Dear Sandy,

Please find enclosed a submission to the Inquiry into Violence and Security arrangements in Victorian hospitals. I am the principle author of this submission, however, it has been done in collaboration with St. Vincent’s Emergency, Security and Management Staff. I can be contacted via email at Georgina Phillips@svhm.org.au or on 9288 4388.

Yours sincerely,

Dr. Georgina Phillips
Emergency Physician
Provider No. 2073852F
I thank the Parliament of Victoria for the opportunity to make a submission to this inquiry into violence and security arrangements in Victorian hospitals. I make this submission in my capacity as an experienced emergency physician working in an inner urban tertiary hospital emergency department (ED). I comment also in my capacity as the co-author of two relevant chapters in the definitive Australasian emergency medicine textbook which cover behavioural emergencies (including the containment and restraint of violent patients), care for prisoners, mental health legislation and violence in EDs. I also provided a clinical and evidence-based update on behavioural emergencies in Australasian EDs at the Australasian College for Emergency Medicine (ACEM) Annual Scientific Meeting in Melbourne, November 2009, and wrote the Behavioural Emergencies section of the 3-day simulation-based education program for the ACEM (the Advanced and Complex Medical Emergencies course).

This submission is based on my professional observations as a senior ED clinician who has worked for well over 10 years at St. Vincent’s Hospital, Melbourne (SVHM) in both a clinical, educational and research capacity. Clinical experience includes daily management and supervision of the ED, assessment, management and supervision of care of unstable, aggressive and violent patients in the ED, care of prisoners (SVHM provides inpatient care for all prisoners in Victoria) and overarching responsibility for all critical incidents occurring in the ED during a clinical shift. I also draw on my research and academic experience around the topics of behavioural emergencies, violence and the care of psychosocially vulnerable patients in the ED. I have also consulted within SVHM in order to complete this submission. In particular, opinions and advice have been sought from ED medical colleagues, senior ED nurses, managers and hospital security staff, who all have experience and expertise in this
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field. Most importantly, this submission has been compiled with the expert assistance of Mr Paul Cunningham, Manager of Security at SVHM, with over 20 years experience in the field of security provision and oversight in a health environment. Additionally, Ms Sue Cowling has provided critical oversight and support, the ED Nurse Unit Manager with over 30 years experience of ED nursing and management.

This submission will address all the terms of reference of the inquiry both from a general knowledge and specific SVHM viewpoint. Due to the unique nature of St. Vincent’s Hospital as the sole provider of inpatient care for prisoners, as well as having possibly the highest number of security incidents in Victoria per day, I believe the submission speaks with particular authority about the issue of violence and management of aggressive and disturbed patients. Additionally, SVHM ED was the site of a fatal shooting incident in May 2002, when an armed security guard shot a potentially escaping prisoner inside the hospital building who subsequently died despite a chaotic resuscitation attempt in the ED. This significant and disturbing event triggered a detailed analysis of the role of weapons within an ED and enabled a clear and unambiguous conclusion that there was no place for guns or any other weapons (regardless of who was carrying them) in a hospital environment.

As a result of the particular situation of SVHM ED, we have developed a targeted and innovative security response system which is highly effective. This approach prioritises prevention and safety within a patient-care focussed framework. This submission seeks to showcase this St. Vincent’s response as a potential model for all EDs throughout Victoria so that aggression and violence can be managed in a safe environment without compromising the care, privacy and dignity of all people who seek emergency care, regardless of their circumstances.

For detailed references on the information provided below, please refer to the textbook chapters referenced at the start of this submission.

**Incidence, prevalence, severity and impact of violence in Victorian hospitals and, in particular, emergency departments**

A number of studies of Victorian and Australasian EDs reveal an incidence of threatening and violent episodes to be in a range from 3-6 per 1000 patient presentations, which corresponds to a security incident every 1-2 days in most EDs. Most episodes occur outside of normal working hours, and whilst spread out through every day of the week, tend to peak on the weekend. All Australasian hospitals and EDs have an internal security code response system which is triggered by any staff member when a violent incident is imminent or occurring. In Victoria, the “Code Grey” response is triggered by any unarmed threat or aggressive, violent episode involving a patient. By contrast a “Code Black” response
indicates the presence of a weapon, or threatening and violent behaviour coming from someone who is not a patient (and therefore not requiring treatment) at the hospital.

