Light at the end of the tunnel

No amount of training, planning or risk assessing can mitigate for incidences of workplace fatalities. Each incident is unique, as are the people involved but do people really understand the after affects?

PTSD (post-traumatic stress disorder) is a familiar term nowadays but the approach and delivery of treatment rarely lends itself to a simple, single approach. NICE's (National Institute for Health and Care Excellence) guidelines on the disorder suggest that EMDR (eye movement desensitisation and reprocessing) is its preferred choice. Other bodies recommend a course of CBT (cognitive behavioural therapy) but do these treatments go far enough and deal with all aspects of recovery?

Sharon Hall, SAS (Staff Absence Solutions) director, said: 'Immediate access and a fluid approach to treatment are crucial when assisting people back to normal life. The therapy offered should be whatever the person responds to, integrating modern psychological and physiological therapies to address all aspects of their condition.'

Incidents of railway fatalities occur around 300 times a year – or five times a week – and the trend shows an increase year on year. Each incident sets off a chain reaction, resulting in emotional upset for those involved, their families and friends, colleagues and, of course, their employers due to diminished performance and absenteeism.

Speaking of the experience that he has gained while at SAS, Mark Eastwood, director, said: 'After a 15-year railway career, my role within SAS has given me a valuable insight into the rehabilitation of people involved in incidents of fatality. I now understand that the rehabilitation of those involved can be improved dramatically with a different, more personal approach to treatment.'

Case study

Following an incident, a driver was referred by his employer on the same day and, at the driver's request, treatment began two weeks' afterwards.

On initial presentation, the driver was hostile and guarded. He was reluctant to engage in any therapy and wanted assurance of confidentiality, insisting that the therapist did not take any notes at any stage of the treatment.

The consultation revealed an incident years earlier at the same location, from which the driver had no side effects, resuming his post within 48 hours. This made the driver angry because he could not understand why this occasion had affected him differently.

Following the latter incident, he was experiencing flashbacks of a decapitated body and felt that he could not function normally, drive his car, travel by train or go near the railway. His relationship with his family was starting to deteriorate and he was suffering from insomnia.

Asking if the therapist ever had to tell their family that they had killed someone, the driver described the vivid flashbacks as a constant interruption, whether he was with his family or attempting tasks around his home. He felt helpless and said the incident had turned his life upside down.

Using a number of modern psychological techniques, the SAS therapist identified all of the issues affecting his life post-incident and addressed them. They began with the driver's insomnia, which is an important part of any rehabilitation.

At each subsequent appointment, the therapist was able to discuss the steps of rehabilitation and, as the driver gained an understanding of his condition, he was able to identify the changes being made. He realised that there were a number of differences between the two incidents, which lead to a heightened state of awareness on the second occasion, causing the long-lasting after-effects.

The SAS therapist was able to quickly assess the driver's state and deliver reactive therapy to assist with his shock, helplessness, guilt, insomnia, anger, headaches and trauma. His treatment then became proactive: addressing fear, loss, anxiety and stress. The driver also experienced back-pain, which was resolved by a physiological therapist.

Throughout the treatment the SAS therapist worked with the driver's GP to end his reliance on prescribed drugs. His feedback at the end of his treatment was simple: 'You fixed me'. Rehabilitation was completed in 18 days and the driver was passed as fit to resume his full duties by an OHS (Occupational Health Service) doctor.

What else should be considered?

Each company involved in incidents of this nature will have their own policies and procedures to manage the investigation but consistency and more care for those involved would inevitably ease the process and deliver benefits all round. Liaison between the Toc, their OHS, human resources, EAP (employee assistance programme) and other agencies involved, such as the British Transport Police, would result in a consistent rail management approach across the industry, considered best practice, and adopted by all.

To reach this point, the following questions should be considered:

- who was actually involved? (This should not be limited to those who were involved directly with the incident, but others who attended the scene or were part of the investigation)
- is the incident high profile and covered by the national press?
- is the deceased known to those involved?
- are there any outside influences, such as issues at work or home?
- how is the general wellbeing of those involved?
- are those involved experienced or new to the role?
- have they been involved in previous incidents?
- was the incident at the start or end of their shift?
- were they working a rest day or overtime covering a colleague?
- was the scene of the incident turned into a shrine?
- has the family of the deceased attempted to, or made contact with those involved?
- has there been a reaction due to being a witness at Coroner's Court?
- is there any previous trauma unattached to the incident that has been revisited?
- did they attend the body at the incident?
- was there any mechanical failure or damage to the train as a result of the incident?
- was there a death or is the person still alive?
- are those involved affected by peer pressure or mess-room banter?
- was the incident a suicide, trespass or accident?
- are prescriptive drugs prolonging the rehabilitation and adding to the symptoms?
- do the employees involved fear for their job?

Symptoms of PTSD

Psychological: Stress, anxiety, depression, guilt, loss, hallucinations, insomnia, fear, helplessness, loss of motivation, shame, nightmares, avoidance, anger, irritability, phobia, drug/alcohol abuse.

Physiological: Muscular pain, IBS, tinnitus, sweating, trembling, headaches, dizziness and stomach aches.

What should treatment look like?

Staff Absence Solutions is of the opinion that treatment must be independent and confidential throughout and must be fluid to reflect progress made at each appointment with a therapist. If consultation fails to identify all of the facets involved, the recovery would be either incomplete or unnecessarily slow, causing additional issues at the time of the treatment, or in the future.

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Assistance should be offered immediately so that those involved understand that support is there when they need it most. This would reduce the reliance on prescriptive drugs, help people understand their condition and provide the strategies they need to cope with their symptoms, until they are back to normal life and return to work.

There is no doubt that there is change happening. The rail industry is taking a lead in the management of PTSD. It can accomplish even more by considering modern, leading-edge therapies to invest in the health and wellbeing of their employees and return them back to normal life. There is still work to be done and SAS will continue to pioneer a renewed approach.

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