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Public inquiries into deaths in care: Effects on emergency responders

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Public inquiries into deaths in care: Effects on emergency responders

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Abstract

In the wake of tragic events involving emergency service response, society has increasingly moved to the process of post-mortem inquiries with the goal of identifying errors and avoiding future deaths. While the goals of public accountability and quality assurance are laudable, these inquiries do not come without cost. The results of this qualitative study of 37 emergency workers who had been involved in inquiries, suggest that they have a profound effect. Participants in this study identified experiences of feeling unprotected, attacked and presumed guilty of incompetence or negligence when testifying at a post-mortem review. These feelings were intensified by the media attention, which was often sensational and vilifying and the subsequent public response of suspicion and blame. They were further intensified by what participants viewed to be an unsupportive organizational response. The result was feelings of betrayal, anger and reduced commitment. Strategies for ensuring that inquiries do not undermine quality service include proactive support, education and legal representation.

Public inquiries into deaths in care:

Effects on emergency responders

Introduction

Emergency service workers are often faced with life threatening and uncontrollable situations where quick thinking and reasoned action is required. While for the most part, these situations resolve favourably, emergency workers are not, and cannot be expected to be 100% successful in all cases. People die in fires, in ambulances on their way to hospital and in violent incidents requiring police intervention. When these tragic events occur, frequently a post-mortem inquiry is held in order to determine whether alternative policies or actions of individuals could have averted disaster. These inquiries take many forms including public commissions, investigations internal to the emergency service organization, and actions initiated through the criminal and civil courts. While the stated goal of post-mortem reviews is to protect the public and improve the quality of service, it is possible that they in fact may have the opposite result. Failure to deal with acute trauma situations in a manner that is viewed optimal by others may result in professional condemnation, community sanctions and possible legal actions against emergency workers. This understandably can be extremely stressful and destructive for workers and their organizations. Stemming from the belief that their efforts are not valued, workers may become demoralized and distanced from the public and disillusioned with their organizations.

Death inquiries have become prominent and powerful political institutions. Critics suggest that they are a socio-political phenomenon which have wide ranging effects on public policy and service delivery (Hill, 1990). In part, inquiries help society deal with moral panic. The public attention becomes focussed on a phenomenon, which is not necessarily driven by an increase in incidence, but instead a surge in attention. If a child dies in a crowded emergency department, attention becomes focussed on the availability of health care resources or on the inexperience or indifference of health care staff rather than neglectful parents or the painful reality that children continue to die of disease. Inquiries are a means for government to demonstrate concern for an issue and to appease the public (Hill, 1990) without necessarily leading to systemic change or increased funding. Further, inquiries themselves frequently take on a tone of moral righteousness. The motto of the Chief Coroner's Office for Ontario who conducts public inquiries into deaths of patients in care, for instance reads "We speak for the dead." This implies that those who disagree with findings or the process by which the inquiry was conducted may perhaps not care for those who have died and their surviving loved ones. All these political factors serve to increase pressures placed on emergency responders whose actions may be the focus of the inquiry.

To date there is a surprising dearth of research on the impact of post-mortem inquiries on emergency service workers. Related research has found that testifying in court is the number one ranked stressor among police officers (Evans & Coman, 1993). A study of female physicians determined that threat of malpractice litigation was a primary source of distress in female physicians (Richardson & Burke, 1993). One study of child welfare workers encountering reviews subsequent to the death of a child, describes the devastating impact on both workers and the organization (Regehr, Chau, Leslie & Howe, in press). Theoretical and anecdotal articles also point to the stress of reviews of performance. Authors point to the stress experienced by nurses (Koehler, 1992) and police officers (Herrman, 1988) when their actions are scrutinized by the media and the court system and the subsequent undermining of the public's confidence when a member of an occupational group is being investigated (McDonald, 1996). Anecdotal literature on child protection workers suggests that death inquiries have a devastating impact on morale. Staff become depressed and anxious, work becomes defensive and routinized, resignations are common and recruitment of new staff is difficult (Hill, 1990; Brunet, 1998). In addition, these inquiries can lead to further consequences such as civil litigation or criminal charges. Following a coroner's inquest into the death of a child in a hospital, two Canadian nurses were criminally charged (MacLeans, 2002). Similarly internal police investigations frequently lead to compensation claims (Bale, 1990).