The aetiology of behavioural disturbance (necessitating a Code Grey response) in patients has been widely studied. Generally speaking around 40-50% is due to primary mental health illness (including psychosis, personality disorder and mood disturbance), another 40-50% is as a result of acute substance intoxication (drugs and/or alcohol), however frequently aggressive patient episodes are a result of a combination of both intoxication and mental illness. A lesser number (around 10%) is due to an organic illness, such as a head injury, dementia or delirium, or other acute medical instability leading to dangerous and threatening behaviour.

Whilst many behaviourally disturbed patients are attended to quite quickly in EDs, it is known that environment factors such as delays and long waits, crowded, uncomfortable waiting rooms, inadequate communication and noisy, chaotic surroundings can lead to escalating aggression and violence. Both patients and their carers are exposed to these stressors which can escalate fear and anger and lead to more unstable and potentially violent behaviour.

Experienced clinicians are able to recognise signs of increasing agitation and anticipate a potential Code Grey episode. Techniques often employed to de-escalate aggression and prevent a security incident include clear communication, removal to a quiet and separate environment and responding rapidly to patient needs and concerns. Providing patients with a semblance of autonomy whilst setting clear behavioural boundaries is a useful technique in controlling potentially violent behaviour.

It is difficult to measure the impact of violence at either an individual or institutional level. A large proportion of violent episodes are under-reported, however with standardised recording of Code Grey responses, some measurement of events and their consequences is possible. Most ED clinicians understand the underlying aetiology of patient aggression and therefore appreciate the imperative to provide medical treatment in a safe environment. Increasingly hospitals are recognising the need for regular training, peer support and institutional leadership with respect to the management of violent incidents and appropriate follow-up for staff.

At SVHM ED the incidence of security responses is at the higher end of the scale, and has been estimated to be around 2%, equating to around 2 Code Grey episodes in the ED per day (up to 6/day hospital-wide). The aetiology breakdown is consistent with evidence from around Australasia, however SVHM receives a disproportionally higher number of aggressive and violent patients.

Importantly, Victorian Police and Metropolitan Ambulance Services (MAS) bring behaviourally disturbed people preferentially to SVHM ED for assessment and treatment.
Police are required under the Mental Health Act of Victoria (Section 10) to apprehend a person who they believe may have a mental illness (including those with suicidal threats or behaviour) and take them to a place for urgent assessment by a medical practitioner. As EDs offer a 24-hour service, are considered to be safe and secure environments and often offer multidisciplinary care, the ED is considered the most appropriate environment for such people. Victorian Police are not required to have any particular clinical skills on which to base their judgements of potential mental illness so will naturally err on the side of caution when bringing people to the ED under a ‘Section 10’. Typically this type of patient is male, intoxicated, possibly with an underlying mental illness and threatening suicide. Often there has been aggression and physical violence involved in the police apprehension of the person, prior to bringing them to SVHM ED. Such patients represent a large proportion of Code Grey episodes at SVHM, and it is noteworthy that the Police choose to bring these violent patients to a hospital environment rather than their own secure ‘lock-ups’ – perhaps in recognition of the therapeutic framework in which EDs operate and in appreciation of the patient and safety focussed, de-escalating security response that SVHM offers.

Similarly, MAS anecdotally report preferring to bring vulnerable patients with behavioural disturbance to SVHM in recognition of our multidisciplinary, patient-focussed care. Increasingly issues such as homelessness, social isolation and escalating substance abuse and mental illness amongst young people are leading to more frequent episodes of violent, aggressive and often self-harming and suicidal behaviour in the community. SVHM has taken a longstanding leadership role in the care of vulnerable patients attending EDs, and so has become a site of preferred treatment.

