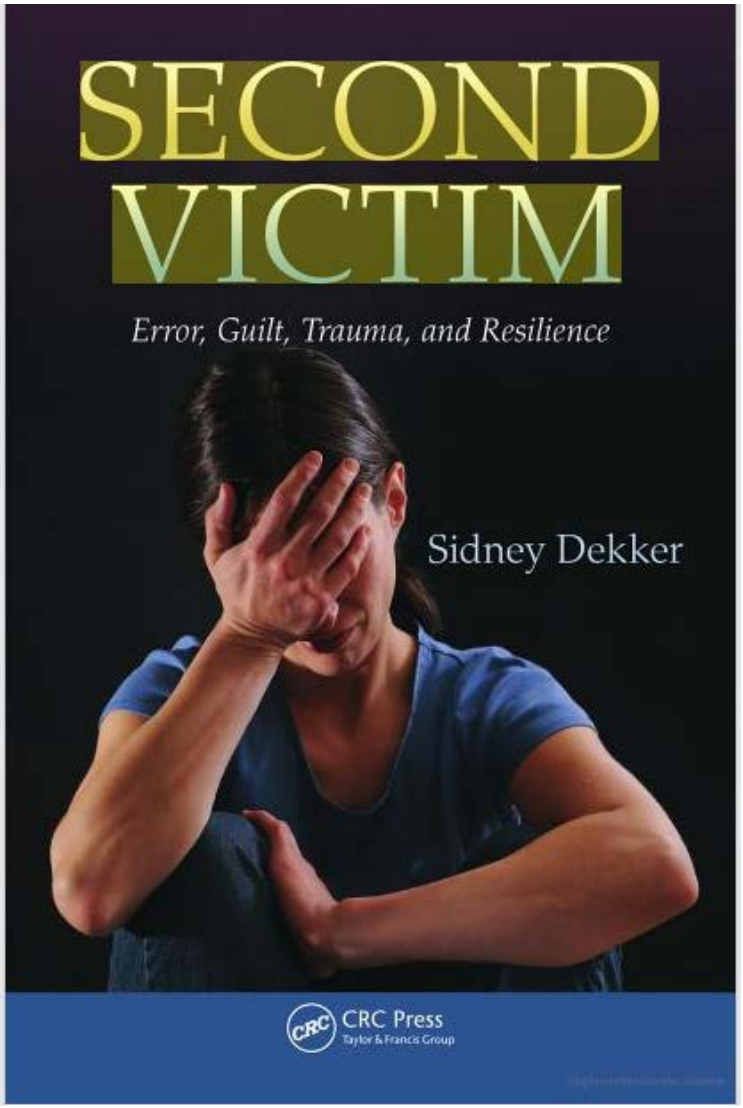
Secondary victimization of professionals accused of white-collar crime

Sofia Wikman, PhD, Criminology

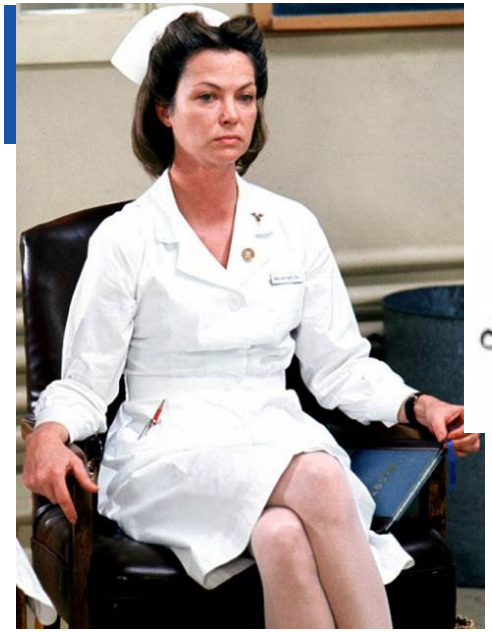

SECOND
VICTIM
Error, Guilt, Trauma, and Resilience
Sidney Dekker
CRC Press
Taylor & Francis Group

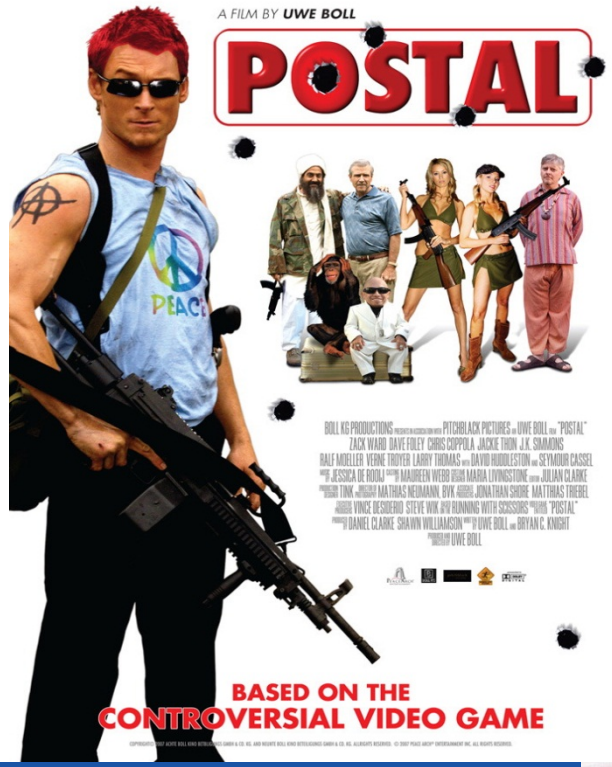
Researcher in criminology at Stockholm University since 2006

Prevalence of, **trends** in, the **nature of the attention** and **interventions**

How can the increasing levels of violence at work be understood?

