Submission No 32

INQUIRY INTO VIOLENCE AGAINST EMERGENCY SERVICES PERSONNEL

Organisation: Health Services Union

Name: Ms Donna Austin

Position: Research Officer

Date Received: 3 August 2016

Submission to the Legislative Assembly Committee on Law and Safety Inquiry into Violence Against Emergency Services Personnel

The Health Services Union welcomes the opportunity to contribute to this review. Our union represents some 33,000 members in both public and private health as well as aged care and the ambulance service, which affords us a uniquely broad perspective on health issues within NSW. In the public hospital system we cover all levels of health professionals and support staff, including security officers, as well as junior medical officers.

When it comes to addressing the problem of violence against emergency service workers, calls are often raised for harsher penalties for offenders; but while tougher sentencing for people convicted of these assaults may be beneficial in some circumstances, in the types of attacks our members are subject to the assailants are not likely to be reflecting on the potential consequences of their actions. Our members see substance abuse and mental health issues as by far the greatest contributors to the violence they face on the job.

Paramedics

Case Study 1: March 2015

My partner and I responded to a suburban house where the male occupant, who was around sixty, had collapsed and had possible head injuries. We found the patient conscious, in a sweaty and aggressive state, in the bedroom. I tried to sit him down so I could assess his condition, but he got up and went into the kitchen where he grabbed a knife.

My partner got out through the front door, but the patient blocked my escape and lunged at me with the knife. All I could do was wrestle him. I didn't get the knife, but I managed to get him onto the ground. During the struggle he bit me and I suffered a cut to the hand.

Having radioed for help my partner returned and together we disarmed and sat on him to restrain him until the police arrived. He was then handcuffed and we took him to hospital.

In the past I have practiced martial arts and this training helped me to protect myself. In other circumstances the patient's attack could easily have been fatal. I later discussed the case with police officers of my acquaintance who told me that if they had been in that situation their training would have told them to shoot him.

In my thirty-five years as a paramedic I have experienced violence on the job before, but I have suffered ongoing psychological distress in the wake of this incident, made worse by the fact that, though the patient was charged with assault, the charges were later dropped by the Director of Public Prosecutions.

Case Study 2: Three Incidents in November 2015

1. First week of November 2015, I was working day shift in Kempsey. We were responded to an elderly male with chest pain. Upon arrival we were met by the patient's wife stating her

husband had chest pain, and her mentally-disabled son was not happy that we were being called. We entered the house and the patient was sitting at the kitchen table with the mid-forties son who was agitated and verbally abusive towards us. As we began treating the patient as per protocol, the son became more aggressive and picked up a plastic Tupperware type container and threw it at my partner, hitting her forehead. We decided to move into the lounge room away from the son.

When moving into the lounge room the son tried to pick up a kitchen chair to use as a weapon. My partner managed to push the chair to the ground and talk the son down. While I continued treating the patient, the son became more agitated and was pacing around the room. He punched his elderly mother a number of times in the arm, ripped curtains off the window and punched a hole in the wall. We decided to leave the house ASAP for our safety and continue treatment in the ambulance. While we were extricating the patient, who could walk, the son lashed out with his arm and struck my right shoulder. He then picked up a ceramic vase and threw it at my head from close range, but I managed to dodge it. I ran from the house and met my partner outside who was getting the bed ready. We transported the patient to Kempsey Hospital.

2. Third week of November 2015, I was working afternoon shift in Port Macquarie. We were responded to Lake Cathie for a male in his fifties who had fallen off a wall and had head injuries. We arrived and found the man, who was highly intoxicated, lying on a concrete driveway where he had landed after falling off a retaining wall. While assessing the patient for spinal injuries I palpated the C-Spine; the patient immediately lashed out with his arm striking me on the shoulder. I managed to talk the patient down and calm him from that point. I warned him that I would call the police if he did it again. He calmed down and we transported him to hospital.

3. Third week of November 2015 and the next shift after assault number 2, I was working night shift in Port Macquarie. We were responded to a local bowling club for a male in his late forties reported as choking. We arrived to find a male lying face-down amidst the pokies with staff members present.