In recognition of these trends, SVHM has developed a security response which focuses on patient and staff safety, patient care, prevention and de-escalation. Additionally, SVHM has made significant changes to the ED environment to facilitate safe and secure containment of aggressive patients. Due to the primacy of staff education and training and clear documentation and follow-up, the impact of regular security incidents at SVHM has been minimised. Staff are well trained and well supported. Whilst SVHM does not accept violence in the workplace, there is a sophisticated appreciation of the causes and triggers of violence, which has led to a more humane approach.

**Effectiveness of current security arrangements to protect against violence in Victorian hospitals and, in particular, emergency departments**

There is great disparity within Victorian hospital EDs in the management of a security incident. Whilst recognition of what constitutes a Code Grey response is consistent throughout EDs, the resources available to safely and effectively manage such an incident are not always available. This is particularly so in rural and regional hospitals (where many ED clinicians, including me, have also worked) which rely on perhaps one hospital orderly or
security officer to manage a violent episode until the local Police officer(s) can arrive. Often staff education and training is insufficient, only inexperienced junior doctors are available and the ED environments poorly suited to safely manage aggressive and agitated patients. Naturally this results in fear of violence from staff, a sense of insecurity and higher impact on staff when violent incidents do occur.

SVHM has an effective security response which we believe to minimise the impact of violence in the ED by protecting staff, patients and their carers. It has been developed and refined over the last 20 years, with continual evaluation for improvement. The key components of this response include:

**Prevention**

- Clear communication at arrival about the triage process, predicted waiting times and options for review if new concerns arise
- Rapid referral from triage to ED-based mental health services for appropriate patients, or to multidisciplinary care coordinators
- Early notification to senior ED medical and security staff of potentially aggressive, agitated or violent patients
- Utilisation of security cameras within the ED waiting room and inside the ED work area to observe potentially violent patients
- Attempted minimisation of prolonged ED waiting times by timely ordering of appropriate investigations and senior ED nurse liaison. (NB: much of the prolonged ED waiting times are beyond the control of the ED and are contingent on hospital-wide factors such as access-block)
- Prophylactic initiation of a Code Grey team response *before* a violent situation has developed. This includes assembling the Code Grey team to receive a potentially behaviourally disturbed patient that is in transit to the SVHM ED by either MAS or Victorian Police services. We receive early notification of such patients through an emergency telephone system.

**Training and education**

- Carefully recruited professional security officers who have as a minimum a certificate 111 in security guard/crowd control and hold a control room operator licence
- Medical and nursing staff education on the aetiology of acute behavioural disturbance and evidence-based recommendations for treatment, including the use of chemical and physical restraints
- Education of all ED staff on the early warning signs of escalating aggression and violence and techniques to de-escalate threatening behaviour
- Regular education and training (including simulated scenario-based training) for all ED staff on the management of a “Code Grey” episode and aggression prevention
management. Staff training is ideally mixed, involving medical, nursing, hospital orderlies and security staff - who all have particular roles to play during a security response. Such multidisciplinary education sessions facilitate teamwork and clarify roles and responsibilities within the team so that a seamless response can occur during a real episode

- All Code Grey training coordinated internally and designed specifically around the health care environment. Training includes theory based presentations with a large emphasis placed on role playing around scenarios that have actually occurred on site at SVHM. All members of our Code Grey team are required to attend refresher training annually and all training is carried out as collective groups to ensure that a total understanding and synergy is achieved across the board. Training is delivered at orientation, on-line and during regular in-person sessions.

- All staff campus wide are expected to undertake on-line training and where possible attend a face to face ‘Prevention of Aggression’ training session. All areas of the organisation are supplied with an emergency procedures manual which clearly defines and explains the role of all staff. Dedicated emergency phone numbers have been established and are present on all land line phones and on all staff identification badges.

- The development and continual review of hospital policies regarding patient aggression and management of both armed and unarmed threats both within a patient-care and legal framework.

