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Ms Elspeth Dyer
Committee Manager
Committee on Law and Safety
Legislative Assembly
Parliament of NSW
Macquarie Street
Sydney NSW 2000

GH:DA/A043893
7th December, 2016

Dear Ms Dyer,

Inquiry into Inquiry into Violence Against Emergency Services Personnel

Thank you for your invitation to provide further information regarding the use of private contractors in NSW public hospitals.

The committee's additional question quotes page twelve of the union's submission that, 'Based on anecdotal evidence, sometimes no or very little information, training, instruction or supervision is provided for hospital security officers before their first shift.' In fact, this is not quite accurate; the relevant section reads in full:

> *Ensuring the timely delivery of, information, training, instruction or supervision, is a critical part of ensuring healthy and safe work for security officers. No security officer should start their first shift without them.*
>
> *The HSU is concerned that this is not the case, based on anecdotal evidence from our members, and that* ***some local health districts are using security contractors with no or very little of the necessary, information, training, instruction or supervision****, to start their first shift in an emergency department.*

My answers will therefore be in the context of reports from our members regarding private contractors.

How often does this happen, to your knowledge?
Can you give examples of consequences of this lack of training?

Whilst the use of contractors is commonplace throughout the state, the level of training (if any) they receive varies from district to district and, within local health districts, from hospital to hospital, as does the range of duties they are expected to undertake.

To take as an example Liverpool and Campbelltown, which both lie within the South Western Sydney Local Health District, the two hospitals work on completely different models.

Campbelltown Hospital has a new model that has dedicated security officers on all shifts with the backup of health and security assistants(HASAs). If a dedicated security officer is not able to be replaced a member of the HASA staff employed at site is moved to the dedicated security position and the HASA position is backfilled with wardspersons or hospital assistants.

Contract security is now only used at Campbelltown to point-guard mental health patients; they do not attend to any duress and code black calls.

By contrast, at Liverpool Hospital, contract security officers are orientated in batches of forty guards. Orientation sessions include the use of radio equipment, duress protocols and hospital layout. At the end of the two-hour orientation they are presented with a white card to say that they are orientated and they must provide this upon sign-on at the facility. A major problem arising from this batch method is that out of the forty guards any one may only work once in a three-month period, and will need to be orientated by hospital security again.

Further problems are occurring when a contract guard shows up to work and cannot produce a white card, meaning they are not able to work and must be replaced with another contract guard. As a result, the hospital is not being fully covered for the most part of two hours before a replacement can be found who does have the white card.

Even where the contractor has a white card, the duties that can be assigned to them are limited by the absence of further training. Hospital-employed security officers are required to have completed violence prevention and management training, which contract security are not. This lack restricts contractors' ability to respond and assist in violent incidents. As a result, contractors are regularly placed in the control room as they cannot be tasked to any particular area.

Some guards are classified as subcontractors of the contract security company and must provide their own ABN. This is a serious concern as the hospital has engaged the company with specific requirements surrounding employment checks, but these checks cannot be applied to sub-contractors.

Our members report that that due to these training issues they do not complete rounds, respond to duress/code calls, back-up or restraint situations with contract security due to fears that it would escalate the situation to a point where someone is injured.

The hospital's emergency department is staffed with contract guards who are rostered two per shift seven days per week. These are only static guards who provide a presence in the department. Hospital security officers are called to respond to any incident that occurs. The contract guards do not have access to security logs, therefore they cannot record any incident that has occurred. This is resulting in an unreliable event history.

Our members have raised a couple of recent occurrences involving security contractors:

- A ward was covered by a contract security officer when an aggressive male patient assaulted a nurse. With no assistance from the contractor, ward staff activated a code black - person threatening or attempting to harm self or others – and hospital security officers dealt with the incident.

- A contract security officer who had not worked in the hospital for two months was unequipped to respond to a code black in mental health. Only one hospital security officer was available to respond, and as a result the patient forced his way out of the unit.

The experiences of our members in public hospitals too often reflect those of the Liverpool Hospital staff. A security officer from Western Sydney Local Health District tells us, 'I have been with the area health service for over thirteen years at three hospitals and have only seen one mandatory training exercise and that was in 2012. I have not seen most of those trainees again over the years and I have never seen any at my hospital in the three years I've been here.' Another from that district says, 'With regards to E-Group the guards that have been sent to my hospital lately have not been orientated to the site they don't know their way around the hospital and grounds. We have to carry them. Some of the guards can't even use a radio. If we have a problem, we have to deal with it and try to tell them what to do which puts our lives and those of staff and visitors at risk. We have mentioned our concerns to management but nothing seems to happen to change things.'

Below is a small sampling of recent incidents.

- South Eastern Sydney Local Health District, October 2016: a security duty controller attempted several times to call contract security officer via two-way radio for a welfare check. The controller became concerned at the lack of response and phoned the nurse manager, who informed him that the patient the contractor should have been guarding had dismantled and hidden his radio, which he had not been wearing and had left unattended.

- In another incident backup security assistance was required when the same patient, again under guard of contractors from the same private company, obtained a pair of scissors, with which he threatened the nursing staff.

- Northern Sydney Local Health District, September 2016: a member reports, 'At 15:15 hrs we received an ART (Aggressive Response Team) page, to respond to Adult Mental Health. I arrived a short time later, and was met at the meeting point by the after-hours manager. A short time later, more of the ART team started to arrive. It was then that I heard a call via our two-way radio from [the contractor] saying, "Ah...Security?" I replied, "Security, go ahead." "Do you want me to come to the ART, or....?" I replied, "Yes, of course."

- About 15:28hrs, the contractor arrived to the aggressive incident, that being thirteen minutes after the initial page was activated. This is an unacceptable response time to an incident where we required as many persons on the ART team as soon as possible, to minimise the aggressive person.

- A further member has made a complaint against a contractor from the same company in the Northern Sydney district: 'At 08.41hrs we received a code red fire alarm from childcare. My supervisor and I were first to arrive on scene. At no time while the incident was taking place did the contractor attend. When we returned to the office I asked him where he was and he said he got lost and could not find the location. He was looking for childcare in the wrong place even after looking at a map in the office.'

Events similar to these are occurring around the state on a daily basis, putting patients, staff and members of the public at unacceptable risk.

I look forward to my next appearance before the committee on 20 February 2017.

Yours sincerely,

Gerard Hayes
Secretary HSU NSW/ACT