The patient was conscious and very intoxicated but not choking. He had fallen off the chair and was unco-operative and did not answer my questions. Again, as per protocol I assessed the patient for spinal injuries. As I palpated the C-Spine he too lashed out with his arm striking my shoulder. He then pulled back his arm with fist clenched ready to punch me in the face. I managed to talk the patient down and explain the seriousness of assaulting a paramedic. He calmed down and we transported him to port base hospital.

These are three minor incidents which when compounded by each other led me to feel depressed and very angry. I had three months off on worker's compensation and attended two counselling sessions.

The nature of their work puts ambulance paramedics in a uniquely vulnerable position. Without any of the authority or protective equipment and restraints of a police officer they deal on a day-to-day basis with people who are under stress, and who are often affected by alcohol, drugs and/or mental illness. As these case studies show, they may be called into premises completely unaware that they are facing a potentially violent situation. Generally working as no more than a team of two, they are often isolated and exposed while treating patients.

Our members are not seeking, and do not want, powers of arrest and restraint or weaponry and equipment similar to those available to police officers; what they do need is the confidence that comes from knowing that they will be supported if they come to any harm in the course of their work. It is an issue on which they have campaigned long and hard.

In 2008 paramedics finally secured, through their award negotiations, a protection scheme that provided both for death and injury. At the time the government agreed to pay 3.6% of salaries towards the scheme with a 1.8% co-payment by paramedics. The Death & Disability Scheme came in as part of general productivity and wage bargaining, and raised their coverage to a level comparable to that of other emergency service workers.

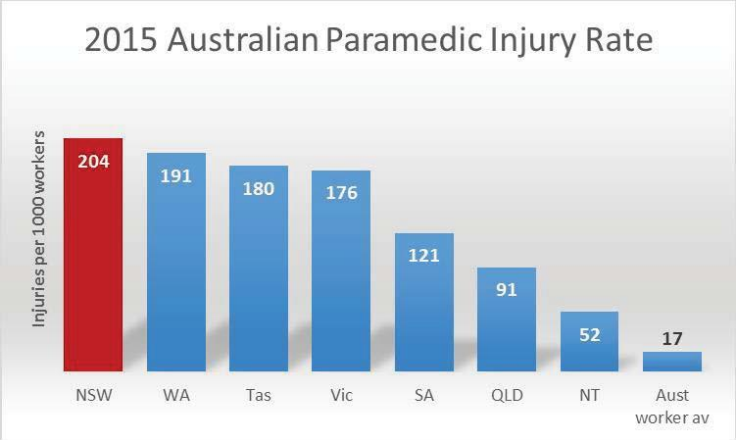
That changed earlier this year when the Ministry of Health downgraded the scheme as a cost-cutting exercise. The old scheme is comparable to those still being provided to other NSW emergency service agencies such as NSW Police. The new Death & Disability income protection scheme sees a reduction of more than eighty percent in the benefits for paramedics who sustain a career-ending injury. (The death benefit remains the same.)

Can't work as a Paramedic again (e.g. Back Injury)	**Old NSWA D&D**	**Ministry of Health IP Scheme (2 years IP)**	**NSW Police Scheme (7 years IP)**
20 years of age	$685 642	$123 487	$432 127
35 years of age	$516 907	$123 487	$432 127
50 years of age	$253 515	$123 487	$432 127

Can't work in any occupation again (e.g. loss of sight/limbs etc.)	**Old NSWA D&D**	**Ministry of Health IP Scheme (2 years IP)**	**NSW Police Scheme (7 years IP)**
20 years of age	$699 635	$123 487	$432 127
35 years of age	$699 635	$123 487	$432 127
50 years of age	$559 708	$123 487	$432 127

(Figures based on base paramedic [P1] pay)

NSW has one of Australia's lowest paramedic-to-community ratios coupled with one of its highest utilisation rates. We believe this under-resourcing directly correlates to NSW paramedics having the country's highest injury rates. NSW Paramedics respond to approximately one million cases per year, any of which could lead to a career-ending injury.