- different approaches and perspectives
- different types of data and analytical methods.
- Trade union press, occupational injury reports, victim surveys

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"LIVE ACTION VERSION OF SOUTH PARK"
- iconsoffright.com
A FILM BY UWE BOLL
POSTAL
BASED ON THE
CONTROVERSIAL VIDEO GAME

What is Workplace Violence?

(Bowie 2002; OHSA- Occupational Safety and Health Administration)

Intrusive violence

- Criminal intent by strangers
- Mental illness or drug-related aggression
- Terrorist act/protest violence

Relationship violence

- Staff- on staff violence and bullying
- Domestic at work

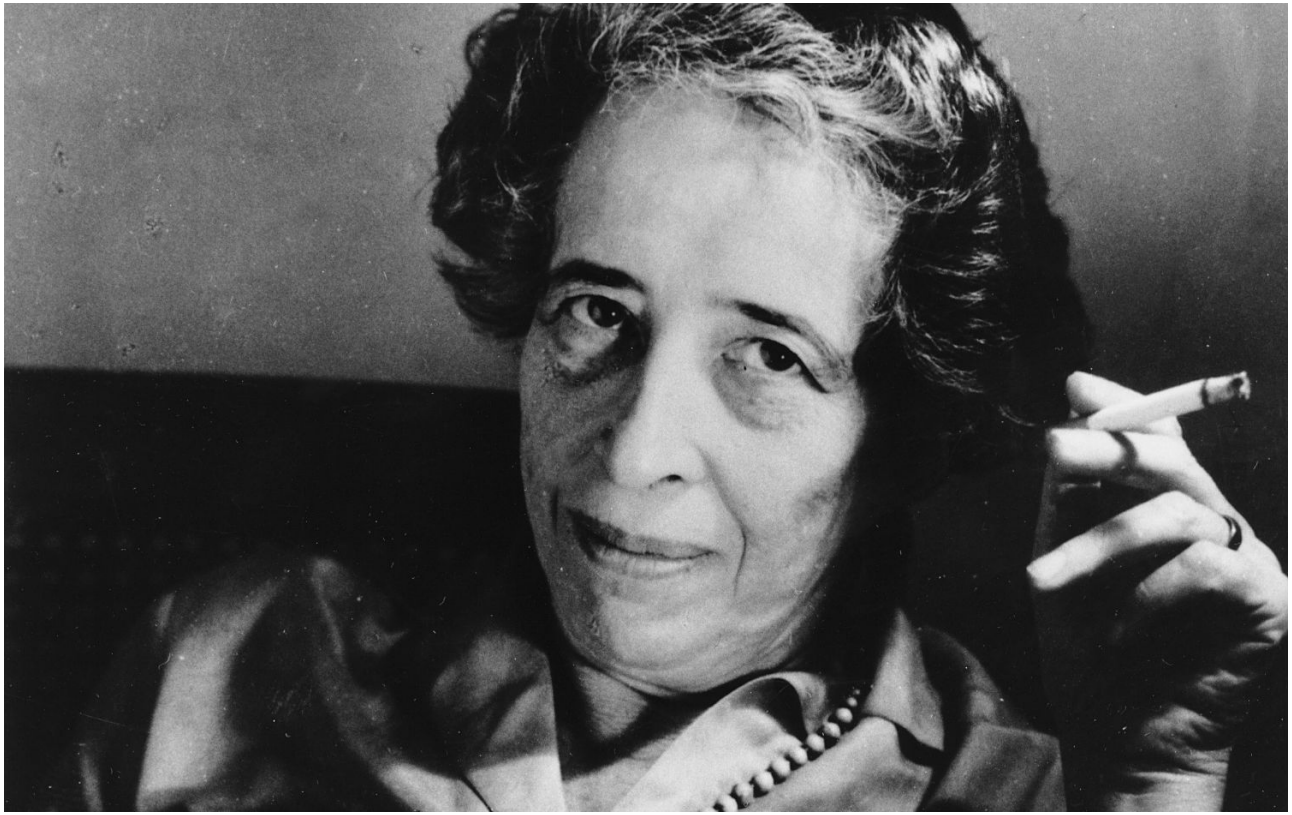
Client violence

- Consumer/client/patients (and family) against staff
- Same as above but reverse

Organizational/structural violence

- Against staff
- Against Client/consumers/patients

The Banality of Evil



Who are violent: Rather ordinary individuals who simply accept the premises of their state and participate in any ongoing enterprise with the energy of good bureaucrats (Eichmann in Jerusalem, Arendt 1963)

What is white-collar crime

A group of criminologists who met specifically to address the dispute over the meaning of the term "white collar crime" came up with the following definition:

> White collar crimes are illegal or unethical acts that violate fiduciary responsibility of public trust committed by an individual or organization, usually during the course of legitimate occupational activity, by persons of high or respectable social status for personal or organizational gain. (Helmkamp, Ball, and Townsend 1996: 351)

Friedrich 2009:
Trusted Criminals: White Collar Crime In Contemporary Society

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TOMORROW 37°F Sunrise: 7.40am

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STAFFORD HOSPITAL SCANDAL: THE FRANCIS REPORT

TODAY'S FINDINGS – FOUR-PAGE SPECIAL INSIDE TOMORROW – EIGHT-PAGES OF ANALYSIS

Patients paid with their lives as hospital cut costs to hit targets

SACRIFICED

By Daniel Wainwright

THE full scale of appalling failings at Stafford Hospital was laid bare today.

