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Early interventions following exposure to traumatic events - psychological debriefing and the law

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Cases: Walker v Northumberland CC [1995] 1 All E.R. 737 (QBD)

Sutherland v Hatton [2002] EWCA Civ 76; [2002] 2 All E.R. 1 (CA)

Howell v State Rail Authority of New South Wales (Unreported, May 7, 1998) (Sup Ct (NZ))

**J.P.I. Law 225* Abstract

In this article Kay Wheat and Stephen Regel discuss the effectiveness of early psychological debriefing for people exposed to traumatic events and analyse the legal liability that may lie where such intervention is either not provided or is provided negligently.

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Introduction

Over the past two decades, it has been well recognised that traumatic events such as rape, serious physical assault, road traffic accidents, natural and manmade disasters, ethnic conflict and combat experience, can lead to the development of severe psychiatric conditions such as Post Traumatic Stress Disorder (PTSD). The concept of PTSD was first officially recognised as a serious mental health problem in 1980 when it was first included in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* [1] one of the two main psychiatric diagnostic handbooks. The diagnostic criteria were revised in 1987 and underwent a further revision in 1994.[2] The text was revised in 2000, but not significantly to affect the diagnostic criteria of PTSD. The current edition, DSM-IV-TR, states that in order to meet the diagnostic criteria of PTSD, the requirements are:

“The development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or physical injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate.”[3]

**J.P.I. Law 226* In addition, the person has been exposed to a traumatic event in which both the following were present:

“Criterion A: (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of others and (2) the person's response involved intense fear, helplessness, or horror. Furthermore, three distinct groups of symptoms are known to arise following a traumatic event: Criterion B, re-experiencing intrusive imagery; Criterion C, avoidant and Criterion D, arousal symptoms. In order to fulfil the diagnostic criteria of PTSD, the individual must experience at least one (or more) symptoms from B, at least three (or more) from C and at least two (or more) from D.”[4]

In a European context, the main diagnostic handbook for psychiatric disorders, the International Classification of Diseases (ICD-10),[5] also recognises the diagnosis of PTSD, albeit with some differences in emphasis (both systems are in use worldwide, the ICD-10 is in current clinical use in the UK, but the DSM-IV-TR is also often used for research and medico-legal purposes). Whilst there continue to be arguments regarding the conceptual validity of PTSD[6] and controversy about issues of

compensation, it is now almost universally accepted that PTSD is a specific disorder and distinct from other conditions such as depressions or phobias. PTSD has also often been described as a “normal reaction to an abnormal event”, the implication being that symptoms of PTSD are indicative of normal processes. This can be a major issue however, as if this were the case, than the prevalence would undoubtedly be much higher. Joseph[7] argues that whilst PTSD provides a useful framework for conceptualising psychological reactions to trauma, they also advocate that the symptoms of PTSD should be viewed as indicative of unresolved processing of the traumatic event.

The development of Psychological Debriefing (PD)

Psychological Debriefing (PD) or “Critical Incident Stress Debriefing” (CISD), was originally developed and formulated for use with emergency services personnel. Essentially based on a crisis intervention model, developed by Mitchell,[8] the technique was further articulated and refined by Dyregrov[9] who coined the term “Psychological Debriefing” (PD). These two terms are often used interchangeably to describe the same process. For the purposes of clarity in this paper and in the context of the recent British Psychological Society's (BPS) Report by the Professional Practice Board into the subject, entitled “Psychological Debriefing”,[10] PD will be used throughout.

Dyregrov defined Psychological Debriefing (PD) as:

J.P.I. Law 227 “…a group meeting arranged for the purpose of integrating profound personal experiences both on the cognitive, emotional and group level, and thus preventing the development of adverse reactions.”

PD represents a structured form of group crisis intervention and represents a discussion and review of the traumatic event or critical incident. The most common current model of PD is facilitated through a series of seven phases. The only differences between Mitchell and Dyregrov are that they use different terminology for some of the phases.