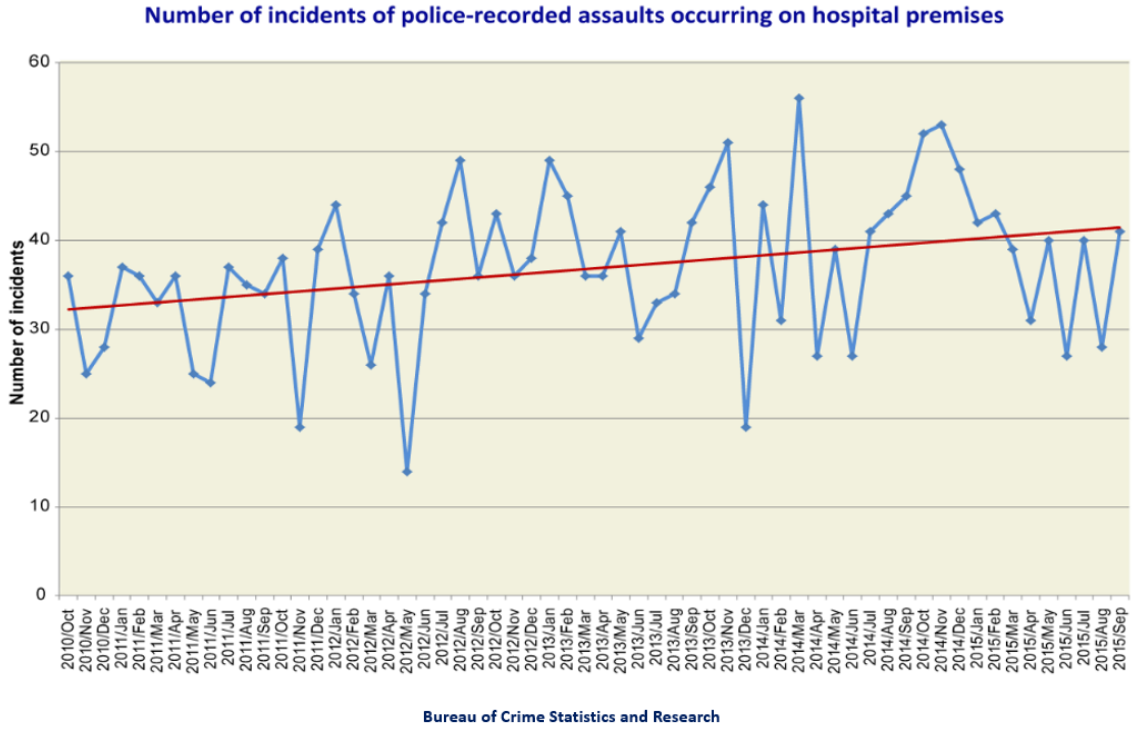


The assaults and abuse that paramedics can suffer in the course of their duties are unpredictable and they often have profound and continuing physical and psychological effects which necessitate treatment and counselling. One thing that can help them to get through a painful recovery process is the security of mind that comes from knowing they and their families are financially secure.

Public Hospitals

Hospitals, particularly emergency departments, are stressful places. People are under pressure, they're tired, and tempers can fray even without the contribution of drugs and alcohol. The combination of this stressful environment with substance abuse and the mental health issues that often accompany it can create a potentially explosive situation.

Between October 2010 and September 2015 in NSW, the number of police-recorded assaults occurring on hospital premises increased by an average of 5.8 per cent per year.