Hundreds of patients died as nurses provided woefully inadequate standards of care and bosses focused on hitting management targets.

Many of the patients died in pain, with harrowing accounts of people being denied access to water and left lying in squalor – some even having to clean the toilets themselves.

Today the chairman of the inquiry Robert Francis QC, revealed his findings. He described the scandal as a "disaster" and added: "There was a lack of care, compassion, humanity and leadership."

The report provides a shocking indictment of staff across the board at the hospital – from senior managers to nursing and care staff on the wards.

Betrayed

Prime Minister David Cameron this afternoon said that patients had been "betrayed" and personally apologised to families who lost their loved ones because failings at the hospital had been allowed to continue for so long.

The findings of the landmark £10 million inquiry into the hospital today concluded it was "the worst crisis a district general hospital in the NHS can have ever known".

Campaigners who kick-started exposure of the scandal at the hospital today called for the resignation of NHS chief executive Sir David Nicholson on the back of the report.

Julie Bailey, who set up Cure the NHS after her 86-year-old mother Rella Bailey died at Stafford Hospital in 2007, said: "We are looking for leadership skills and the man at the top of the NHS has not got the leadership skills."

The report into the hospital, where between 400 and 1,200 people died between 2005 and 2009 because of poor care, revealed managers were trying to cut costs so it could win coveted 'foundation' status.

The probe found the hospital was "deprived of a proper level" of nurses to make its finances look healthier, leading to a "completely inadequate standard of nursing". More than 150 nurses had left between 2005 and 2009.

The 1,781-page, three-volume report comes following a 136-day inquiry in which staff past and present, politicians, unions, patients' families and medical professionals attended. It found:

- Managers had "no culture" of listening to patients
- Board members "failed to get a grip" on accountability
- An "unacceptable delay" in addressing the issue of nurse shortages
- Too great a degree of "tolerance" of poor standards and risk to patients
- Patients were left for hours with food and drink out of reach.

The report said there had been a "failure of communication" between different agencies to share their knowledge of concerns.

It said assumptions were made that monitoring or intervening was the "responsibility of someone else".

Leaders were accused of failing to appreciate the enormity of what was happening.

A string of clinical blunders including bad operations were also identified.

And the report revealed misdiagnoses and drugs either not given or given too late.

The report makes 290 recommendations for the future, including making individuals responsible for what they do rather than just the health trust, better training for nurses and managers and a statutory duty of "candour" requiring health trusts to be honest with patients if things have gone wrong.

The recommendations have serious implications for the entire NHS and call for a "single regulator covering everything from financial management to patient safety".

Mr Cameron was today announcing the creation of a new chief inspector of hospitals who will be responsible for making sure they are delivering good care not just trying to meet targets. Speaking in the House of Commons, he said: "Hundreds of people suffered from the most appalling neglect and mistreatment.

"There were patients so desperate for water that they were drinking from dirty flower vases. And relatives were ignored or even reproached when pointing out the most basic things which could have saved their loves ones from horrific pain or even death. We can only begin to imagine the suffering endured by those whose trust in our health system was betrayed at their most vulnerable moment."

Julie Bailey with members of Cure the NHS today demanding resignations in light of the Stafford Hospital inquiry findings

Nurses had no respect or care

Robert Francis QC this afternoon spoke of his shock at appalling neglect at Stafford Hospital. This is his statement on the scandal

"There was a lack of caring, compassion, humanity and leadership.

The most basic standards of care were not observed and fundamental rights to dignity were not respected. Elderly and vulnerable patients were left unwashed, unfed and without fluids. They were deprived of dignity and respect. Some patients had to relieve themselves in their beds when they were offered no help to get to the bathroom.

Some were left in excrement stained sheets and they had to endure filthy conditions in their wards.

There were incidents of callous treatment by ward staff. Patients who could not eat or drink without help did not receive it.

Medicines were prescribed but not given. The accident and emergency department, as well as some wards, had insufficient staff to deliver safe and effective care.

Robert Francis speaking today

Patients were discharged without proper regard for their welfare. The many experiences like this were truly shocking to hear.

Many will find it difficult to believe that all this could occur in an NHS hospital.

What is required now is a real change in culture – a refocussing and recommitment of all who work in the NHS from top to bottom of the system on putting the patient first.

We need a common, patient-centred culture which produces at the very least the fundamental standards of care to which we are all entitled at the same time as celebrating and supporting the provision of excellence in healthcare.

This is a story of appalling and unnecessary suffering of hundreds of people. They were failed by a system which ignored the warning signs and put corporate self interest and cost control ahead of patients and their safety.

The trust board was weak. It did not listen sufficiently to patients or staff, ensure the correction of deficiencies brought to its attention. It didn't tackle the tolerance of poor standards and a disengagement of senior clinical staff from managerial and leadership responsibilities.

There was a failure of the NHS system at every level to detect and take action that patients and the public were entitled to expect. The patient voice was not heard or listened to."