- Involvement of key stakeholders in developing, refining and practising the SVHM security response, in particular with mental health clinicians. This has led to a particularly skilled and nuanced Code Grey response for patients with known mental illness.

Environment

- Security staff are strategically located in the ED waiting area and the office is centrally located campus wide, allowing for quick responses to high risk areas such as ED and the Mental Health Unit. There are adequate staff numbers per shift to allow for security responses throughout the hospital, yet still prioritise the high risk areas.

- Renovation of the ED waiting room to include more comfortable chairs, reading material, art on the walls and a large television screen

- Triage and administrative area protective features such as a reinforced, shatter-proof protective window, large desk separation and duress alarms. Effort was made to allow for staff protective features without compromising the ability of triage nurses to safely assess patients and offer comfort, and to minimise the impression of increased fortification

- Clear visibility between patients and carers in the waiting room and the triage staff
The creation of a purpose built containment area for all patients with acute behavioural disturbance; the Behaviour Assessment Room (BAR). This is a small room at the ambulance entrance and adjacent to the resuscitation cubicles of the ED which is bare but for concealed access to oxygen and suction as an emergency requirement. It is separate to the main patient and work area of the ED and separate to the triage and waiting area and permits ease of access and egress. Potentially violent patients delivered by ambulance or police have direct access to the BAR without passing through any other location in the ED, and agitated or aggressive patients within the ED work area are moved to the BAR during a Code Grey in order to contain their behaviour. By removing and containing a violent patient in the separate BAR, the therapeutic equilibrium of the main ED and other patient / carer safety is maintained, and the privacy and dignity of the agitated or aggressive patient is protected. Other benefits include a positive impact on clinical treatment times and ED length of stay. Most importantly, the BAR and associated Code Grey team response increases staff perception of safety and improved patient management. Details of this novel yet vital environmental tool can be found in the reference below.

Technique and skills (description of actual response)

• Primacy is placed on de-escalation techniques, which can include establishing rapport, clear communication, prioritising specialist (including mental health) review, mitigating pain, offering simple sedative medications and setting clear boundaries whilst respecting as much patient autonomy as possible. At times it may be something as simple as taking the patient out for a cigarette; and the SVHM approach is to be as flexible and responsive as possible in order to maintain a calm environment and therapeutic relationship.

• Removing patients to the BAR with a Code Grey team show of strength can often be enough to resolve an imminently violent situation and allow for clear communication about behaviour expectations in a private environment.

• The overarching approach of the Code Grey response is to facilitate the requirement for medical treatment. When security staff are called to deal with situations where aggression and violence may be present, they always bear in mind the well-being of the patient and their need for medical care, and strive to deliver their services within the values and principles of the SVHM mission (compassion, justice, human dignity, unity and excellence).

• The Code Grey team comprises 2 security officers, 2 orderlies, at least 2 senior nurses, a senior ED doctor and is supervised by the Hospital Emergency Coordinator. Often an ED mental health clinician will also be present. The security officers and trained orderlies are responsible for the safe physical restraint of the patient if required until a sedating medication can be given and its effect commence. Much
training and practice is behind the skilled application of physical force without causing injury to the patient; there are no weapons or tools used, only gloved hands. The ED doctor and senior nurse are responsible for a rapid diagnostic and risk assessment of the patient and for the administration (either orally, intramuscularly or intravenously) of an appropriate sedative medication. Once the patient is adequately chemically restrained (drowsy, calm and cooperative, or asleep), they are moved to a high visibility cubicle in the main ED work area where they are carefully monitored and observed. At times physical restraints are applied (shackles), although these are less preferable to chemical sedation and should only be applied for short periods of time. Commonly, re-sedation is required and the whole Code Grey team response in the BAR is activated again. Frequently the patient will wake up several hours later, having sobered up from their substance intoxication and have no recollection of their earlier aggressive and violent behaviour. Often multidisciplinary care input is required at this stage to facilitate a safe discharge from the ED.