This study seeks to understand the experience of emergency service workers in testifying in a post-mortem review following the death of a person in their care or during an incident in which they were involved. Through the analysis of qualitative interviews conducted with workers, reactions to the event leading to the inquiry, reactions to the review

process, the impact of the media and public attention and perceptions of the organizational response and support are considered.

Method

The research was conducted with members of four emergency service organizations which provide services in a large urban area, two policing organizations, one ambulance service and one fire department. The entire study had two components, quantitative data gathering through the use of questionnaires and qualitative interviewing. The total for the quantitative sample included 338 emergency service professionals (Regehr, et al., in press). Workers who participated in the quantitative component of the study were asked if they would be willing to participate in an interview in order to more fully explore their experiences. Seventeen paramedics, 9 firefighters and 11 police officers were included in qualitative interviews. Purposive sampling was used in order to ensure that participants represented a wide range of experiences in terms of length of time with the service, types of critical events encountered and participation in post-mortem reviews. The sample size is somewhat larger than that recommended for the long-interview method of data collection (McCracken, 1988). This larger size was selected in order to ensure that saturation had occurred (Cresswell, 1998).

Interviews followed a semi-structured interview guide which included questions about events that led to post-mortem reviews, the effects of both these events and the post-mortem review on themselves and others, organizational supports, public and media response to the inquiry and suggestions for change. The interviews were audio taped to ensure accuracy of data and transcribed. Data was analyzed for themes with the aid of a computer program (Nvivo). In the initial stage, open coding allowed for the development of broad categories, after which selective coding allowed the researchers to attempt to develop a meaningful narrative of the experience of the workers. Other sources of data included the notes recording the interviewer's impressions.

Erlandson and colleagues (1993) identify four primary criteria for judging the reliability of qualitative research, credibility, transferability, dependability and confirmability. In this study, credibility was established through triangulation of quantitative and interview data. Throughout this research process, members of emergency service organizations have acted as community partners working to develop the research questions, and discussing data as portions of the analysis was completed. This process has provided an opportunity to confirm and expand upon the trends developed in the analysis. Tentative analyses were then presented to a group of emergency responders on two occasions and their reactions and comments further enhanced transferability and confirmability (Cresswell, 1998; Erlandson, Harris, Skipper, & Allen, 1993). Dependability or reliability was enhanced through the process of having two research assistants work together to develop the coding tree and ensure consistency in the manner of coding. The principle investigator then reviewed the open coding and collaborated on the axial and selective coding.

All participants in this study had been involved in some sort of review following the death of a person in care. The types of reviews varied greatly. Some emergency responders were involved in criminal trials of others whose actions led to death. Two were involved in trials where they had been charged and were later acquitted in relation to deaths of persons in care. Others had been involved in civil trials as witnesses and defendants. Several had testified in public inquiry processes in the form of coroner's inquests. In Canada, a coroner may decide to hold an inquest when it is believed that circumstances relating to a particular death or deaths warrant public attention, or that recommendations might be made by the inquest jury to prevent similar deaths in the future (Ministry of the Solicitor General, Office of the Chief Coroner, 2002). Originating in 11th century England, the present day Canadian inquests are presided over by a coroner and witnesses are examined by a crown attorney, before a jury. The inquests are open to public and the media.

In addition, all of the participants in this study had been involved in reviews of deaths of persons in care within their own organizations. The types of events leading to the inquiries included failed rescue attempts, shootings of civilians by police, deaths of elderly individuals in nursing home fires, deaths of prisoners in custody and deaths of patients on their way to hospital. At times, many people from the organization participated in the review, at times it was just one responder and their partner and at times the responder alone was subject to the review.