NOT JUST THE BOSSES AT FAULT OVER APPALLING CARE – SEE E&S COMMENT PAGE 8

Victim surveys about workplace violence

Survey	Producer	Size
The Swedish Population's Living Conditions (ULF)	SCB (Statistics Sweden)	~6 000
The Work Environment (AU)	SWEA (Swedish work and environment agency)	~15 000-20 000
The Swedish Crime Survey (NTU)	BRÅ (Swedish national crime council)	~20 000

Similar questions

SCB/ULF *Have you during the last twelve months been exposed to violence?*

SWEA/AV *Have you been exposed to violence the last 12 months?*

BRÅ/NTU *Did anyone hit or punch or kicked you or expose you to physical violence so you got hurt last year?*

Violence prevalence

Data	Women	Men	All
The Swedish population's living conditions (SCB/ULF)	3,6	1,7	2,6
The Work Environment (AU/SWEA)	18	10	14
The Swedish Crime Survey (NTU)	1,8	1,2	1,5

What can explain the differences?

The major differences reflects the importance of the definition and context, for the victim's understanding of what is regarded as violence.

The National Crime Council (BRÅ) captures fewer events, perhaps because many people maybe not connect the violence they are subjected at work as a crime.

Work Environment Authority captures more incidents.

Conclusions

- Levels aren’t of so much use but trends can be used to see patterns.
- Context is important. We don’t know what kind of violence the victims have been exposed to.

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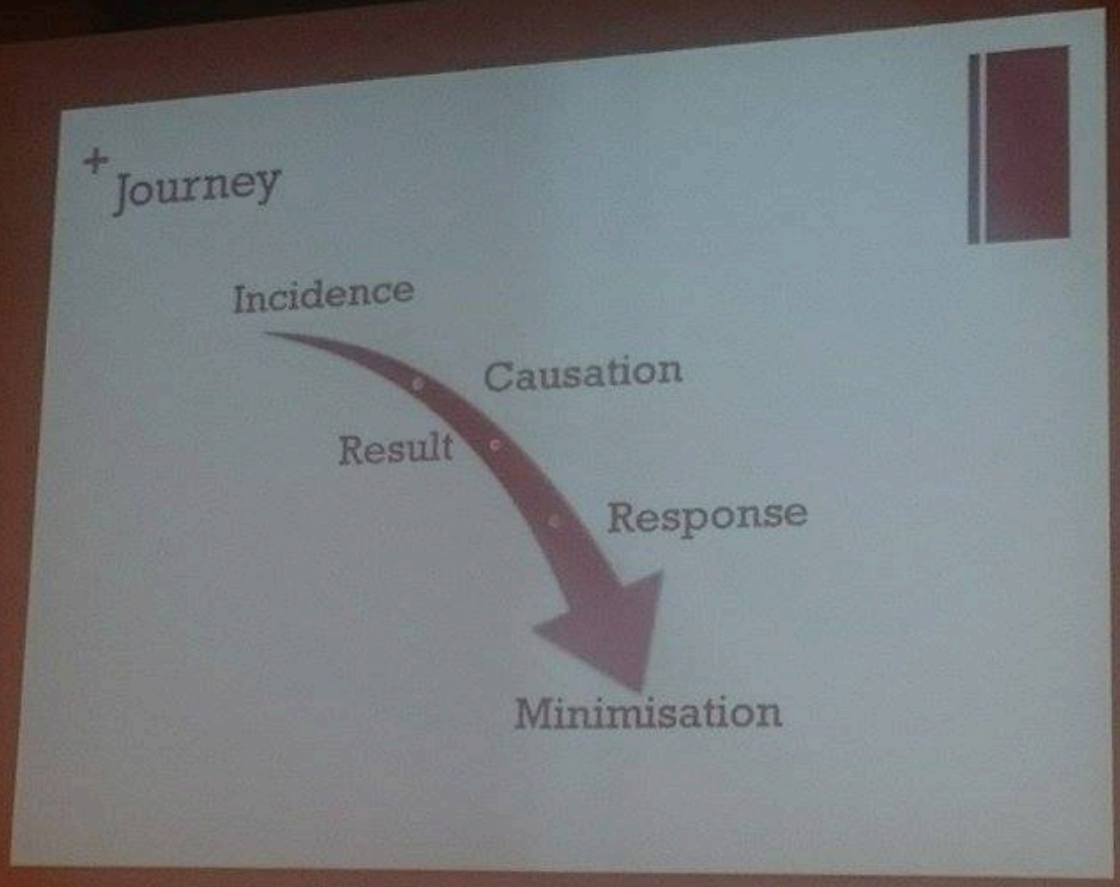
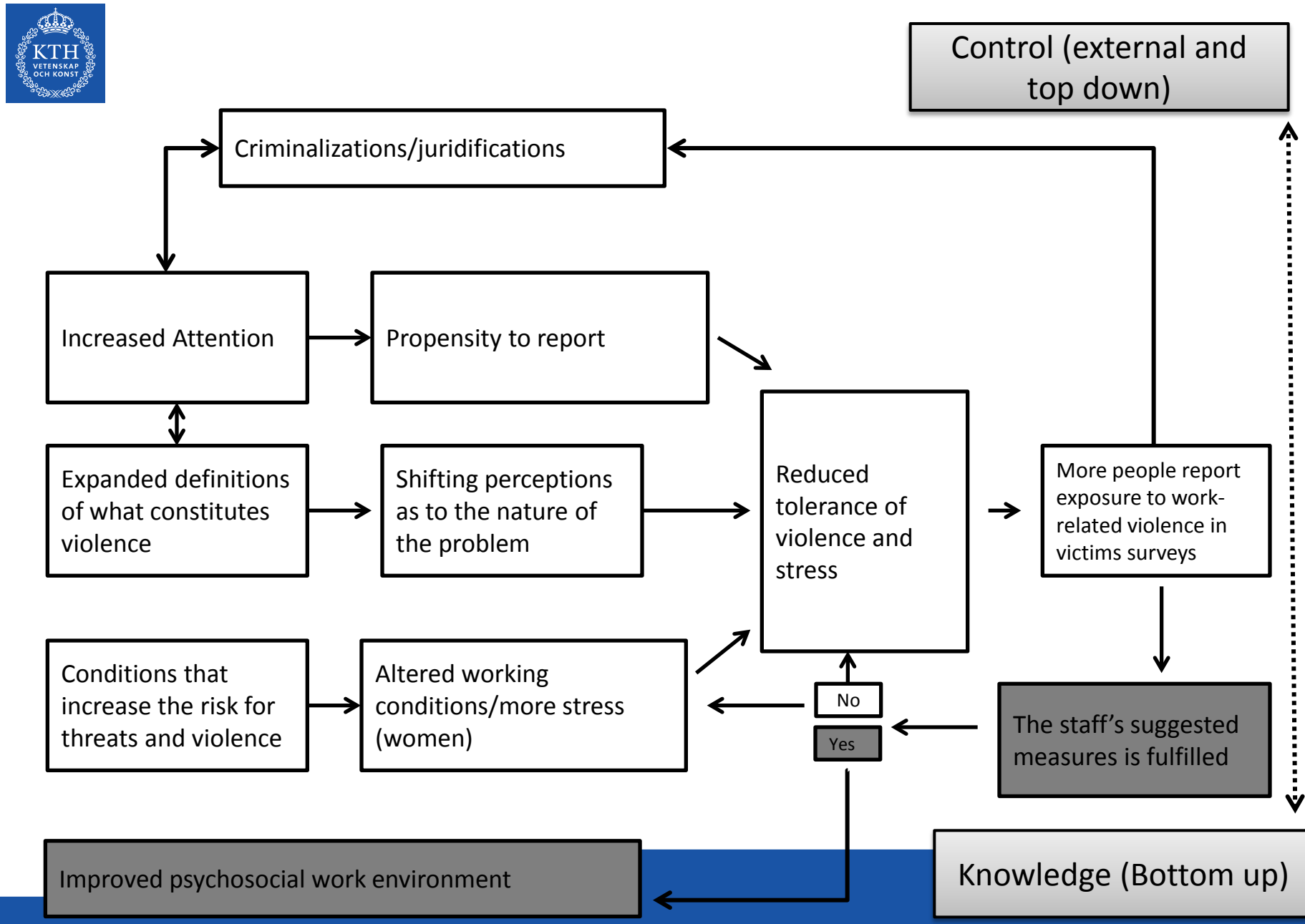
The next step?