- In recognition of the ‘least restriction’ principle enshrined in the Victorian Mental Health Act, ED clinicians at all times are balancing the autonomy of the behaviourally disturbed patient with the safety needs of all other patients and carers in the ED as well as fellow staff.

**Documentation, quality control and follow-up**

- All Code Grey episodes are clearly documented. For the ED clinicians, a specially designed chart is used where all actions taken and medications given are carefully recorded and filed in the patient history at the end of their ED stay. For the hospital coordinator and security staff, a record is made of the details of the Code Grey including triggers, time, duration of response, and outcomes.

- Any incident that requires further review (unusual events, negative outcomes, harm to staff, harm to patient) is analysed at regular Code Grey committee and Emergency Coordinator meetings attended by ED medical and nursing staff, senior hospital leaders, Manager of Security and hospital emergency coordinators.

- Analysis of Code Grey episodes and staff feedback informs ongoing review of procedures and refinement of training and technique.

- Ongoing departmental research projects have ensured critical analysis of the SVHM Code Grey response and allows for comparison with other practices both locally and Australasia-wide.

Examination of current and proposed security arrangements in Australia and internationally to prevent violence in hospitals and, in particular, emergency
departments, including the appropriateness of Victoria Police Protective Service Officers in Victorian hospital Emergency Departments

Despite significant research and experience around the issues of behavioural emergencies and violence in EDs, I am unaware of any model superior to the one practised at SVHM and other similar urban EDs in Melbourne. It may be that less restrictive measures are used to contain aggressive behaviour in EDs throughout Europe and the UK, however it is possible that police apprehension practises, treatment of mentally unwell patients and mental health legislation differences has led to a reduced burden of violent and aggressive patients on EDs in these environments. Circumstances in Victoria, such as increasing drug and alcohol use, youth homelessness, psychiatric de-institutionalisation and social isolation, have ensured a growing burden of extremely vulnerable patients presenting to EDs. When combined with Victorian Police preferences for ED containment of people with altered and aggressive behaviour, the SVHM security response model is both appropriate and desirable.

In environments where increased fortification of EDs, including the presence of firearms and other weapons held by ED staff for apparent protection, incidents of extremely harmful and fatal violence have occurred. Police in these environments physically restrain patients in lethal ways and ED staff themselves often bear the brunt of escalated violence.

It is known that a structured approach to violence in the hospital and ED environment can mitigate the severity and impact of violent episodes. The three key structural components encompass environmental issues, personnel (including training and education) and enshrining systems which are led by hospital managers and industry groups. Much of the environmental issues have been mentioned; comfortable waiting rooms with clear visibility, safety features such as protective screens, duress alarms, security cameras, timely care of patients and separate areas within the ED for isolation and containment of aggressive and agitated patients. Staff training and education is pivotal to the safe management of ED violence and has been previously addressed. Understanding the aetiology of violence, learning and refining de-escalation and restraint techniques as well as developing careful self awareness are all essential tools for staff working in EDs.

How violence is managed by the ED and hospital leadership is vital. Adequate documentation, follow-up and peer support is essential to shift consequences of violent episodes from individual responsibility to institutional ownership. Medical and Nursing industry groups have a role to play in crafting careful policies and guidelines for managing violence and ensuring the therapeutic framework of ED care is maintained.

Most hospitals now recognise this framework for dealing with violence in their EDs and have taken steps to enshrine good workplace practises. Resourcing hospitals for adequate environment improvements and sufficient staff recruitment, training and education is the challenge that many Victorian hospitals now face.
The SVHM security response model was developed 20 years ago and has been refined and improved since then. It takes many years of practical involvement and training to truly understand and comprehend the synergy in which security, nursing and medical staff operate during a Code Grey response in the complex hospital environment. Security personal must be able to act quickly, respond to requests from medical staff and assist in the patient care under extreme duress. It takes an unique individual to work as a security officer in this environment which is why all staff are employed in-house. There must be clear direction and management from one source only.