Mitchell's stages of PD	Dyregrov's stages of PD
1. Introduction	1. Introduction
2. Facts	2. Facts
3. Thoughts	3. Thoughts (and expectations)
4. Reactions	4. Reactions (and sensory impressions)
5. Symptoms	5. Normalisation
6. Teaching	6. Future planning and coping
7. Re-entry	7. Disengagement

Stages of Psychological Debriefing

It typically takes 1.5-3.0 hours to facilitate and is usually held 2-14 days post incident. The aim of PD is also to provide education about normal and pathological reactions to traumatic events, indicate resources for further help and support if necessary and facilitate the process of psychological “closure” upon the traumatic incident. Both Mitchell and Dyregrov have always maintained it was never intended as a “stand alone” intervention or as a substitute for psychotherapy.[11] However, the most significant factor in the controversy that was to follow its widespread use was the assertion that it could prevent the development of PTSD.

An extensive review of the literature on work place trauma and its management carried out by the Institute of Employment Studies for the Health and Safety Executive[12] described research that examined psychological outcomes relating to emergency work. Studies have examined the impact of exposure to traumatic events in ambulance service workers,[13] firefighters[14] and police officers.[15] PD or variants of the model is now widely used not only with emergency service personnel,[16] the armed

forces,[17] aid agencies,[18] but in a variety of other situations where individuals or groups ***J.P.I. Law 228*** have been exposed to traumatic events, such as post office workers,[19] mental health professionals[20] and victims of violent robbery.[21]

The controversy over Psychological Debriefing

Over the past two decades PD has been widely used with the emergency services and a number of other survivor and professional groups in the US, Australia, New Zealand, Scandinavia and throughout Europe, including the UK. However, in 1994, the first doubts and questions were raised about the efficacy of PD, with calls for more research into its application, using randomised controlled trials.[22] Finally the results of two randomised controlled trials were published. The studies were carried out with burn trauma victims[23] and injured road traffic accident survivors.[24] Both studies demonstrated negative effects among the intervention groups. Furthermore, the influential Cochrane Review, a systematic (but selective) review of the published literature in this area, concluded:

"There is no current evidence that psychological debriefing is a useful treatment for prevention of post traumatic stress disorder after traumatic incidents. Compulsory psychological debriefing for victims of trauma should cease."[25]

Detractors of PD argued that here at last there was evidence that PD as an early intervention was ineffective and therefore should cease, especially at a time when clinical governance and evidencebased practice are much in vogue. However, the studies were not without their limitations. In the Bisson 1997 study on burn trauma, the authors acknowledged that the vagaries of randomisation meant that all the subjects with the highest levels of subjective life threat, previous psychological morbidity and previous psychological treatment--all factors predictive of poor psychological outcome--ended up in the intervention group. In addition, the authors viewed PD as a treatment and described it as "intense imaginal exposure to a traumatic incident".[26] Imaginal exposure is a psychological treatment technique, which is often used with trauma survivors as part of a comprehensive psychological treatment package.[27] It is a technique that involves the patient reliving the traumatic experience as if it were occurring again, describing their experience in the first person and in the present tense. It is a demanding and anxiety provoking procedure, which is only conducted after careful assessment and consent of the patient within the confines of an established ***J.P.I. Law 229*** therapeutic relationship. Practitioners trained and experienced in the process of PD should not utilise therapeutic techniques. Clearly, this is a significant issue, particularly as PD was never intended as a treatment or counselling strategy. Nevertheless, the notion and concept of counselling has become synonymous with PD, a factor which has only served to cloud the issue further.

The Hobbs 1996 study was also not without limitations. Hobbs and Adshead[28] in a later volume describing the study in detail acknowledged that: "After the first ten subjects, the interventions were undertaken instead by the research assistant. The intervention therefore immediately followed the screening interview, with which it became merged to some degree, and interviewer 'blindness' was inevitably compromised".[29] Therefore, the two most quoted studies casting doubts on the efficacy of debriefing, are methodologically flawed and thus cannot be seen as representative of research in this field.