+ Journey
Incidence
Causation
Result
Response
Minimisation


Control (external and top down)
Criminalizations/juridifications
Increased Attention
Propensity to report
Expanded definitions of what constitutes violence
Shifting perceptions as to the nature of the problem
Reduced tolerance of violence and stress
More people report exposure to work-related violence in victims surveys
Conditions that increase the risk for threats and violence
Altered working conditions/more stress (women)
No
Yes
The staff's suggested measures is fulfilled
Improved psychosocial work environment
Knowledge (Bottom up)

Post doc researcher at Royal Institute of Technology, (KTH) department of philosophy

We have come to know more and more about less and less (p.23).

Owen Barfield, 20th Century philosopher

The Rediscovery of Meaning

Cognition and sociotechnical complex systems

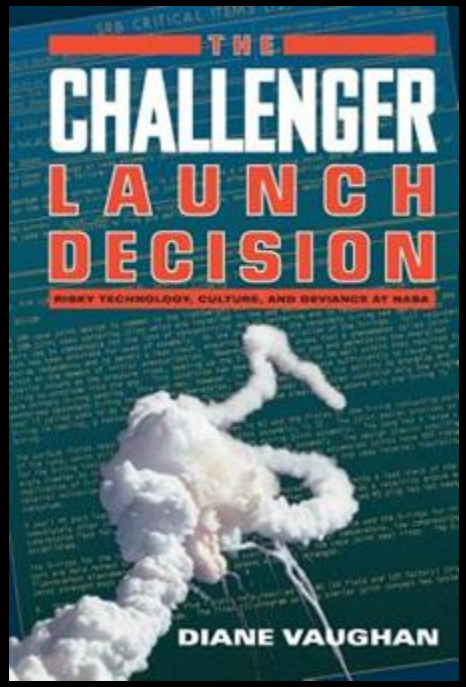
From the ”Banality of Evil” to the ”Banality of Accidents”

Banality of accidents means that the vulnerable conditions, rule transgressions or mistakes were not unique to that event or had no demonstrable causal connection to that partcular outcome.

