



How Fire Investigation Organizations Get in Trouble with Preventable Errors

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Defining Errors

- Type 1 Error: Determining a fire is arson when it is not
- Type 2 Error: Failing to recognize an arson fire



Identifying Errors

- Noting deviations in the investigation from established best practices defined in the fire investigation literature through quality control methodology within the chain-of-command
- Use of independent peer-review
- Retroactive case reviews to ensure convictions meet current science



What is the error rate in fire investigation cases?

- Unknown
- Lack of consistent systems in place to determine errors
- Some fires are easy to make a determination while fully-involved structure fires can be much more difficult. These can be more prone to errors in fire cause determination.
- Fire Investigations organizations must be okay with a finding of “undetermined” when appropriate



How do we respond to these errors?

- Avoid “knee jerk” denial
- Don’t wait for a wrongful conviction
- Address “near misses.” (dismissals, acquittals)
- Have a goal of preventing the next error
- Understand that we are scientists, and that the legal system may not always respond appropriately



How do we respond to these errors? (cont.)

- Root-cause analysis needs to be done to avoid identifying symptoms versus getting to the true causes. “The Tricks Used by Pilots, Surgeons & Engineers to Overcome Human Error” by Douglas Star (May 2015)
- Critical need to examine all components of the fire investigation system – not just certain parts of it that gets the most attention such as cases exposed in the media
- “Mending Justice” Sentinel Events Analysis
- See a wrongful conviction as the “organizational accident” that it is



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Who is responsible?



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Who is responsible?

EVERYONE INVOLVED!



Breaking down the fire investigation system

- Educational background of fire investigator applicants
- Training of new fire investigators and continuing education
- Resources available to fire investigators (public vs. private)
- Case load
- Availability of scientific experts to assist fire investigators, prosecutors, and defense attorneys working within a very science-centric fire investigation environment



How does the fire investigation system prevent errors?

- Have a system that supports being progressive and transparent
- Strong leadership
- Create a process to follow best practices by keeping up with current fire investigation literature
- Hire investigators with a scientific background and/or make available scientists and engineers to be involved with fire investigations
- Diverse training and evaluation of performance
- Implement a Science Advisory Workgroup (SAW) comprised of experts with diverse expertise available for training and retroactive case reviews
- Follow the 17 recommendations in the Texas Forensic Science Commission report issued in April 2011



How does the system react when errors are identified?

- Again, there has to be an organizational culture that demands transparency and is committed to improving the criminal justice system. Egos must be kept in check!
- Notification of prosecutors and defense attorneys occur when problems with a fire investigation are identified post-conviction
- Use that error as an opportunity to evaluate the system to take corrective and preventive actions
- Always seek the root-cause versus the symptom. Do the analysis.
- Share this analysis within the profession for continual improvement.



Conclusion

- Fire investigation organizations must have strong leadership
- Demanding training program – Professional development plan
- Preferred hiring of fire investigators with scientific background and/or have scientists and engineers available to assist
- Follow best practices
- Embrace current fire investigation literature
- Establish a SAW to assist with training and retroactive case reviews



Conclusion (cont.)

- Perform root-cause analysis to minimize errors
- Commit to transparency by reporting forensic errors to prosecutors and defense lawyers
- Review new errors and implement changes to avoid them in the future through further root-cause analysis
- Continually seek improvement in the organization



Questions?