SVHM security staff have never been issued with accoutrements such as handcuffs, batons or the like. They operate under the ethos of the SVHM mission and work within a patient-focussed and ‘do no harm’ principle. There has never been a need for weapons or tools during a Code Grey response, in fact the presence of such attachments would hinder the ability of staff to respond smoothly and introduce a new risk into an already tense situation. Should an armed guard or protective service officer be stationed in the ED, critical questions arise. Who would develop their job description and who would they report to? What would be their key result areas and key performance indicators? When would it be deemed acceptable (if ever) to produce the weapon? Would they be part of the Code Grey team, would they answer to the Manager of Security or the Hospital Emergency Coordinator? How would the introduction of an armed officer not disrupt an already highly developed and effective team response? How would staff and patient safety be protected by the introduction of a lethal weapon into a volatile situation?

Whilst we commonly work well together, Victorian Police officers and health workers, including security staff that work in hospitals have a fundamentally different approach to aggression and violence in an ED environment. Indeed, we rely on the assistance of the police during a ‘Code Black’ event, yet police presence in the ED can escalate agitation and led to increased aggression. When faced with a violent patient, police can react rapidly and forcefully – sometimes against the wishes of ED staff and in conflict with our principles of patient care and safety. De-escalation techniques are rarely employed. They do not answer to our SVHM Security staff nor to the Hospital Emergency Coordinator and therefore are not able to work effectively in a Code Grey team response. At times, a patient will calm down and become cooperative only after police have left the ED environment.

All the significant negative security events that have occurred at SVHM have involved Victorian Police or armed Protective Services Officers. Three examples suffice to illustrate the inherent risks of introducing arms into the ED environment.

• Fatal shooting
In May 2002 a patient at SVHM ED who was a prisoner and therefore accompanied by an armed Protective Services Officer apparently attempted an escape after attending for a radiological investigation. He was handcuffed and was shot by the Officer as he was running through a busy hospital corridor used by patients and staff alike. As he was lying on the ground bleeding heavily, SVHM ED staff were initially prevented from providing life-saving assistance by the armed Security Officer. He was eventually carried to the ED resuscitation area where he remained handcuffed throughout a frantic, yet unsuccessful resuscitation attempt. The patient died in the ED.

The recovery time for the ED and directly involved staff in the aftermath of this extremely traumatic event was prolonged and included a drawn-out Coroners and court investigation. As a direct result of this shooting incident, at least one senior ED doctor terminated their career in emergency medicine.

- **Near miss**
  Around the same time as the fatal shooting, a ‘near miss’ episode involving an armed Victorian Police officer occurred. An unstable patient was able to unholster a gun from a uniformed officer who was distracted. The gun was secured without discharging amidst a sea of hands and confusion. No patient or ED staff member was harmed.

- **Recent capsicum spray attack**
  Within the last few weeks, 4 Victorian Police Officers attended the ED with an aggressive and potentially violent patient. They remained with the patient as he was sitting in an ED cubicle awaiting treatment and denied him a request for a cigarette. They were unable to anticipate his increasing agitation until he had secured a small, essentially harmless suture-cutting blade from the room where he was waiting and had commenced scratching his skin. There was no attempt at de-escalation or behaviour control. Instead the Police Officer commenced shouting at the patient and drew the Capsicum spray to point at him. Without warning and against the wishes of the ED staff, the patient was sprayed with Capsicum spray, which rapidly spread throughout a large area on the ED. This resulted in evacuation of surrounding areas of the ED and distress to other patients, carers and ED staff. The subsequent cleaning up of the patient and ED area was prolonged, not to mention the de-escalation required of the attending Police Officers.

SVHM undertook an extensive process of debriefing and discussion after the fatal shooting episode with all hospital stakeholders. The end result was to strive to make SVHM a totally gun and weapon-free environment. This careful decision was made in the recognition that
any weapon (regardless of who is carrying it) introduces an unacceptable risk in to a hospital and represents the antithesis of what should be a safe and therapeutic environment.