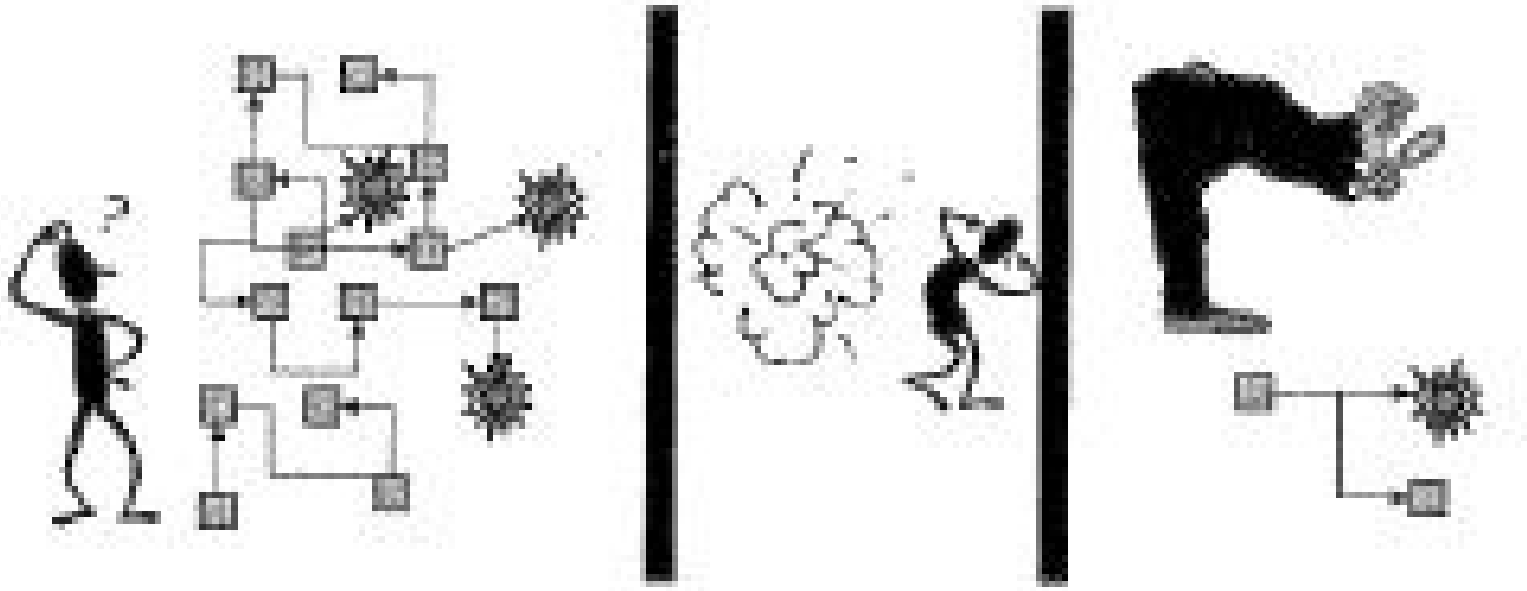
The Challenger launch decision

"Mistake, mishap and disasters are socially organized and systematically produced by social structures. No extraordinary actions by individuals explain what happened: no intentional managerial wrongdoing, no rule violations, no conspiracy. The cause of the disaster was a mistake embedded in the banality of organizational life and facilitated by an environment of scarcity and competition, an unprecedented, uncertain technology, incrementalism, patterns of information, routinization, organizational and interorganizational structures"