As the controversy over the provision of PD continued, there were also calls to discontinue its use because of the possibility of litigation. Avery,[30] citing Freckleton,[31] added a further dimension, indicating that issues of legal accountability could influence the debate and suggested that "…the spectre of litigation looms large".[32] Avery and colleagues were also critical of Mitchell and others on a number of fronts, but the possibility of litigation is a crucial one, especially as the studies suggested that providing early interventions following exposure to traumatic events could also have negative effects. This was a factor no doubt influential in the issuing of a press release in June 2000 from the Royal College of Psychiatrists warning against early psychological interventions for victims of road traffic accidents.

Legal Issues

The reference to a serious threat of litigation requires some scrutiny as it is by no means clear why this should be anticipated. There are two ways in which litigation could arise. First, there could be a failure to provide debriefing. In order for this to give rise to legal action it would have to be shown that there was a positive obligation to provide it. Secondly, the "debriefer" might carry out the procedure carelessly, causing the "debriefee" harm, so as to be liable in negligence.

A duty to provide debriefing?

The most obvious context where there might be a positive obligation to provide debriefing is where it forms part of an employer's common law duty to care for the health and safety of its employees, or in analogous situations.[33] An employer owes a tortious duty of care towards its employees in respect of their health and safety, more specifically there is a duty to provide a safe ***J.P.I. Law 230** place of work including safe plant and equipment, competent fellow-employees,[34] and a safe system of work. There is also an implied contractual term that the employer will care for employees' health and safety, although how far this differs (if at all) from the tortious duty is not clear.[35] In *Walker v Northumberland County Council* ,[36] the judge, Colman J., held that, as the duty of care was set in a "contractual framework", there was no need to consider "policy" arguments against imposing such a duty. Whatever the precise relationship, and delineation, between obligations in tort and contract, it is uncontroversial that a duty is owed in respect of mental as well as physical health, and this will give rise to situations where it can be argued that there is an obligation to provide some form of support in suitably serious, traumatic situations. The Court of Appeal conjoined appeal cases of *Sutherland v Hatton* [37] provided guidance on so-called occupational stress cases. The court took a pragmatic view of the employer's obligation, stressing that there are important differences between psychiatric and physical harm occasioned in the workplace. First, the employer is expected to know if there is a risk to the employee's health and safety when this can be externally observed. However, it is less easy to know the precise psychological profile of employees which will affect their approach to their work, the way in which they prioritise and so on, and there is, therefore, far less scope for the employer to control the situation. Similarly, if employees are vulnerable because of events in their personal lives, the employer cannot be expected to be aware of this unless it is brought specifically to its attention. It was also acknowledged that, understandably, employees are not likely to want to present themselves as being vulnerable or unable to cope. For these reasons, the Court of Appeal decided that, in the absence of plain indications of impending breakdown, the employer would not be liable. This is not a licence for an employer to make unreasonable demands upon employees, as, if the demands were unreasonable i.e. if it were foreseeable that such demands would cause a competent and reasonably resilient employee to break down, then the employer would be in breach of the duty of care. Where the breakdown or other psychiatric condition is due simply to the nature of the job, or the way in which the employee has approached the job, then without those plain indications an employer could not be expected to be aware of this.

First, it must be said that none of the cases under consideration concerned employees who had been exposed to sudden trauma. They were all about either heavy workloads or situations where an employee was required to comply with new or varied demands. The court referred to the provision of counselling, but did not go so far as to say that there was any general obligation to provide such services. The situations we are concerned with here are where an employer has not behaved unreasonably; it is simply that the unavoidable nature of the work is stressful. However, it is arguable that if the employee is subjected to some particularly upsetting incident, then support should be provided. In the case of *Re Dassanayake* (CICA: Quantum: 2001)[38] disapproving comment was made when the claimant's health service employer failed to provide counselling after she had been violently assaulted by a patient.