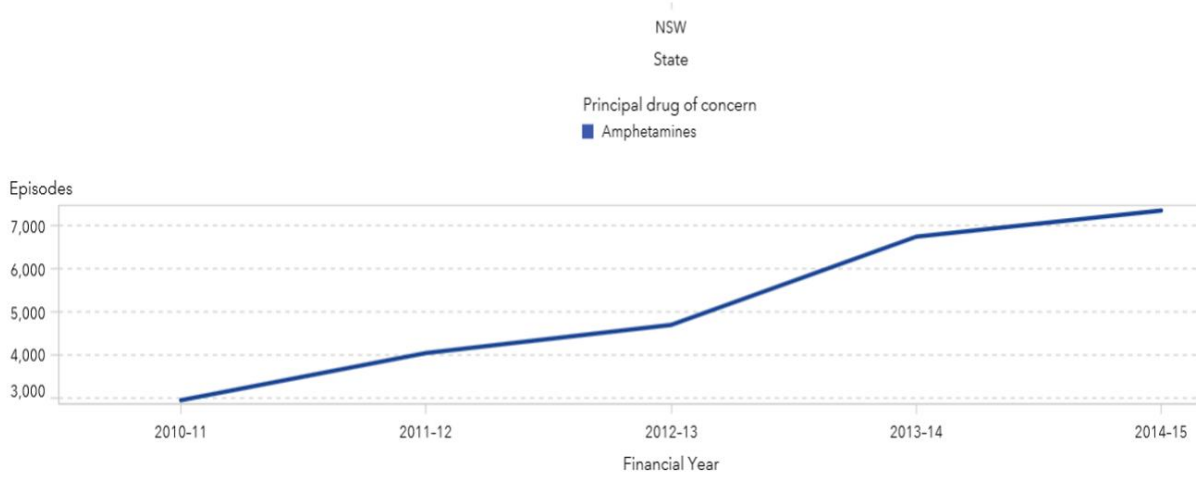
July 2014: I was attacked by a known methamphetamine user while working my security shift in the emergency department. Repeated calls to call police were ignored by nursing staff due to the physical size and drug use of the patient. I defended myself using the C-ART training holds that are not adequate to restrain a patient or defend yourself with. As a result of the assault my left shoulder was severely and permanently injured.

Security officer, Northern Sydney

June 2013: Patient was young male under influence of a substance. He had been arrested for a number of offences against police and property. He was in the custody of two police officers and I was escorting them to get an X-ray done on his alleged fractured hand. Police decided to take one handcuff off prisoner. Within a minute a struggle took place. Other staff were present and he was trying to abscond. I had no choice but to help. I was bitten on my chest. Punched and accidentally tasered by the police.

Security officer, North Coast

Attacks like this are on the rise. Statistics from the Australian Institute of Health and Welfare show that amphetamine use in NSW more than doubled over the period from 2010-11 to 2014-15. Over roughly the same period, amphetamine-related hospitalisations more than doubled from 136 per million persons to 341 per million persons. The picture for alcohol is similar: according to the National Drug and Alcohol Research Centre, alcohol-related violence is increasing in this country even though there's been no real increase in alcohol consumption.

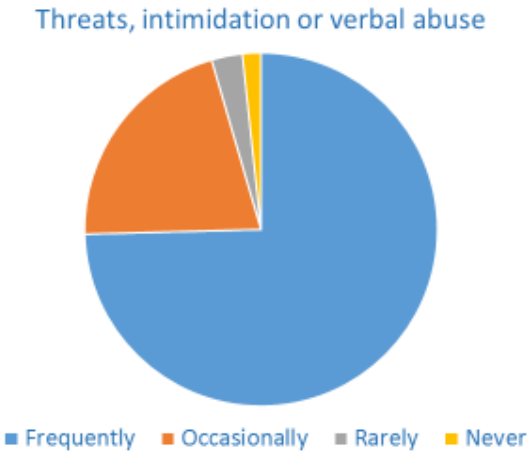


Source: AIHW Alcohol and other drug treatment services in Australia report

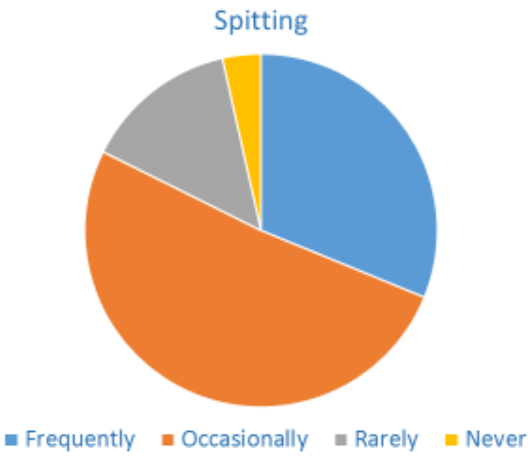
In January this year we had the shooting of a police officer and a security guard by a violent methamphetamine addict who'd arrived at Nepean Hospital earlier that day in police custody.