Results

Replaying the event – The critical incident

Each of the events leading to the postmortem reviews emanated from tragic situations. Consistent with secondary traumatic reactions in emergency service workers found in other studies (Fullerton, McCarroll, Ursano & Wright, 1992; Gibbs, Drummond & Lachenmeyer, 1993; Marmar et al, 1999; Regehr, Hill & Glancy, 2000) workers describe a wide range of symptoms. Participants reported disturbances of appetite “I didn't want to eat for a few days” and of sleep “I couldn't sleep well, my mind was essentially on the call.” They referred to intrusive thoughts when trying to respond to other calls, nightmares and flashbacks.

“So for a long time after that.. every time I closed my eyes what I saw was this guy's face, and it kind of bothered me for a long time.”

Involvement in the event caused them to question their judgement and second-guess their career choice. Participants described generalized anger directed at colleagues and family members. On the other hand, witnessing the trauma of others caused some participants to value their relationships more highly and created the need to “Go home and hug the kids.” These intense reactions to the event itself, provided an important backdrop to the inquiry that followed.

Guilty until proven innocent – The post-mortem review

The disturbing nature of the post-mortem review in many ways seemed to emanate from the manner in which the process was structured. Depending on the type of review, emergency responders often felt that no protection was afforded to them. In a coroner's inquest for instance, the rules of evidence are less structured than that in a civil or criminal court. Jury members are permitted to ask questions, anyone (such as family members of the deceased) can have standing and have lawyers represent them. “It is probably the most horrible experience because you don't have rules of evidence.. so things like badgering and that kind of thing are allowed.” Respondents described the manner in which reviews whether they were internal to the organization, a coroner's inquest or a trial, caused them to feel powerless “it's out of our hands, it's out of our control”.

Regardless of the intent of the review, respondents felt that it was adversarial in nature and that they were “on the hot seat”. One respondent suggested that “The job of the lawyers is to discredit you.” Another felt that the cross-examination process was aimed at “twisting the truth”. Several respondents suggested that in the quest to find the truth and determine who was to blame, the process tarnished all participants. “Even if you are just presenting evidence, it is as if you are on trial”. When the actions of emergency workers were in question, this was intensified. Respondents felt that there was an assumption of guilt or wrong doing throughout the review process. “The way you are treated is that you are already guilty... [for public] they are innocent until proven guilty.”

This had the effect of making participants feel that the review system strips workers of their sense of professionalism. “There was no courtesy, there was no professionalism, it was just a complete joke”. This had a profound effect on the participants sense of personal and professional self. “Your identity is through your work, and I'm a police officer, I'm a paramedic, I'm a fireman.” “The greatest fear of an emergency health worker, is that someone is going to question your abilities to do your job.” Further, while undergoing the review process, emergency workers began to question themselves even if they felt that they had done the right thing and had nothing to hide. “On the stand I was doubting my own mind, and this lawyer was trying to crucify me.” “Hindsight is 20/20 you know. You make the best decision at the time, but you say something, and the lawyers twist what you are saying around and then you get confused and look like an idiot.” Respondents were not only concerned about themselves in this respect, but also the organizations for whom they worked. “The crown seemed to have a grudge against the ambulance service.” “They think that all cops are just gun happy.”

Other aspects of the process also created distress. One aspect was the length of time that could be involved in an inquiry. “I was exonerated, the other [person] that was named was exonerated, everything was fine, but I mean it took eight years.” Throughout this time, emergency responders are constantly reminded of the tragic event. “Some things you just want to leave behind you”. Another issue was dealing with a foreign environment and unfamiliar legal jargon. In addition, in reviews where there was another individual accused of the death, such as in a criminal trial, participants

described their discomfort in facing the accused. There was also a perception that in the zeal to determine what emergency responders could have done better, attention is deflected from the civilian offender. One responder described how the inquiry into the shooting death of a police officer became focussed on the ambulance response and not the fact that he was shot dead by a civilian.