Secondly, it has to be questioned whether an employer is entitled to expect employees to possess a "normal" degree of fortitude or resilience. In the case of *Walker* the claimant was a social worker who had to manage an increasing number of child abuse cases and who persistently asked for some ***J.P.I. Law 231** help. None was forthcoming and he became ill. On returning to work, he was promised some assistance but, again, it did not materialise and he became permanently ill after a second nervous breakdown. Damages were awarded for the second breakdown only because the first was unforeseeable on the basis that there was nothing in Mr Walker's personality to alert his employer to an impending breakdown, and no other employee of the social services department had suffered in this way. The "eggshell skull rule" says that, as long as some damage is foreseeable (as in the second nervous breakdown of Mr Walker), damages can be awarded for excessive damage which results because of the particular vulnerability of that particular employee.[39] However, it could be argued that it is reasonable to expect a degree of robustness in an employee that will vary depending upon the job. The case of *Unwin v West Sussex County Council* [40] concerned a teacher who was awarded damages of £2,500 for the aggravation of her depressive illness by the county council's failure to monitor her condition after being put on notice that she was suffering from stress. If it had been properly monitored she would have been treated more sympathetically. However in *Sutherland v Hatton* [41] the Court of Appeal declined to find that there should be specific systems in place to offer help. The court held that, if it was generally felt that this would be a good thing then it should be put

on a statutory footing. Importantly, however, the court did state that, if there were schemes set up by an employer to offer advice and help on a completely confidential basis then it would be unlikely for that employer to be found liable. Although the case was not about debriefing, by analogy, it is arguable that if competent, confidential debriefing is provided by an employer, it would be unlikely that the employer could subsequently be found to be in breach of the duty of care.

The second type of scenario that is more obviously connected with debriefing is where employees are exposed to a particularly traumatic incident. This was explored in the Australian case of *Howell v State Rail Authority of New South Wales.* [42] The claimant, who was an assistant station master, was, as part of his contractual duties required to supervise the transfer of any injured persons from any incident where an employee or member of the public is injured. A woman threw herself in front of a train and the plaintiff attended the scene. Shortly after completing his duties he received brief telephone calls from a psychologist instructed by the State Rail Authority Rehabilitation Service, but there was never any face-to-face contact. The claimant subsequently suffered from PTSD. He brought a claim against his employer, alleging, first, that he should never have been expected to be exposed to the trauma in the first place; secondly, that, in the event of the first argument failing, he should have received pre-trauma counselling, and thirdly, that the conduct of the psychologist fell below the necessary standard of care. The first two claims were dismissed by the judge, but he upheld the latter. However, of significance is the fact that the whole case proceeded upon the basis that debriefing would have been effective. There does not appear to have been any argument on the part of the rail authority alleging that debriefing is controversial and that there are those who say it is ineffective. The case was successfully appealed on the ground that there had been no evidence given that debriefing would have worked. In consequence, a retrial was ordered. At the retrial, McFarlane, an eminent psychiatrist working in the trauma field, gave evidence that his cognitive behavioural programme should have been offered to the claimant and that this had a 70 per cent success rate. However, McFarlane's proposed therapy is not the same as psychological debriefing. It is almost certain that no English court would decide that employers should provide ***J.P.I. Law 232** something akin to McFarlane's therapy immediately after an employee has been exposed to trauma. In the context of standard of care, if we consider the principle of the “magnitude of the risk”[43] then highly expensive therapy of this nature, provided as a matter of course, would almost certainly not be justified in the light of the risk of development of illness without such therapy. Nevertheless, it is important to note that in Howell, a cognitive behavioural programme was being considered as appropriate as a form of preventative action, as opposed to treatment for the PTSD itself, which many might consider to be the proverbial nut-cracking sledge hammer.

What of people who do not want to participate? If they are employees, are they under some sort of obligation to do so? A refusal would, of course, be relevant to any later claim made by the employee either that the employer had not cared adequately for his or her health and safety (of course, the employee would have to show that the debriefing that had been on offer was in some way defective) *and that some other form of intervention or therapy should have been on offer instead* so it would be a fairly tall order for the employee to succeed on this basis. However, it is unlikely that there could be any positive obligation to participate. It was held in the *Herald of Free Enterprise* arbitrations that it was legitimate for those people traumatised by their experiences to refuse treatment for their PTSD on the basis that the treatment itself would be painful.[44]

Liability in negligence

If debriefing is provided, when might the debriefer be liable for any harm caused to the debriefee? It will be assumed that, if this were to arise at all, it would arise through the negligence of the debriefer (*i.e.* not through deliberate acts). There is little doubt that the debriefer would owe a duty of care,[45] the problematic issues are the appropriate standard of care and causation. Although debriefing is not medical treatment, the nearest analogy that can be found is with psychiatric and psychological treatments for psychiatric disorder. Such cases rarely appear in the case law. Psychiatrists are more likely to be sued because of their role in compulsorily detaining patients under mental health legislation, and their role in administering drug and other treatments, but even here there are relatively few cases, even less so in the field of psychology.[46] However, clearly PD is intended to be therapeutic, even if it is not treatment for a particular psychological disorder, and it is arguable that, in considering the elements of an action in negligence, the courts would follow the pattern set by cases of clinical negligence.