After the Nepean incident we conducted a major survey of our members in hospital security and it paints an alarming picture of their day-to-day working lives, showing how often they have been subjected to a range of intimidating and violent behaviours.

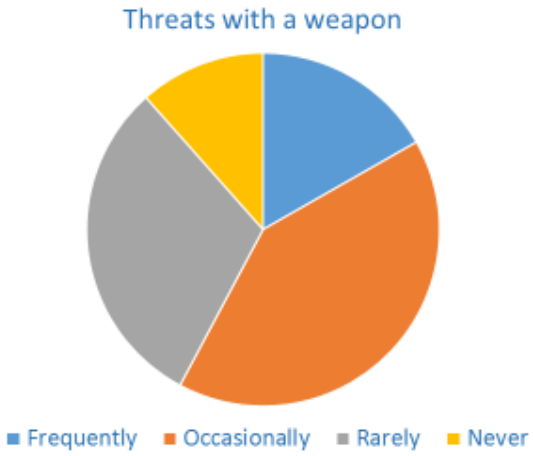
Hospital security officers' survey



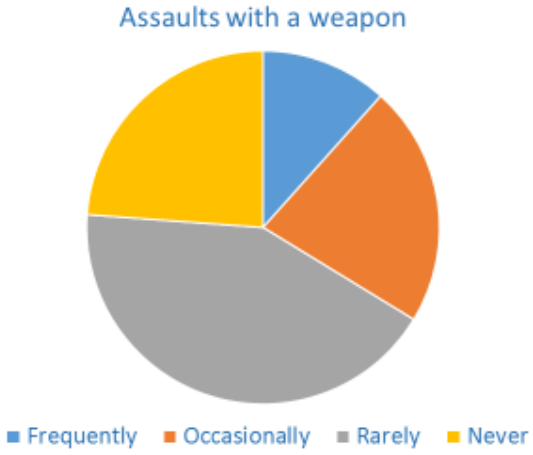
Hospital security officers' survey



Hospital security officers' survey



Hospital security officers' survey



In detailing incidents in their workplaces, members report that emergency departments are badly designed and under-resourced.

> June 2013: *Patient came to my window in Emergency Reception, pulled out a large syringe filled with fluid, pointed it at my face through the hole in glass window, and squirted it on me.*
> Female administration officer, South Eastern Sydney

> September 2010: *Trying to restrain a violent patient with the assistance of two police officers and four security. I was kicked to the ground and my head was stomped on multiple times. I sustained a fractured skull, traumatic brain injury bilateral hearing loss, tinnitus, neck and back injuries.*

The environment within the emergency department was inadequate…no policies existed to cover such an occurrence. There were also no safe assessment rooms.

Female administration officer, South Western Sydney

March 2015: *We have not had 'take-down' training for over seven years. The reason given, is we haven't enough staff members for a take-down team*.

Male Health and security assistant, Mid North Coast

June 2016: *I was rostered on duty by myself as usual. With the current level of increasing violence in my work place it is imperative that we have a long overdue and immediate increase in staff to a bare minimum of two security officers on a shift. Why should I not be provided with a safe work environment every day when I come to work? Apparently I am expected to be a punching bag as part of my role.*

Male security officer, Northern NSW

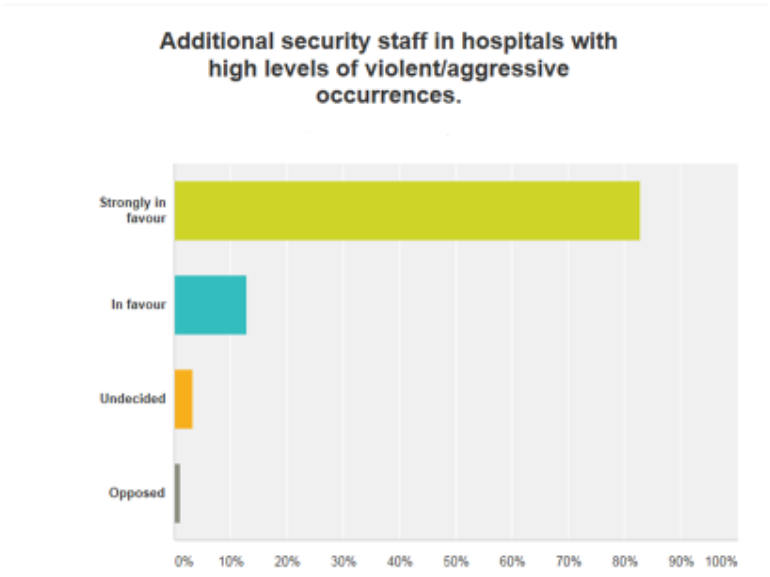
Live monitoring is available only in major metropolitan hospitals. Rural, regional and most suburban hospitals might have video surveillance, but there's nobody watching. Clearly, investing in staff is key to keeping people safe in our hospitals.