Responders discussed the lack of preparation they received before attending the inquiry. They were not told about the process of the inquiry and were not given legal advice regarding their rights and responsibilities and were not given time to prepare. "They hand you the subpoena and then you go." When the organization did have legal representation, responders often felt that the lawyers did not have sufficient knowledge about the organization to be able to adequately represent their issues.

Finally the outcome of the review process was generally viewed as negative. "There is never a positive outcome." When actions of responders have been questioned, a cloud of suspicion remains. "The investigation never says you did the right thing or just something to remove the air of mystery from the whole thing. They just don't. That's sad." "So you never get justice." "In the eyes of the public all it says is that the cops got away with it again." Further, a common theme was that responders involved in inquiries very frequently were not notified of the outcome. "Was it my fault? Was I partially to blame? Or was I not at fault? I never heard the results." "I know it was not my fault, but still to get that official OK would have meant something."

Are you guys really that bad? – The media and public response

Participants had a great deal to say about the media coverage of the events and the negative impact that this had on them as individuals, on their families and on the organization. "The biggest problem with media is having parents in another city read what a bad guy their son was". "The media wrote things and said things on the air, and then I get friends and family phoning up and saying "Are you guys really that bad?"". People that the responder would run into casually would ask about the inquest and question their skills and integrity. Responders suggested that the neighbours would pass judgement based on the media coverage.

"I wasn't getting a lot of support outside of the organization, in fact I actually took to not walking in the immediate vicinity of my home because people assumed I had done something wrong."

The fact that frequently responders viewed the coverage as biased compounded this problem.

"There was a lot of media coverage, and there was one, I still have all the articles, X was her name, this media reporter, she hated my guts, every time she walked into the court room, she scowled at me and, like I don't know what I did to her.. even when the evidence came out that what we did was right, she would put a spin on it to make it look bad."

In the end, two responders described how negative media coverage ceased to have an impact.

"Fifteen years ago I cared about what the media said....You just get used to it."

"The negative media attention, over the year you realize the reason, they are just trying to sell papers. You got no control. That won't change how I feel about people on the street."

Treated as an outcast – The organizational response

A major issue described by respondents was humiliation within the organization. This included organizational responses in which they were given a change of duties, were transferred to another division or in the case of police officers, had their gun taken.

"I was horrified, in that I was taken off [my duties] and the only time you are taken off [duties] in here is a disciplinary issue because you f...ed up. So the implication being that I did something wrong. Did this guy die because I did something wrong? Did I do something wrong? Could I have done something better? None of those questions were asked, [fault was] just implied."

Such changes in duties was reported to result in gossip within the organization and speculation about who was at fault. Further, when major events occur, generally organizations conduct an internal review to determine if there has been any wrongdoing. Participants viewed these reviews as highly stressful and undermining of their sense of support. "Then there's the internal review but I think their main function is so that the organization can cover themselves...that's more a stress than a help."

A little thing happens and there is a knee jerk reaction. Everything is blown out of proportion. – people are left scattered and destroyed afterwards – regardless of the outcome. Changed attitude to the organization.

“in making sure their ass is covered, [the management] forget the human side of things and they forget that there are people working here.”

Respondents repeatedly discussed the lack of management support. Management did not attend the inquiries and emergency responders were left to fend for themselves. Management questioned the actions of workers. When responders attempted to discuss their concerns and stress, they believed that they were dismissed as complainers. In one case where the organization elected to settle a civil suit – the responder felt betrayed by the organization. The individual was clear that he was in the right and the choice to settle for the sake of expediency appeared to be an admission of guilt. In another case, despite the fact that the worker was found not responsible in the external inquiry, he still felt that management viewed him as responsible for the tragedy.

“The witnesses perjured themselves and still I didn't get support from management....They still wanted to discipline me in the internal accident review committee”

Picking yourself apart – Personal reactions

Respondents described the stress experienced by both themselves and their families during the review process. Common themes included sleeping on days off and waking throughout the night.

“and suddenly I'm sitting on the edge of the bed, not sure what is going on. Like it was scary, I didn't know what was going on.”

