Secondary victimization of professionals accused of white-collar crime

Sofia Wikman, PhD, Criminology
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
DISGUSTING. OFFENSIVE. STUPID.
“LIVE ACTION VERSION OF SOUTH PARK”
A FILM BY UWE BOLL

POSTAL
BETWEEN THE VIOLENT AND ABUSEFUL FRONT "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

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

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

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
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

Nurses had no respect or care

Robert Francis QC this afternoon opened his report into appalling neglect at Stafford Hospital. The original statement on the scandal

“Patients were not treated as individuals”

Betrayed

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.

There was evidence of a "culture of secrecy" as "healthcare was compromised at the expense of patients’ safety and dignity." Despite the evidence of the inquiry, "patients were not treated as individuals".

"It seems that the important thing was that the standards of care were being maintained and that the targets were being met".

"This is a wake-up call for all hospitals to the importance of patient safety and the need to prioritise it above all else."
# Victim surveys about workplace violence

<table>
<thead>
<tr>
<th>Survey</th>
<th>Producer</th>
<th>Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Swedish Population’s Living Conditions (ULF)</td>
<td>SCB (Statistics Sweden)</td>
<td>~6 000</td>
</tr>
<tr>
<td>The Work Environment (AU)</td>
<td>SWEA (Swedish work and environment agency)</td>
<td>~15 000-20 000</td>
</tr>
<tr>
<td>The Swedish Crime Survey (NTU)</td>
<td>BRÅ (Swedish national crime council)</td>
<td>~20 000</td>
</tr>
</tbody>
</table>
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

<table>
<thead>
<tr>
<th>Data</th>
<th>Women</th>
<th>Men</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Swedish population’s living conditions (SCB/ULF)</td>
<td>3,6</td>
<td>1,7</td>
<td>2,6</td>
</tr>
<tr>
<td>The Work Environment (AU/SWEA)</td>
<td>18</td>
<td>10</td>
<td>14</td>
</tr>
<tr>
<td>The Swedish Crime Survey (NTU)</td>
<td>1,8</td>
<td>1,2</td>
<td>1,5</td>
</tr>
</tbody>
</table>
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.
The next step?
Journey

Incidence

Causation

Result

Response

Minimisation
Control (external and top down)

More people report exposure to work-related violence in victims surveys

The staff’s suggested measures is fulfilled

Knowledge (Bottom up)

Improved psychosocial work environment

Yes

No

Reduced tolerance of violence and stress

Shifting perceptions as to the nature of the problem

Altered working conditions/more stress (women)

Conditions that increase the risk for threats and violence

Expanded definitions of what constitutes violence

Propensity to report

Increased Attention

Criminalizations/juridifications
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
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 particular outcome.
“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)
“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)
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”

<table>
<thead>
<tr>
<th>First Stories</th>
<th>Second Stories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human error is seen as cause of failure</td>
<td>Human error is seen as the effect of systemic vulnerabilities deeper inside the organization</td>
</tr>
<tr>
<td>Saying what people should have done is a satisfying way to describe failure</td>
<td>Saying what people should have done doesn’t explain why it made sense for them to do what they did</td>
</tr>
<tr>
<td>Telling people to be more careful will make the problem go away</td>
<td>Only by constantly seeking out its vulnerabilities can organizations enhance safety</td>
</tr>
</tbody>
</table>
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 porrdröttningen i morse vad som egentligen hände på porrklubbarna.

Det började med en annons i Dagens Nyheter:

– 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
Traincrash in Saltsjöbaden 2013

Sara, 22, talar ut om tågkraschen i Saltsjöbaden
"Just Culture" Decision Tree
Rules of Fair Play for Managers

START HERE ▼

- Was the Job understood?
  - Yes
  - No *

- Were the actions as intended?
  - Yes
  - No

- Were the results as intended?
  - Yes
  - No

- Knowingly violating procedures?
  - Yes
  - No *

- Are procedures clear and workable?
  - Yes
  - No *

- Reckless Violation?
  - Yes *
  - No

- Pass Substitution Test?
  - Yes *
  - No

- Defective Training or Selection Experience?
  - Yes *
  - No

- Negligent Error?
  - Yes
  - No *

- History of Violating Procedures?
  - Yes *
  - No

- Repeated Incidents with Similar Root Causes
  - No Blame Error

QA CHECK

Increasing Individual Culpability / Diminishing Individual Culpability

- Severe Sanctions
- Final Warning and Negative Performance Appraisal
- First Written Warning
- Coaching / Greater Supervision Until Behaviour is Corrected
- Documented for the Purpose of Prevention Awareness and Training will Suffice

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