Two months after the Nepean incident, we conducted a follow-up survey, this time open to all of our public hospital members, asking them what they thought would be the most valuable steps that could be taken to improve hospital safety.

Top of the list was staffing.

HSU NSW / ACT

All hospital staff survey



The rest of the top three preferred options were:

- Ensuring the physical design of emergency departments which have had the most significant increases in "ice"-affected patient presentations is suitable for safely managing these patients;
- Training sessions for clinical and security staff working in emergency departments with a high level of "ice" presentations; and
- A review of current arrangements with NSW Police about how to address aggression from drug and alcohol-affected patients.

On top of issues of staffing and training, there is considerable confusion about the role and capabilities of security officers in public health.

Security powers in general

The power of security guards, even licensed ones, to wield specific powers is not well defined under Australian legislation. In NSW, Section 8 of the Security Industry Act 1997 says that the holder of any licence can carry out the functions authorised by the licence but that a licence does not confer on the licensee 'any function apart from a function authorised by the licence.'

Those authorised functions, for a class 1 license holder, are defined by Section 11:

(1) Class 1 licences are to be classified into subclasses. Those subclasses, and the authority they confer, are as follows:

(a) Class 1A-authorises the licensee to patrol, protect or guard any property while unarmed (and whether while static or mobile);
(b) Class 1B-authorises the licensee to act as a bodyguard or to act in a similar capacity;
(c) Class 1C-authorises the licensee to act as a crowd controller or to act in a similar capacity;
(d) Class 1D-authorises the licensee to patrol, protect or guard any property with a dog;
(e) Class 1E-authorises the licensee to patrol, protect or guard any property while carrying on monitoring centre operations;
(f) Class 1F-authorises the licensee to patrol, protect or guard approved classes of property while armed (but only under the authority of a licence or permit to use or possess firearms under the Firearms Act 1996);
(h) Any other class prescribed by the regulations-authorises the licensee to carry on the security activity prescribed by the regulations in relation to the prescribed class of licence concerned.

There is nothing in the legislation that confers police-like powers of search, restraint and detention, or that provides for any indemnity against prosecution for the attempted use of such powers.

Interstate: Hospital Security under Review in Victoria

Around the country, in most cases the duties and training levels of hospital security guards are set by individual health services. A state-by-state review of job advertisements shows that in most circumstances the applicant either must possess or be working towards a current security license under the relevant state legislation, or else possession of a license is described as highly 'desirable.' In cases where a level of training is specified it is the Certificate 3 – unarmed category. There is no mention of any specific powers beyond those of the general public.

Victoria has had the most comprehensive recent review of issues relating to security and aggression-control in hospitals. In 2011 the parliamentary Drugs and Crime Prevention Committee undertook an

inquiry into 'violence and security arrangements in Victorian hospitals and, in particular, emergency departments.' Terms of reference for the inquiry included:

(a) The incidence, prevalence, severity and impact of violence in Victorian hospitals and, in particular, emergency departments;
(b) The effectiveness of current security arrangements to protect against violence in Victorian hospitals and, in particular, emergency departments;
(c) An 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;
(d) A 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.

