Assessing Liability In The Context Of Corporate Misconduct

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High-profile accusations of corporate misconduct, and their accompanying litigation, regularly make today's headlines. The nature of these incidents varies tremendously, spanning securities fraud, ethics violations, data breaches, automotive recalls, industrial accidents, and environmental contamination. Increasingly, the claims made in a litigation context go beyond the specific actions or decisions that precipitated the incident, and include accusations that the organization as a whole and its executive leadership are culpable because of a "failed" or "broken" culture, organization or infrastructure.

For plaintiffs and defendants alike, drawing an accurate distinction between an isolated incident or decision and broader organizational misconduct can be the difference between compensatory and punitive damages and, potentially, criminal liability. Consider the recent conviction of former Massey Energy CEO Don Blankenship. A jury found Blankenship guilty of "willfully" violating mine health and safety standards. Federal prosecutors said of the verdict that "[t]he evidence overwhelmingly showed an enterprise that embraced safety crimes as a business strategy" and that "[t]ime and time again the defendant chose to put profits over safety[1]." Following the verdict, there was public discussion over whether the evidence presented at trial actually supported this conclusion[2].

The issue of corporate misconduct is also routinely addressed in regulatory contexts, where the results may have longer-term implications. A recent whitepaper, "Rigged Justice: 2016," by Sen. Elizabeth Warren, D-Mass., identifies 20 high-profile cases for which, in her view, the "corporate offenders" were "let off easy[3]."Her call for more aggressive

enforcement and increased accountability has the potential to raise the stakes even higher.

In both litigation and regulatory settings, well-established scientific methods from the field of organizational reliability and culture can provide the basis to support or counter these types of claims.

A Scientific Approach to Organizational Assessments

Over decades of research on organizational design and culture, scholars have developed robust methodologies for assessing organizations' capabilities to prevent errors, accidents, and untoward behavior, and to respond effectively if — or, more likely, when — an incident occurs[4]. Research in this area is grounded in empirical, evidence-based assessments of high-performing organizations in complex, high-risk industries such as health care and transportation.

Many organizations use the insights from these types of assessments in the normal course of business to evaluate cultural norms and employee behaviors; to assess whether leadership has effectively communicated that safety, reliability and accountability are priorities; and to examine the strength of organizational capabilities, systems and processes. These types of assessments can help to emphasize continuous improvement and minimize the probability of errors, accidents or untoward behavior across any type of organization.

In a litigation or regulatory context, these assessments can provide a window — removed from the specific allegations in the case — into key dimensions of the organization. This includes the potential of the organization to succeed or fail when it encounters low-probability or high-risk situations; the ability of individuals within the organization to understand and manage unexpected events when they occur; and the effectiveness of the response to a specific error, accident or incident that has occurred. More broadly, but also relevant in these contexts, ascertaining whether an organization has been on an upward or downward trajectory of improvement and learning from past errors, accidents and incidents can also be included in the scope of an assessment of organizational reliability and culture.

Root Cause Analysis Is Not Enough

Often, in the aftermath of an incident or accusation, an organization will commission a "root cause analysis" to pinpoint the circumstances that led to the event. The experts involved in these types of analyses generally arrive with skill sets that are highly specific to the circumstances of the event itself. In the case of a mechanical failure, for example, an engineering expert might be brought in.

While this approach can be helpful in a forensic sense, root cause analyses are often hyper-specific to a particular incident. They very rarely offer the types of generalizable conclusions — such as those produced by assessments of organizational safety, reliability and accountability — that can be used to put a particular incident into context.

By focusing on understanding why something went wrong, root cause analyses tend to overlook what went right. They generally do not establish whether the probability of the incident, ex ante, was high or low. Nor do root cause analyses typically establish whether a particular incident is part of a larger pattern of errors, accidents or behaviors, or whether the organization's "tone at the top" reinforced values and behaviors that would minimize the risk of such incidents. Thus, a root cause analysis cannot speak to the organization and its leadership's culpability more broadly.