As far as the standard of care is concerned, it is reasonable to suppose that the test is the ubiquitous *Bolam* test[47] (generally, treatment will not be negligent as long as it is an accepted practice) as refined

by *Bolitho v City and Hackney Health Authority* [48] where it was said that even if treatment was supported by a responsible body of medical opinion, if there was no logical basis for carrying out the treatment then the court could reject it as being negligent. Arguably, the fact that debriefing is not medical treatment (it could not be, when there is no diagnosed condition to ***J.P.I. Law 233** treat) makes no difference.[49] It means that the standard is that of the ordinarily competent debriefer acting in accordance with an “accepted practice”. The fact that some debriefers might not have adopted the methods used in a particular case will make no difference; the debriefer will escape a finding of negligence as long as there is a responsible body of opinion which supports the approach taken. However, problems can arise, when one asks precisely who the debriefer might be? Psychological debriefing might be carried out by people from very different backgrounds, for example, psychologists (and, of course, this is a generic term for people with varying degrees of education, training and practical experience), nurses, counsellors and so on. If we are looking for a generic “debriefing background”, then we might look in vain. For example, a number of organisations, such as the police utilise “peer debriefers”. These are often serving police officers and support personnel who are trained to provide PD within their own organisations. This is common practice in many countries such as in the US, Australia and Scandinavia. Will the “responsible body” then relate to the debriefer's own background? For example, if the debriefer is a counsellor who has undertaken a counselling course then it might be thought that the appropriate standard of care is that of the ordinarily skilled counsellor. This might be the case, but it is arguable that the debriefee should be aware of, for example, the counsellor's background and, perhaps relatively limited expertise, and, secondly, that the counsellor should be aware of his or her own limitations.[50]

It is also arguable that the debriefer should comply with the general requirement imposed by the law that sufficient information has to be given to the debriefee about, and risks associated with, the debriefing procedure. Although the implication of the judgments in *Sidaway v Bethlem Royal Hospital Governors* is not entirely clear as far as the *Bolam* test is concerned, it seems clear that the debriefee must be alerted to consequences that are grave and adverse.[51] It is, perhaps, difficult to gain some sort of consensus on the subject of side-effects (could there be any risk of suicide or of severe depression?), and is difficult to apply to the present analysis, but an example of treatment of this sort might be ‘recovered memory therapy’.

As far as the responsible body of professional opinion is concerned, the ‘body’ does not have to be substantial.[52] A debriefer who can garner the support from a respected source should, therefore, be able to avoid liability. A form of PD using internationally recognised models of practice and endorsed by recognised practitioners in the field, or by the British Psychological Society, for example, would satisfy this test. Debriefing procedures might be regarded as ‘innovative’, though given that it has been used for almost two decades, this may no longer be the case. However, it could be argued to be innovative if introduced into an organisation which previously had no such strategies for staff support. In the *Sidaway* [53] case, Lord Diplock said that to use only well-tried, standard practices would stifle the development of medical knowledge and lead to the practice of defensive medicine “with a vengeance”. It has been argued[54] that innovative therapy must be ***J.P.I. Law 234** treated in the same rigorous way in which formal medical research is treated because at least part of the motivation is to test a new form of treatment as well as the hope that it will also make the patient well. If a form of PD was adopted which might be regarded as “innovative” then it might be possible to take the matter a stage further and argue that recovered memory therapy is not intended (or was not) to be therapeutic at all, but merely the testing of a theory. If that were the case it would be pure research and both ethically, and legally, the *Bolam* test would simply not apply and detailed disclosure of the precise nature of the process on offer, must be given to the proposed debriefee. However, it is arguable that this should not give rise to concern, as it can be said that it is standard practice when utilising the models described as above.