The length of time before an inquiry was called added to the trauma for some workers.

“There is the issue of going to court and having to relive [the trauma], usually a couple of years down the road just when you think you have come to terms with it, now all of a sudden you've got to go to a coroner's inquest or a homicide trial.”

Respondents indicated that family members commented on their change of mood and irritability during the review process. Some respondents reported feelings of isolation as they perceived that they were unable to discuss their concerns with family or colleagues for fear that they may be called as witnesses in the inquiry. They discussed the stress of being questioned during the inquiry and reported that they began to question themselves. “You start to second guess yourself.” “You are your own worst enemy, you're literally picking yourself, picking your activities apart and questioning your own judgement.” They are worried about the outcome. “If I lose my job, who will support my family?”

They also worried about family members who had to deal with the reactions of neighbours to the media reports. In the end, even though the workers were exonerated, the cloud of suspicion continued. “Even though judge says you were acting properly, that does not get fully reported.”

Outcomes

Despite the fact that all respondents described negative experiences during the inquiry process, several described positive outcomes. A frequently reported positive outcome was the learning that was derived from the experience. This included how to plan for the attack of opposing counsel, identifying means of documenting and ensuring their work was well represented and then providing this information to new staff.

One positive outcome for some of the respondents was recognition for a job well done. Some respondents discussed the appreciation that they received from emergency workers in other agencies, others received thanks from relatives of the victim. “The relative coming up and shaking my hand, there was no question that was um, the most positive aspect of it.” Another respondent spoke about his sense that the inquiry was listening and trusted the skills of responder, “that gave me confidence”. Similarly, many responders identified that the most positive outcome was that they were exonerated. “The only positive thing I think that came out of the inquest was the fact that my partner and I did our jobs properly.” Others felt that as a result of their involvement in the inquiry justice had been served through the conviction of a guilty person. One respondent reported feeling good about “contributing to getting these people the punishment they deserved.”

System change was another positive outcome. Some respondents identified that recommendations made did in fact lead to improved policies and better quality assurance. For instance, one respondent was pleased that as a result of the inquiry, CO detectors are now mandated by law. Recommendations from the inquiry at times led to more resources in that they were used in negotiations for increased staffing. Sometimes the positive outcome was policy change in another organization who was “slammed” and in one case the reported positive outcome was that a nursing home was closed down.

There were also many themes about long-term negative outcomes of inquiries these included reduced commitment to the job and the public, increased stress and increased anger.

“You get more perspective, you know trying to do too many things at once, I was a very energetic [worker], I still am, but this puts it in perspective a little more.. I am not going to die of a heart attack when I'm 50 or 55.”

“Everything is being scrutinized so much more than it used to be. And that's not a bad thing, it's changed, tightened up, and made procedures better, and that is more accountable than it used to be. But the price is, that when things don't go well, there is more accountability for the [workers] that have to pay the price for it. That has added a lot more stress to the job.”

“[People are] anxious and just angry, probably anger and resentment more than anything, is the ripple effect of everything you go through, it just puts more demands on everybody, there's a lot of pressure.”

In general however, the respondents believed that the increased accountability and scrutiny is a fact of life that must simply be dealt with.

“The public wants us to be accountable and we have to realize that as a group, whether you like it or not....That cat is out of the bag, you're not shoving it back in.”

Suggestions for change

While inquiries may be an inevitable part of the work of the emergency responder, participants offered many suggestions to reduce the strain that they placed on workers. A common theme was education including coaching, information regarding the process, training, role playing, attending reviews and or watching testimony on tape. Responders suggested that education regarding the process and watching of tapes should be part of the standard training, offered when an individual first begins work with the organization. This could then be upgraded at different stages of an individual's career and include role playing testimony and attending reviews that may be conducted. Any time someone is called to testify, an immediate education session should be available, again reviewing the process, the possible outcomes and role playing answers to challenging questions.