(Vaughan 1996:xiv)24

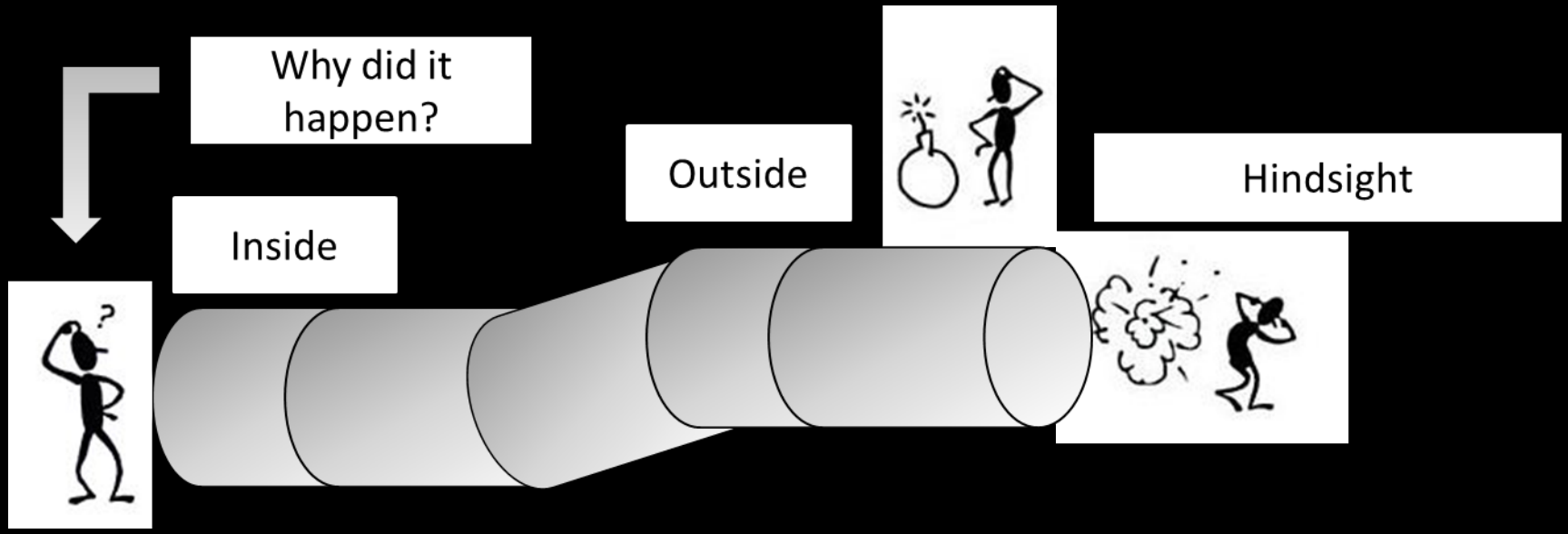


“Accidents come from relationships, not broken parts”



So what is the cause of the accident? This question is just as bizarre as asking what the cause is for not having an accident. There is no single cause. Neither for failure, nor for success. In order to push a well-defined system over the edge (or to make it work safely), a large number of contributory factors are necessary and only joint sufficient (Sidney Dekker 2006:80)

Hindsight bias



If there is not "Eureka part" to point to, no agent to whose mistake events can be attributed, then it becomes difficult to hold people accountable (Sharpe 2004)

Lack of terminology to address the experience of the victims.

The second victim

Secondary victimisation relates to further victimisation following on from the original victimisation. For example, victim blaming, inappropriate post-assault behaviour or language by medical personnel or other organisations with which the victim has contact may further add to the victim's suffering.

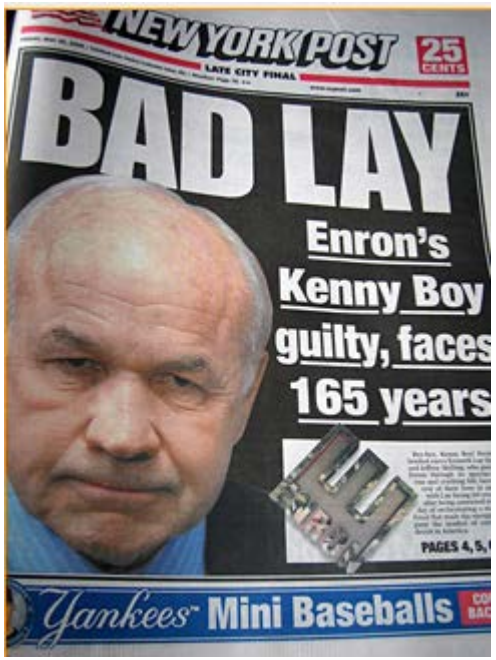
Victims may also experience secondary victimisation by justice system personnel upon entering the criminal justice system.
Victims will lose time, suffer reductions in income, often be ignored by bailiffs and other courthouse staff and will remain uninformed about updates in the case such as hearing postponements, to the extent that their frustration and confusion will turn to apathy and a declining willingness to further participate in system proceedings.

The re-traumatisation of the sexual assault, abuse, or rape victim through the responses of individuals and institutions is an example of secondary victimisation..

The ideal victim?

Aung San Suu Kyi

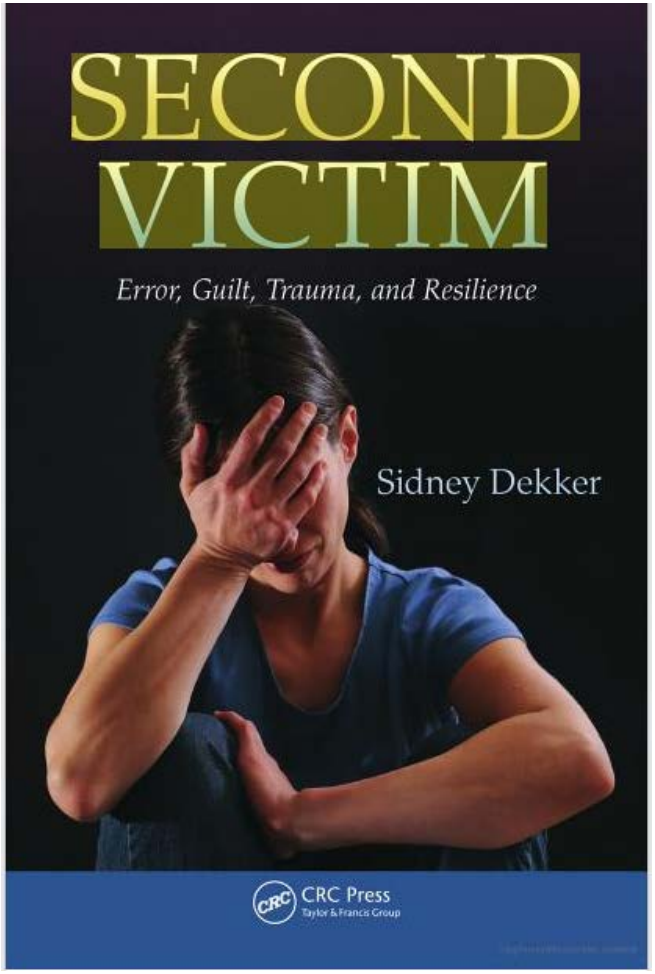
The ideal perpetrator?



Prosecuting professional mistake. Secondary victimization, accountability and organizational learning.