To sum up on the standard of care in the debriefing process, it can only be said that precisely because of the controversial nature of PD, proving that a debriefer had failed the “accepted practices test” would be tough. However, if the view were to prevail that, in providing PD, there are no proven benefits, and there are potentially harmful consequences, it might be argued that to use PD *at all* fails the *Bolam* test. This is because, although many practitioners use PD, the only research done in the area shows that, at best, it is ineffective, and at worst is positively harmful. However, as has been highlighted earlier, it could be argued that the studies which sparked the controversy are not only methodologically flawed, but also did not apply the intervention in settings for which it was originally intended. A major problem is the fact that different practitioners of debriefing mean different things by it.

The final hurdle for the claimant to clear in a negligence claim is that of causation. Proving that the

resulting condition, whether it is psychological or physical, was actually caused by the failure to attain the standard of care is difficult in medical negligence cases. Disentangling the original disorder from any subsequent condition and ascribing the difference to the medical intervention is fraught with difficulties. It should also be noted that, if there is an odds on chance that the patient would not have responded to the intervention, *i.e.* would be in the same psychiatric condition as he is now regardless of the carelessness, then, again, causation will not have been proved. The patient cannot argue that he has lost the chance of an opportunity to receive treatment without favourable statistics that he would have benefited from it (*Hotson v East Berkshire Health Authority* [55]).

The current status of Psychological Debriefing as a supportive intervention within organisations

Psychological Debriefing, despite the controversies generated by some of the recent research, has been shown to be an effective form of crisis intervention and support following exposure to traumatic incidents, especially if it is part of a comprehensive Critical Incident Stress Management (CISM) framework, rather than a stand alone intervention. The effectiveness of integrated multicomponent CISM programmes has also been demonstrated through qualitative analyses[56] and empirical investigations.[57] Whilst there is clearly a need for further research for the efficacy and ***J.P.I. Law 235** specific effects of early interventions, such as Psychological Debriefing following exposure to extremely stressful or traumatic events, there seems little evidence to indicate that it should be discontinued in organisations where there are considered policies and protocols for its implementation. In addition, there is evidence that many organisations such as the British Police, the Royal Marines and major aid organisations such as the United Nations High Commissioner for Refugees (UNHCR), the International Federation of the Red Cross (IFRC) and Médecins Sans Frontieres (MSF), are providing early interventions such as PD for personnel following critical or traumatic incidents.

The British Psychological Society's (BPS) recent report on “Psychological Debriefing” has also introduced balance into the debate, concluding that some of the most widely publicized studies were found to be methodologically flawed and that if PD were to be successful, it has to be undertaken by competent practitioners, within an appropriate setting, with support and supervision.

It appears that more research is required to establish the effectiveness of PD, whether it should form part of a wider programme of stress management, and the type of debriefing techniques which are preferable. As far as the law is concerned, case law indicates that the law would not impose a positive requirement on employers to provide PD, save perhaps in an extreme case, but that if it is provided by competent practitioners (albeit it that they might be the employees' peers) then, in the appropriate circumstances, it might be an effective insurance policy against claims for PTSD or other work-related psychiatric disorders.

J.P.I. Law 2003, Dec, 225-235

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1. American Psychiatric Association, *Diagnostic and Statistical Manual for Mental Disorders* (1980) Washington, D.C.

2. American Psychiatric Association, *Diagnostic and Statistical Manual for Mental Disorders* , (4th ed., 1994) Washington, D.C.

3. American Psychiatric Association, *Diagnostic and Statistical Manual for Mental Disorders,* (4th ed., Text Revised , 2000), Washington, D.C.

4. *ibid.*

5. International Classification of Diseases, Version 10 (ICD-10), WHO, Geneva.

6. Summerfield, (2001) “The invention of post traumatic stress disorder and the social usefulness of a psychiatric category” (2001) 322 British Medical Journal, pp.95-98.

