Abstract: While the number of officer involved shootings to officer encounters with the public is actually very low, any officer involved shooting can bring tremendous stress to the officer, family members, and community. For that reason, a review of literature of officer training, officer policies, and successful interventions was conducted in order to enlighten healthcare providers on how best to assure primary, secondary, and tertiary prevention. Officers and former officers were interviewed to obtain anecdotal evidence that supported the published literature. Recommendations would be that healthcare providers learn more about officer involved shootings from the officers’ viewpoint in order to best care for the officers, their families, and their community.

Keywords: “Officer-involved shootings,” “Forensic nursing,” “Law-enforcement assisted suicide”

If one were just to watch the news, one would believe that there was an epidemic of officer involved shootings in America today. Although there has been an increase in reports of officer involved shootings in the past few years, it is important to put the officer involved shooting issue in context. According to Department of Justice (O’Leary, 2015) statistics, there are over 40 million encounters between law enforcement officers and civilians each year. The Washington Post keeps a scoreboard of how many police shootings occur every year, and by the end of 2016 there were less than 1,000 (Washington Post, 2016). Although one might say that that is too many, it still is a very small percentage of the total encounters. However, it does make examination of the issue an important part of every healthcare worker’s education.

For this reason, it is vital for healthcare providers to examine the officer involved shooting issue from the viewpoint of the officer and from the evidence published in the law enforcement journals. Providers need to understand the training of officers, the folklore that builds a culture around them, and the repercussions of an officer involved shooting in order to best care for officers and their families.

This article will examine the issue from three views: primary prevention, secondary prevention, and tertiary prevention. First, I will examine how healthcare providers can collaborate with law enforcement to reduce the number of officer involved shootings. Second, I will describe the processes that exist that create stress for the officer and the officer’s family after a shooting has taken place and explore how healthcare workers can best support the
entire family. Lastly, I will posit how the healthcare worker and act within the community to reduce violence in general and to help the community recover from a violent incident.

Primary Prevention

Officers do not desire to fire their weapons. The firing of a weapon, whether justified or not, brings with it massive amounts of paperwork, judgment by peers, administrative leave, and self-questioning. Officers fire their weapons primarily to protect themselves and their communities. They fire their weapons when they feel threatened or feel that others are threatened. Blaney (2014) reported that the most frequent victim of officer involved shootings is actually dogs. Why are dogs so frequently shot by officers? They are unpredictable, do not take direction, and are frequently attacking vulnerable populations like children. Healthcare providers have patients who are unpredictable, threaten others, and bully vulnerable populations. Often, these patients are mentally ill and do not understand the implication of their behavior or the significance of the encounter with the officer. Other times, they would profit from some education about gun safety, behaviors that others might consider threatening, and stress management. Healthcare providers have done good work in reducing cavities by teaching dental hygiene, in reducing burns by teaching fire safety, etc. Perhaps it is time we taught our clients about gun safety and safe behaviors when interacting with law enforcement officers.

The Supreme Court of the United States ruled in Tennessee vs. Gardner (1985) that “The use of deadly force to prevent the escape of fleeing misdemeanants and non-dangerous fleeing felons violated the Constitution and was unreasonable but “Where the officer has probable cause to believe that the suspect poses a threat of serious physical harm, either to the officer or to others, it is not constitutionally unreasonable to prevent escape by using deadly force. And if, where feasible, some warning has been given. “This means that if a person is fleeing an officer and that officer suspects that the person might harm others, it is reasonable to use deadly force. Thus, even if the person feels that they are justified fleeing the officer because the crime was petty, the standard that the Supreme Court holds is that the officer must feel the person is a threat to the community in order to shoot. This needs to be taught in our homes and public centers. Fleeing the police is not an option, especially with a weapon.

The Supreme Court of the United States also addressed the idea of “20/20 hindsight” that social media often has by ruling in 1989 that “Reasonableness of officer on the scene at the time supports officers who make split second decisions acting in good faith without malicious or sadistic intent to cause harm, attempting to maintain or restore order, and who were justified in their actions.” In other words, the officer only has to believe that a threat is possible to fire. If the officer later finds out that the gun was a toy gun, the officer may still be justified in using deadly force because that fact was not known at the time. Healthcare workers need to teach the public how to make effective calls to dispatch such as “My son is mentally ill and playing in the park with a toy gun. I am afraid he may frighten someone or get shot accidentally.” It is important to teach those who care for patients with cognitive impairments or substance abuse how to make dispatch calls that fully describe the situation without posing an unnecessary threat to the patient. They need to describe that while the patient is mentally ill, he is not usually violent or can be calmed in a certain way. Using this technique should cause the officer to approach the patient with a thought to de-
escalate rather than confront. Officers focus on fixing the immediate situation, but sometimes need to know if a long-term situation will impact the encounter.