A gun safe was therefore established in the SVHM Security Office (adjacent to the ED and main entrance of the hospital) where all armed Police and Security Officers would be invited to securely store their weapons prior to entering the hospital environment. Unfortunately, SVHM does not have the power to enforce the removal and safe storage of a firearm from such officers. As this is at the discretion of each individual officer, our gun safe has largely been ignored by those it should serve, and we continue to have to work with the additional risk that weapons in the ED and hospital environment bring.

Recommendation of initiatives to enhance the overall security arrangements and safety in Victorian hospitals, particularly emergency departments to ensure appropriate levels of safety for health professionals and the general public without compromising patient care

In light of the evidence presented throughout this submission, which is based on objective research and extensive experience, the following recommendations are made:

- That a structured approach to violence be standardised throughout Victorian hospitals, focussing on the 3 key features of environmental improvements, staff recruitment, education and training and structural supports to ensure appropriate follow-up and support
- That the creation of a BAR be considered as the most appropriate environmental improvement to EDs in Victoria to ensure safe, timely and private care for aggressive and violent patients
- That the SVHM model of a Code Grey team security response (as previously outlined) be considered the ‘gold standard’ of appropriate security response for hospitals and EDs in Victoria, and adequate resources be provided to hospitals to allow for adoption of such a model
- That all Victorian hospitals and EDs be declared gun and weapon-free environments, and all armed Police and Security Officers be encouraged, or even mandated, to leave their weapons in secure storage facilities provided by the hospital
- That under no circumstances should armed Victoria Police Protective Service Officers, or any other armed officer be placed in Victorian Hospitals or EDs to assist with security
- That hospitals themselves be responsible for the oversight, training and management of all security incidents within their institution through the auspices of an in-hospital Security Department. Government should consider greater resources and funding solutions-based packages to assist health care organisations in their training initiatives
• That Victorian Police receive specific education and training around security incidents in health care environments, including the management of aggression and violence in patients with potential mental illness. Such training can be done in collaboration with health care professionals and experienced health care security officers. Police liaison officers are recommended to facilitate relationships between hospitals and local police stations and coordinate training session where both ED staff and Victorian Police officers can attend

• That ongoing audit and critical review of violence and security incidents be conducted across Victorian Hospitals with the assistance of an expert panel comprising ED and mental health clinicians, hospital Emergency Coordinators and specialist health-care Security Officers, so that continual development and improvement of security responses can occur

A further recommendation can be made regarding the development of centres-of-excellence for the care of patients with acute behavioural disturbance. As Trauma Centres have become the accepted standard for the care of all patients with traumatic injuries requiring urgent care, there is an argument for similarly specialised centres within EDs to expertly manage patients with acutely altered behaviour, including aggression and violence. Timely, skilled care in appropriate environments is known to improve staff perception of safety and patient management. A ‘Behavioural Emergency Centre’ as part of an ED would strive to deliver optimum evidence-based care in the safest environment, as well as offer the wealth of multidisciplinary services that these vulnerable and complex patients require. SVHM already has expertise in this area and could provide a suitable environment for such a centre.

Conclusion

The inquiry into violence and security arrangements in Victorian hospitals is a welcome opportunity to investigate this critically important issue that affects all hospital staff. Whilst acknowledging the disparity amongst Victorian EDs and pressing security needs of some hospitals, it is crucial to acknowledge that the solution lies in prevention, not increased weaponry and fortification. This submission offers a detailed analysis of the aetiology, prevention, management and follow-up of violent episodes in hospital EDs and recommends the highly developed and effective SVHM approach. In the SVHM model, both safety of health professionals and the general public is maintained, yet care for the patient remains the uncompromised central focus.

We would be happy to provide verbal evidence if required at a future hearing on this matter.
Inquiry in violence and security arrangements in Victorian Hospitals – submission from St. Vincent’s Hospital, Melbourne

  Chapter 21.5: The challenging patient in the emergency department  
  Chapter 25.1: Mental Health and the Law: the Australasian and UK perspectives  
  As above  