7. Joseph, William, and Yule *Understanding Post Traumatic Stress - A Psychosocial Perspective on PTSD and Treatment* (Wiley, Chichester, 1997).

8. Mitchell "When Disaster Strikes - The Critical Incident Stress Debriefing Process" (1983) *jems* 36-39; Mitchell "Development and Functions of a Critical Incident Stress Debriefing Team" (1988a) *jems* 43-46.Mitchell "The History, Status and Future of Critical Incident Stress Debriefings" (1988b) *jems* 47-52.

9. Dyregrov "Caring for Helpers in Disaster Situations: Psychological Debriefing" (1989) *Disaster Management* Vol.2, No.1, 25-30.

10. British Psychological Society, *Psychological Debriefing Report of the Professional Affairs Working Group,* (Leicester, UK, 2002).

11. Mitchell, and Everly, *Critical Incident Stress Debriefing: An operations manual for the prevention of traumatic stress among emergency services and disaster workers.* (2nd ed., revised, Ellicott City, Md.: Chevron Publishing Company, 1996) and Dyregrov, "Psychological debriefing--an effective method?" (1998) *Traumatology-e, The International Electronic Journal of Innovations in the Study of the Traumatization Process and Methods for Reducing or Eliminating Related Human Suffering.*

12. Health and Safety Executive (1998) "From Accidents to Assaults" *Contract Research Report,* 195.

13. Clohessy and Ehlers "PTSD symptoms, response to intrusive memories and coping in ambulance service workers" (1999) 38 *British Journal of Clinical Psychology* 251-265.

14. Regel, and Woodward "An Audit of Operational, Organizational and Traumatic Stressors in Firefighters and Control Room Staff" (2002) Fire Brigades Union, Surrey.

15. Brown and Campbell, *Stress and Policing - Sources and Strategies* (Wiley, Chichester, 1994).

16. Mitchell and Dyregrov, "Traumatic Stress in Disaster Workers and Emergency Personnel: Prevention and Intervention". in *International Handbook of Traumatic Stress Syndromes* (Wilson and Raphael eds, Plenum, New York, 1993).

17. Deahl, Srinivasan, Jones, Thomas, Neblett and Jolly "Preventing psychological trauma in soldiers: The role of operational stress training and psychological debriefing" (2000) 73 *British Journal of Medical Psychology* 77-85.

18. Armstrong, O'Callahan and Marmar, "Debriefing Red Cross Disaster Personnel: The Multiple Stressor Debriefing Model" (1991) *Journal of Traumatic Stress* Vol.4, No.4, 581-584.

19. Tehrani and Westlake "Debriefing individuals affected by violence" (1994) *Counselling Psychology Quarterly,* Vol.7, No.3, 251-259.

20. Flannery and Penk, "Program Evaluation of an Intervention Approach for Staff Assaulted by Patients: Preliminary Inquiry" (1996) *Journal of Traumatic Stress* Vol.9, No.2, 317-324.

21. Richards, "A field study of critical incident stress debriefing versus critical incident stress management" (1996) *Journal of Mental Health,* Vol.10, No.3, 351-362.

22. Raphael, Meldrum and McFarlane, "Does debriefing after psychological trauma work?" (1995) 310 *British Medical Journal* 1479-1480 and Bisson and Deahl, "Psychological Debriefing and Prevention of Post-Traumatic Stress" (1994) 165 *British Journal of Psychiatry* 717-720.

23. Bisson, Jenkins and Alexander, "Randomised controlled trial of psychological debriefing for victims of acute burn trauma" (1997) 171 *British Journal of Psychiatry* 78-81.

24. Hobbs, Mayou and Harrison, "A randomised controlled trial of psychological debriefing for victims of road traffic accidents" (1996) 313 *British Medical Journal* 1438-1439.

25. Wessely, Rose and Bisson, "A systematic review of brief psychological interventions ('debriefing') for the treatment of immediate trauma related symptoms and the prevention of post traumatic stress disorder" (1998) *The Cochrane Library,* Issue 4, Oxford: Update Software.

