testimony of doctors and use it alone to establish the guilt of the accused.

SBS was a prosecution paradigm, a category of cases involving functionally similar facts. Edmunds's case fell squarely within this paradigm. Her trial took place in 1996, when SBS-based charges were becoming increasingly common. The caregiver consistently maintained her innocence. No witness purported to have seen her shake the baby. There were no apparent indicia of trauma. Yet solely on the basis of expert testimony regarding the triad, Edmunds, a mother of young children, was found guilty of reckless homicide. The triad convicted her, and she was sentenced to eighteen years in prison.

In the intervening decade, SBS diagnoses proliferated in the United States. Over 1,000 new cases were identified each year, and an unknown number of suspected perpetrators were sent to prison.<sup>1</sup> A new crime model, one fully constructed by science, had emerged. This development prompted no real scrutiny—a failure best appreciated in retrospect. Because the science that underpinned SBS was viewed as unassailable, few questioned whether the criminal justice system was functioning as it should. Those who bothered to notice that guilt was being proven in an unprecedented manner might well have marveled at the wonders of scientific understanding and its utility for prosecution.

After *Edmunds*, however, doubt suddenly loomed large. In a case representative of the category, a conviction was undone because of changed science. According to the Wisconsin appeals court, “a shift in mainstream medical opinion” undermined the validity of the diagnosis, posing the distinct possibility that Edmunds, who was still in prison, had done nothing whatsoever to harm the baby. Without the science upon which her conviction fully rested, there was good reason to believe she was innocent.

The opinion received little attention at the time, and Edmunds's victory went mostly unnoticed. When I happened upon the decision, it was the first time I had thought about SBS since my time as a prosecutor in New York County. During my years in the District Attorney's office, I handled, among other crimes, child abuse investigations, including allegations of shaking. I had been taught that classic SBS cases fit a pattern—a pattern epitomized by the facts of *Edmunds*. I read the court's decision to vacate the caregiver's conviction in light of my prosecutorial experience, and I was struck by its potential significance.

The criminal justice implications were staggering. The mainstream medical rethinking recognized by the court could not undermine this one conviction without undermining the convictions of others whose cases also depended on the triad. If the *Edmunds* court was right in its assessment—as I would

later conclude—a great number of cases, likely many hundreds, would need to be revisited. Science and law had been commingled, and science then progressed; the law would now need to adjust by unwinding itself. A categorical challenge of this nature had never before confronted our justice system. *Edmunds* seemed positioned as the impetus for a massive institutional effort to correct error. The question would be how best to accomplish this feat.

Or so I thought. Instead, the story of SBS has turned out to be far more complicated. It is not an account of systemic self-correction, at least not yet. Rather, the account exposes a criminal justice system ill equipped to vet medical expertise, and even less capable of reversing direction to undo mistakes. Throughout the process—from prosecutorial decisions, to evidentiary rulings, to judicial review—we see a drive to push forward rather than revisit. A diagnosis of SBS sets in motion systemic confirmation, first in the clinical realm, and then the legal. The course of injustice is almost immovable.

But it can be moved. In the years since *Edmunds*, I have tracked the criminal justice system's response to SBS. I have gathered published and unpublished judicial opinions;<sup>2</sup> collected media accounts of arrests and case outcomes in the hundreds; assembled hearing and trial transcripts; and spoken with doctors, prosecutors, and defense attorneys, all in an effort to understand how allegations of shaking are being resolved, and why. To be clear, my findings are not quantitative. Rather, they are based on years of assembling what I believe is a fairly comprehensive picture of our criminal justice system's treatment of the SBS triad. What I describe throughout the book should be viewed against this backdrop.

The picture is limited in a number of ways. First, I focus on triad-only prosecutions, rather than those involving medical evidence of abuse apart from the triad. Cases involving the three classic neurological signs (or two of the three) constitute the SBS archetype, and they arise with frequency. Other fact patterns occur too, but they warrant separate consideration.

Second, I do not attempt to depict a worldwide response to SBS. Too much of this account is bound up in American law and society; as we will see, there are particular reasons for our embrace of SBS and our slowness to reconfigure the legal approach to it. A look at the United Kingdom, Canada, Australia, and Sweden would likely suggest that we lag behind greater institutionalized skepticism on the part of other nations. But, again, I do not undertake this comparison here.

Last, given how the diagnosis impacts child custody determinations, the family court treatment of SBS merits its own examination. Again, my focus remains on the criminal justice system.<sup>3</sup>

From this perspective, the book recounts the strange career of SBS. It explains how three neurological symptoms became synonymous with homicide, and why the diagnosis has kept hold of our collective consciousness—and our law—despite the collapse of the triad’s scientific underpinnings. It shows how the criminal justice system is primed to stay the course. And it demonstrates that, even despite these limitations, the course can be altered. Today, an acceptance of triad-based prosecutions that once was complete has dissolved—alas, to be supplanted by a distribution of justice that is halting and unequal, with disadvantage breaking along familiar lines. The book depicts a system adapting, yet in woefully inadequate ways.

We have yet to confront the cautionary tale of SBS. Though its particulars are unique, its central themes are universal, raising questions about the workings of justice.<sup>4</sup> In this era of DNA exonerations, we acknowledge that innocents are convicted. But we have not grappled with what to do when there is no test for innocence. Surely science cannot always come to the rescue; at times, an unyielding faith in its promise may be the very problem.

This is not a story about bad individual actors or any other discrete source of error. It is instead about how interactions among institutional structures—in this instance, medicine, law, and culture—can result in flawed outcomes.<sup>5</sup> The fate of SBS affirms that good faith alone cannot forestall terrible mistakes,<sup>6</sup> and that the surest of convictions may not stand in for truth.

Where guilt is supposedly backed by the authoritative declarations of science, the challenge for criminal justice is compounded. Because the nature of scientific knowledge is contingent, it can advance. Our system must better deal with this eventuality, lest justice be in constant pursuit.