Secondary victimization refers to professionals involved in the incident/accident by turning him or her into a criminal suspect, a problem that could borrow from research in victimology but that seems hampered by several practical as well as theoretical obstacles.

Notion of blame or individual responsibility are often problematic to apply in this area, because ‘root’ or probable cause to accidents is potentially unhelpful in the context of complex systems.



The idea of digging deeper into the circumstance and environment that an engineer found themselves in is called looking for the “Second Story”

First Stories	***Second Stories***
Human error is seen as cause of failure	Human error is seen as the effect of systemic vulnerabilities deeper inside the organization
Saying what people should have done is a satisfying way to describe failure	Saying what people should have done doesn’t explain why it made sense for them to do what they did
Telling people to be more careful will make the problem go away	Only by constantly seeking out its vulnerabilities can organizations enhance safety

Swedish Economic Crime Authority – their first case

Porrdrottningen i rätten i morse

Porrkungen Carl Serung skulle mördas av sina rivaler. Det avslöjade hans förra fästmö, när rättegången fortsatte mot henne i dag.

Med sorgsen blick och med en vass tunga berättade den 24-åriga porrdrottningen i morse vad som egentligen hände på porrklubbarna.

Det började med en annons i Dagens Nyheter:

– Våren 1993 svarade jag på annonsen och fick jobb på Cabaret Royal. Jag dansade och tog hand om gästerna. Det var så jag kom i kontakt med Carl Serung.

– Verksamheten gick i en berg-och-dalbana. Ibland var det höga intäkter, ibland gick de ner.

PORRDROTTNINGEN HÖRDES AV RÄTTEN I DAG Carl Serungs förra fästmö hördes av rätten i dag. ”Carl Serung skulle mördas”, avlöjade hon i den fullsatta rättssalen. Foto: RICKARD KILSTRÖM

Ekobrottsmyndigheten
Swedish Economic Crime Authority

http://www.nytimes.com/2015/01/25/world/africa/mosquito-nets-for-malaria-spawn-new-epidemic-overfishing.html?_r=0#slideshow/100000003439608/100000003439612

Traincrash in Saltsjöbaden 2013

Sara, 22, talar ut om tågkraschen i Saltsjöbaden

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- Ja
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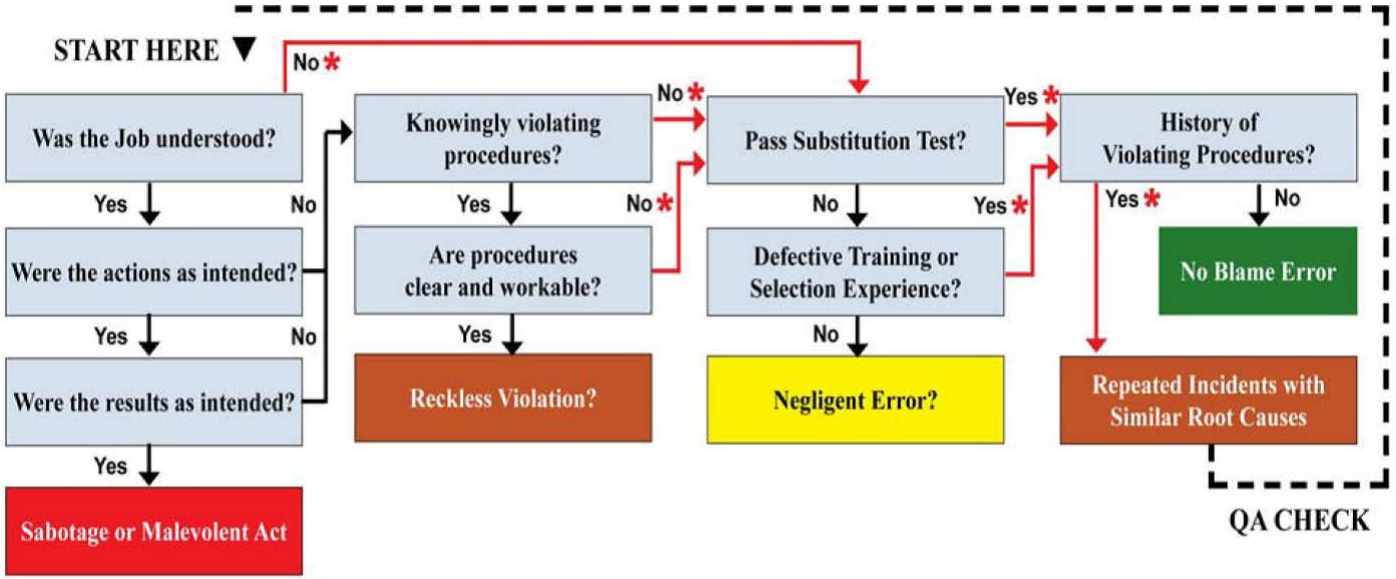
RÖSTA

"Just Culture" Decision Tree

Rules of Fair Play for Managers



* Indicates a "System" induced error. Manager/Supervisor must evaluate what part of the system failed, and what Corrective and Preventative Action is required.

From riskperception to variability

We have through centuries become so accustomed to explaining accidents in terms of cause-effect relations – simple or compound – that we no longer notice it. And we cling tenaciously to this tradition, although it has becomes increasingly difficult to reconcile with reality.

Risk and safety analyses should try to understand the nature of everyday performance variability and how this lead to both positive and adverse outcomes.