26. Bisson, Jenkins and Alexander, *op.cit.,* n.25, at p.80.

27. Richards and Lovell, "Cognitive behavioural therapy for PTSD" in *Post-Traumatic Stress Disorders: Concepts & Therapy* (Yule ed., Wiley, Chichester, 1999)

28. Hobbs and Adshead, "Preventative psychological intervention for road crash survivors" in *The Aftermath of Road Accidents.* (Mitchell ed. Routledge, London, 1997).

29. *ibid.,* p.167.

30. Avery, King and Bretherton, “Deconstructing psychological debriefing and the emergence of calls for evidence based practice” (1999) *ESTSS Bulletin* Vol.6, No.2, pp.7-11.

31. Freckleton, “Critical Incident Stress Intervention and the Law” (1998) 6 Journal of Law & Medicine 105-113.

32. Avery, *op.cit.,* n.32 at p.8.

33. Although technically police officers are not “employees”, for these purposes they can be regarded as such (see *White v Chief Constable of South Yorkshire Police* [1999] 2 A.C. 455). It might also be arguable that, in the face of a large scale disaster, there might be some obligation on statutory bodies to provide some kind of support to members of the public generally, who are most affected by it.

34. Employers will, of course, be vicariously liable if their own employees are negligent in the provision of debriefing; if the employer uses an independent contractor there will not normally be liability unless there is some form of culpability in their original or continuing choice of provider.

35. Lord Hoffmann stated in *White* (*op.cit.* , n.32) at 505 that “contractual liability obviously raises different questions”.

36. [1995] 1 All E.R. 737.

37. [2002] 2 All E.R. 1.

38. [2001] 5 Q.R. 10.

39. See, for example, *Brice v Brown* [1984] 1 All E.R. 997.

40. 2001 WL 825227.

41. Cited above, n.38.

42. This unreported case was before the Supreme Court of New South Wales on June 7, 1996; the Court of Appeal NSW on December, 19, 1996 and the Sup Ct NSW May 7, 1998.

43. See *Read v J Lyons & Co Ltd* [1947] A.C. 156. The general principle is that the greater the risk of significant harm then the more the defendant must guard against it happening.

44. The *Herald of Free Enterprise* arbitrations first appeared in the *Personal and Medical Injuries Law Letter* , published by Legal Studies and Services, June 1989.

45. There might, of course, be primary liability on the part of the employer of the debriefer if the debriefer has been given no, or inadequate training.

46. For an example see *Haines v Bellimissio* (1978) 82 DLR (3d) (Ontario High Court).

47. *Bolam v Friern Hospital Management Committee* [1957] 1 W.L.R. 582.

48. [1997] 4 All E.R. 771.

49. The *Bolam* test applies to professional people generally; McNair J. referred to those who have “some special skill or competence”.

50. The general principle that inexperience is no excuse, however, remains (*Wilsher v Essex Area Health Authority* [1987] Q.B. 730, Court of Appeal.

51. *Sidaway v Bethlem Royal Hospital Governors* [1985] A.C. 871.

52. *Defreitas v O'Brien* [1995] 6 Med. L.R. 128. In that case the court held that, out of a dozen specialists in the UK, three of them (including

the defendant doctor) could constitute a responsible body of medical opinion.

53. Cited above, n.52.

54. See Kennedy and Grubb, *Medical Law* , (London: Butterworths, 2000) p.1686. Generally it is thought that the obligation to disclose information to research participants is more stringent than in medical treatment (see for example, Royal College of Physicians, *Guidelines on the Practice of Ethics Committees in Research Involving Human Subjects,* (London: RCP, 1989).

55. [1987] 1 A.C. 750 HL.

56. Everley, Flannery, and Mitchell "Critical Incident Stress Management: A Review of the Literature" (2000) 5 *Aggression and Violent Behaviour. A Review Journal* 23- 40.

57. Flannery and Penk, "Program Evaluation of an Intervention Approach for Staff Assaulted by Patients: Preliminary Inquiry" (1996) *Journal of Traumatic Stress* Vol.9, No.2, 317-324 and Flannery "The Assaulted Staff Action Programme (ASAP) and Declines in Assaults: A Meta Analysis" (2000) 2 *International Journal of Emergency Mental Health* , 143-146.

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