Organizational Assessments Provide a Valuable Perspective on the Evidence

In litigation and regulatory settings, assessments of organizational reliability, accountability and culture apply established methodologies and frameworks to put the at-issue incidents into context with evidence from an organization's ordinary course of business. Context is critical, because decisions and unexpected outcomes are frequently portrayed as obvious and inevitable in retrospect, when in the moment these same decisions and outcomes were far from transparent. All too often, any uncertainty that had impacted individuals' perceptions and decision-making at the time of the incident is obscured behind the knowledge of the result. A holistic view, based on contemporaneous evidence, is required for a more accurate portrayal.

Consider the production of email messages that notified employees of a looming danger prior to an incident. On the one hand, these emails could indicate that employees were aware of a potential safety hazard and nonetheless acted recklessly. On the other hand, these same messages might more accurately indicate a safety-conscious culture in which employees paid extra attention to potential hazards and confronted risks head-on. Experts in organizational reliability and culture can assess whether the record indicates the former or the latter.

Data and information gleaned from ordinary course of business activities and records — including internal audits, presentations, planning documents and surveys — can support or refute general claims about whether individuals were mindful of potential illegal or unethical behavior, risks or problems in their day-to-day activities. Analyzing training requirements, performance reviews, headcount allocations and budgets enables an assessment of the degree to which leaders in the organization prioritized safety, reliability and accountability, and incentivized others to do the same.

An independent expert opinion, based on an accepted scientific methodology, should be central to these investigations and conclusions. This opinion can also include an assessment of whether the scope, the process and the tools employed by internal, regulatory or third-party investigators into the at-issue incident were appropriate — and whether or not their conclusions, based on the same evidence, were valid.

Introducing organizational assessments of the evidentiary record can help to counter hindsight bias, anecdotal evidence and broad generalizations, allowing triers of fact to distinguish between discrete errors or accidents and widespread, pervasive issues

within an organization that may have contributed, ex ante, to an incident or behavior. They are effective means to make sense of the evidence presented and to more accurately determine where liability may or may not actually reside.

Endnotes

1 "Federal Jury Returns Guilty Verdict in Blankenship Trial," U.S. Department of Justice press release, Dec. 3, 2015, http://www.justice.gov/usao-sdwv/pr/federal-jury-returns-guilty-verdict-blankenship-trial.

2 "The Blankenship Verdict," Wall Street Journal, Dec. 6, 2015, http://www.wsj.com/articles/the-blankenship-verdict-1449446531.

3 The 20 cases/defendants are: S&P; "The Cartel"(Citigroup, JPMorgan Chase & Co, Barclays, UBS AG, and Royal Bank of Scotland); Deutsche Bank DOJ LIBOR Settlement; Citigroup; Deutsche Bank SEC Derivatives Settlement; JPMorgan Conflicts of Interest; EDMC; Navient and Student Loan Servicers; GM; Honda Airbag Settlement; Graco Children's Products; The Upper Big Branch Mine Disaster; DuPont and Methyl Mercaptan; Exxon-Mobil Pegasus Pipeline Oil Spill; Bayer CropScience LP; BP Deepwater Horizon Final Civil Claims Settlement; Guatemala's violation of CAFTA labor standards; Peru's violation of the U.S.–Peru Trade Promotion Agreement; Columbia's violation of labor obligations; and Novartis. See "Rigged Justice: 2016 – How Weak Enforcement Lets Corporate Offenders Off Easy," January 2016, available at http://www.warren.senate.gov/files/documents/Rigged_Justice_2016.pdf.

4 See, for example: Reason, James, Managing The Risks of Organizational Accidents, Aldershot, U.K.: Ashgate, 1997; Dekker, Sidney, The Field Guide to Understanding 'Human Error,' Aldershot, U.K.: Ashgate, 2006; and Weick, Karl E. & Kathleen M. Sutcliffe, Managing the Unexpected, San Francisco: Jossey-Bass, 2001, 2007, 2015.