When examining the statistics of officer involved shootings, it is important to note a societal phenomenon called “law enforcement assisted suicide.” Often also called “death by cop,” this is a societal problem in which a suicidal person causes a law enforcement officer to be an unwilling party to the suicide by threatening the officer or community and forcing the officer to shoot. Hatch (2003) in a 10-year study revealed that 13% of all officer-involved justifiable homicides were actually law enforcement assisted suicides. The officer’s duty to protect the public and the officer will supersede the duty to preserve the life of the suspect who is threatening the public. It is important for healthcare professionals to assess for suicidality and treat patients who are suicidal to reduce law enforcement assisted suicides.

Healthcare professionals can work with law enforcement officers to educate them not just on how to work with patients with dementia, but also with the more complex mental illnesses and substance abuse issues. Healthcare professionals are part of a team that can provide useful education to law enforcement to prevent situations from escalating unnecessarily. In some jurisdictions, psychiatric nurses accompany law enforcement officers on calls involving mental health issues. All these interventions can reduce some officer involved shootings.

**Secondary Prevention**

After a shooting, it is a very traumatic situation for the officer and the family. Usually the weapon is taken away as evidence. Jones (1989) described the officers as feeling “castrated” by being stripped of their weapon which symbolizes their professional identity. They are usually isolated alone in a room with a paper and pencil and asked to write down what happened. After a shooting, their memory is distorted and they tend to second guess themselves. They often feel they will be reprimanded, suspended, fired or even tired and sent to jail because of the shooting. They go through a moral self-questioning in which they do not feel like a hero or community servant, but a killer.

After a shooting, officers are very fatigued (Blake & Cumella, 2014), and often given nicotine and caffeine to stimulate them. Because of the flight or fight reaction, the officer may also have a stress response of involuntary urination and defecation, crying, blurred vision, speech impairment, dizziness, tremors, nausea/vomiting, hallucinations and unrealized wounds (Jones, 1989). Their memory is very focused and they tend to remember only what they were paying attention to (Galvin, 2008). In fact, Artwohl (2002) stated that their memories are less of a “flawless videotape” than they expect but instead is based on past experience, is distorted in time, is intuitive and holistic. Although waiting for a few days would make their memory sharper, they are forced to document their recollections immediately and then criticized if their accounts are not accurate. Healthcare providers need to educate the officers that the memory is focused and distorted immediately after the event, but will return over time (Alpert, Rivera, & Lott, 2012).

Bohrer and Chaney (2010) found officers were prepared for shootings but not for investigation afterwards! After the shooting, many withdraw from spouses and significant others, not wanting to share their thoughts and hurt feelings with them. They experience denial, social withdrawal, survivor’s guilt, impaired memory or concentration, inability to handle reminders of the shooting, self-punishment, waking
flashbacks, guilt, fear of future incidents, avoidance of the scene, substance abuse, inability to tolerate noise, chronic tension, and thrill seeking behaviors (Jones, 1989). Healthcare providers should prepare them for the normal responses after these very traumatic events.

Indeed, the shooting while traumatic to the victim of course is very traumatic to the officer. Sewell (1981) found taking a life in the line of duty to be the third greatest stressor for an officer, after violent death of a partner in the line of duty and dismissal. Healthcare professionals need to be alert to offer support to officers and their families, to refer to appropriate counseling, to shield the family from media, and to educate the officer and the family that many of the feelings that they are having are normal responses to this kind of stress. Two very good support programs are: VALOR (Preventing Violence Against Law Enforcement and Ensuring Officer Resilience and Survivability), and Law Enforcement Assistance Programs (LEAP).

**Tertiary Prevention**

Miller (2012) said that stopping violence is separate from justice. Whether or not a healthcare professional believes that officer involved shootings are justified, all healthcare professionals can support decreasing violence in the community. Efforts to improve community relations with law enforcement officers can mean that everyone goes home alive at the end of a day. The public needs to be taught how to interact with law enforcement—be respectful, cooperate, show hands at all times, and do not reach for weapons or make threatening gestures. Officers need to be taught to work with patients who are mentally ill or who do not behave in predictable ways. Healthcare workers should collaborate so if there is a negative encounter with law enforcement, patients are able to talk about their feelings, process the encounter, and learn from it. In West Virginia, for example, a project called “Handle with care” notifies the school if a law enforcement officer has been in the home for a reason, so that the school officials can meet with the child and process the encounter (such as arresting a family member or deescalating a domestic violence altercation). Being hesitant to shoot can cost lives, so a community should not be hasty to judge the officer until all the facts are known. Our community servants need to feel that the community embraces them. The healthcare professionals can improve communities by promoting cyber security, preventing child abducting, reducing human trafficking, and collaborating on common issues with law enforcement. Violence cannot become an accepted form of problem solving in our communities as a ritualized predatory combat. Instead, healthcare workers and law enforcement should work together to make healthy communities for all lives matter.

**References**