Another suggestion for improvement was legal representation for all workers who were acting not only as defendants, but also as witnesses, as they may be found to have been responsible by making self-incriminating statements. It was strongly suggested that the union or management hire lawyers whose sole responsibility in the matter is to represent the specific needs of workers. It was also underlined that these lawyers must be knowledgeable both about the unique nature of the inquiry process and the job demands of emergency responders.

Finally proactive support and assistance for both the emergency responder and their families was recommended. It was underlined by several respondents that support should not be offered only when the person experiences distress, but should be a matter of course. Support for the worker could include a peer attending the inquiry with the worker, a mentor who had been through the process that could offer guidance and support and/or confidential counselling – though several respondents were suspicious about counselling and suggested that it could never be confidential in an emergency service organization. As family members often were identified to feel uniquely isolated and distressed, specific counselling programs and perhaps mentor/peer companions consisting of other families who have survived the process could be of use. Families require information not only about the review process but also about common reactions of workers encountering the process and strategies for dealing with media, the public and the questions of their children.

Discussion

It is now well documented that emergency service workers encountering tragic events frequently experience a variety of traumatic responses. Research has identified trauma reactions in police officers following a shooting incident (Gersons, 1989; Solomon and Horn, 1986); in firefighters following immense blazes (Fullerton, McCarroll, Ursano and Wright, 1992; McFarlane, 1988a); in nurses following the death of a child or colleague (Burns and Harm, 1993) and in ambulance workers involved in recovering bodies following mass disasters (Thompson, 1993). Symptoms described include recurrent dreams, feelings of detachment, dissociation, guilt about surviving, anger, irritability, depression, memory or concentration impairment, somatic disturbances, alcohol and substance use and re-experiencing of symptoms when exposed to trauma stimuli (Gersons, 1989; Solomon and Horn, 1986). The results of this qualitative study confirm these experiences in emergency responders following a failed attempt to save lives.

When tragic events occur however, they rarely end with the tidying of equipment and completion of paperwork. Rather, society has increasingly moved to the process of post-mortem inquiries with the goal of identifying errors and avoiding future deaths. While the goals public accountability and quality assurance are laudable, these inquiries do not come without cost. The results of this study suggest that there is a profound effect on the emergency workers who testify in the inquiries. Police, firefighters and paramedics who participated in this study identified experiences of feeling unprotected, attacked and presumed guilty of incompetence or negligence when testifying at a post-mortem review. These feelings were intensified by the media attention, which was often sensational and vilifying and the subsequent public response of suspicion and blame. They were further intensified by what participants viewed to be an unsupportive organizational response. Emergency responders in this study stated that the organization often seemed more interested in appearing publicly accountable and avoiding liability than supporting workers. This finding is particularly important in light of previous research which has suggested that social supports and organizational environment have a significant influence on responses to traumatic events in rescue workers (Alexander & Wells, 1991; Fullerton, et al, 1992; Regehr, Hill & Glancy 2000; Weiss, et al, 1995). That is when people feel supported and valued, they experience lower levels of distress. As a consequence, emergency workers reported symptoms of intrusion, avoidance, arousal and self-doubt that began with the tragic event itself and continued throughout the review process. In the end, several respondents were able to identify positive outcomes from the review process such as new learning, some positive recognition, system change and most importantly vindication. Nevertheless, a dominant theme was that of betrayal, anger and reduced commitment.

The findings of this qualitative study point to some important issues for society and for emergency service organizations. As pointed out by some of the participants in this study, accountability of emergency service workers is a reasonable expectation of the public and society. As a result, death inquiries as a form of achieving this goal are probably here to stay. In order that these inquiries meet their goal of improving service, it is important that organizations provide support for emergency responders participating in these processes. Supports recommended by police, firefighters and paramedics in this study include education, legal representation, proactive assistance, attendance at hearings by a peer, mentor and most importantly signals of support and recognition by management and superior officers. Everyone in the emergency services, as in any other profession, will at times not function at the optimal level and will not always make the best decisions in the heat of the moment. If we focus our efforts on vilifying those who seek to help the public, we cannot expect that they will continue to risk themselves for the safety of others.

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