A Death in the Family: Lessons From a Tragedy

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> "...You've got to remember that things as bad as this and a hell of a lot worse have happened to millions of people before and that they've come through it and you can too. You'll bear it because there isn't any choice–except to go to pieces. . . . It's kind of a test, Mary, and it's the only kind that amounts to anything..."
> *James Agee, A Death in the Family*[1]

On January 20, 2015, a member of our hospital family, Michael Davidson, a young cardiovascular surgeon and interventionalist who had trained and then stayed on at Brigham and Women's Hospital, interrupted his clinic to speak with the adult son of a deceased patient. The son shot Michael and then himself. Michael was rushed to the Emergency Department and then the operating room where colleagues from several specialties spent the rest of the day attempting to repair his multiple injuries. His pregnant wife, Terri Halperin, a plastic surgeon who had also trained with us, waited upstairs. His injuries eventually proved fatal.

Although there is evidence that violence directed at health-care workers is increasing,[2] hospital-related shootings remain relatively rare events. In the United States from 2000 to 2011, there were 154 hospital incidents, with 235 injured or dead.[3] The most common victim was the perpetrator (often suicide) with 20% of victims being health-care workers; 3% physicians and 5% nurses. Fifty-nine percent of events were in the hospital itself while the remainder were on hospital grounds. Active shooter incidents like this, defined by the US Department of Homeland Security as "an individual actively engaged in killing or attempting to kill people in a confined and populated area," represent a small subset of shootings.[4] The murder–suicide profile in this case is similar to that of 2 of the 4 active shooters identified in US health-care facilities between 2000 and 2013, suggesting that there are common threads in these events that may inform our response.

Our institution has spent the year since this unthinkable event responding, debriefing, reflecting, and slowly recovering. Within a few hours of the shooting, as police was embarking upon their investigation of the crime scene, we had already begun an in-depth after-action review to examine individual and collective responses, identify opportunities for improvement, and define future actions. Such analyses require looking at the event objectively through 3 distinct lenses: prevention, response, and recovery. The process itself has helped us to move forward, but we will never forget. The lessons learned are unlikely to prevent this specific scenario from recurring; however, we believe they have strengthened our ability to respond if and when it does.

With an eye to prevention, we conducted an in-depth analysis of the circumstances of the event, in particular our emergency management and security functions. Although we did not identify any interventions that would have prevented this incident, we have made some changes that will strengthen our procedures and hopefully begin to reassure our staff who have inevitably felt vulnerable. For example, we added key card locks in some areas and additional panic buttons in others. We hired an external security consultant to review all our processes and we are implementing the recommendations. We reviewed the placement of metal detectors at our entrances, a solution that most health-care facilities have chosen to forgo because it is nearly impossible logistically with more than 25,000 people accessing our facility daily and seems antithetical to our identity as a safe haven and welcoming environment. In fact, the data suggest that metal detectors are likely to prevent less than a third of these unusual episodes.[3] Finally, although we had previously implemented a de-escalation strategy for threatening behavior in the inpatient areas, we are expanding and adapting this protocol to our ambulatory sites although again de-escalation would not have been possible in this instance.

We were not unprepared for this incident. Beginning in 2012, spurred by active shooters in Aurora, Colorado and Newtown, Connecticut, our emergency management team had prioritized an active shooter event in its hazard vulnerability analysis. In the course of such an analysis, we prioritize planning, mitigation, response, and recovery activities and assess our needs as an institution. Our staff had participated in a number of exercises to prepare for such an event. We performed drills in close collaboration with law enforcement, fire, emergency medical services, clinicians, and administrators. These exercises had the added benefit of building a level of teamwork and trust within our organization, helping us to clarify how each arm of the hospital can best leverage its strengths.

Drills and exercises are still inadequate to prepare a staff of 17,000 people to execute the specific procedures necessary during a live event. Thus, we created an instructional video dramatizing an active shooter scenario within our own facility. We deliberately chose plain language, dispensing with jargon like "Code Silver" in favor of more explicit terms like "active shooter," "life-threatening situation," and "shelter in place." Some staff members had provided us earlier feedback that they could not immediately recall the meaning of all the various color-based codes. We recognized that our public address code announcements, such as "code gray" for a security issue and "code blue" for cardiac arrest, were designed to activate a specific response by a trained cadre of responders. In contrast, the warning for an active shooter event needs to alert everyone—all the 25,000 visitors, patients and family members inside our walls each day—so transparency, clarity, and timely communications were our focus.

We also examined the value of social media. During the Boston Marathon bombings, individuals near the scene posted a massive amount of useful intelligence to social media sites, enhancing situational awareness. However, due to the lack of sensitivity or specificity of these reports, some of the posts contained misinformation.[5]

In 2014, we participated in the first national symposium on active shooters in hospitals and health-care settings, organized by the Johns Hopkins Office of Critical Event Preparedness and Response.[6] The meeting gathered expert panelists to discuss complicated issues including providing care to a shooter. Patient abandonment, particularly the dilemma that providers face in choosing to "run,

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