The final report with its thirty-nine recommendations is available online, as is the government's response. The key recommendations include:

- That the Victorian government provides ongoing funding which is within the health sector budget which would provide funding for safety and security of staff in accordance with the particular needs of health services.
- A specific offence of assaulting, obstructing, hindering or delaying a hospital or health worker or a licensed security guard or emergency worker in the execution or performance of their duties be considered in Victoria.
- Hospitals should be encouraged to form security and aggression management committees and teams with representation from executive management, security staff, medical, nursing and allied staff including, where relevant, members of mental health and alcohol and drug teams.
- Hospital policies to address violence should utilise a risk management approach. Formal risk assessments should be conducted at each workplace, taking into account the times most likely to result in violent events. Continuous monitoring and evaluation of outcomes need to be undertaken to assess the effectiveness of the risk management strategies that have been implemented. The outcomes of such evaluation should be reflected in updates to violence risk management plans.
- Visible, uniformed, unarmed security staff should be positioned in close proximity to emergency departments, psychiatric units and other areas of the hospital where violent incidents may have the potential to occur.
- Accepting that long waiting times in the emergency department and triage rooms is one of the main contributors to frustration and aggression, the Committee recommends that the hospital explore options for the better communication of likely waiting times and alternatives sources for medical attention in cases of non-critical presentations.
- In addition to holding a licence under the Private Security Act 2004 (Vic), all hospital based security personnel must have received nationally accredited training in the specialised nature of providing security in a health setting. This will include culturally sensitive training in dealing safely with aggressive behaviours due to drug and alcohol abuse, mental health conditions, intellectual disabilities and other clinical conditions including dementia and acquired brain injuries. Training must also include communication skills and comprehensive instruction on

safe restraint techniques and appropriate response to patients with various medical conditions and injuries that render usual restraint procedures inadequate.

The committee's recommendations and comments on issues of the powers, procedures and equipment of security officers are worth quoting in full, as they directly and thoughtfully address issues that are currently under debate within NSW.

11. The Committee recommends that Protective Service Officers (PSOs) not be employed in Victorian hospitals and health services. Such a measure is inappropriate and contrary to the good management of security in hospitals and poses a greater safety risk.

The overwhelming response to this Inquiry has been that under no circumstances should either armed or unarmed Victoria Police Protective Service Officers or any other armed officer be placed in Victorian Hospitals or emergency rooms to assist with security. This view has been repeatedly stated to the Committee by doctors, nurses, ambulance officers, and executive hospital management amongst others. The reasons for this position are many and are expounded in full in the relevant chapters of this Report. In particular, however, hospital staff are concerned that the presence of armed guards would increase rather than reduce the potential for violence in the hospital environment. The introduction of armed officers has the potential for unintended serious consequences for the safety of staff and patients should firearms be discharged in close confines. This has certainly been the case in the United States of America. Moreover, according to many witnesses the sight of guns has the potential to unnecessarily intimidate patients or the public. Secondly, there are concerns from hospital management that if Protective Service Officers were introduced the hospital 'chain of command' could be compromised. In particular, the issue of whom Protective Service Officers would be answerable to and take direction from would be blurred. This is particularly the case given that emergency risk management should be clinically-centred rather than security-centred according to most witnesses.

12. The Committee recommends that hospital security guards should not possess, carry or utilise firearms, capsicum spray or tasers in the course of their duties.

Whilst the evidence to the Inquiry has emphatically been opposed to the introduction of armed PSOs or security officers, the arguments are less clear-cut for the use of other forms of weapons, restraint procedures or security equipment.

The use of capsicum spray and tasers is particularly contentious. Many witnesses to the Inquiry have given evidence that the deployment of such spray in the close confines of the emergency room can have a deleterious effect on staff and patients alike. At the very least its use would require the vacation of the immediate environs causing disruption to the smooth running of the emergency room. The evidence received by the Committee suggests that on balance it would be inappropriate for security officers to wear or use tasers or capsicum spray/foam.

As for other forms of restraint and security measures, for example handcuffs, physical restraints and metal detectors, the Committee believes each hospital should develop its own policies and procedures according to its own individual needs. In all cases however, hospitals must comply with and act according to the provisions of the state government policy 'Deter, detect and manage: A guide to the better management of weapons in health services'.

Work Health and Safety Considerations in Hospital Emergency Departments

When security officers are faced with individuals who have been restrained by police officers in an emergency department drop off situation they, like all workers, have the right to work that is as healthy and safe *so far as is reasonably practical*, (Work Health & Safety Act [WHS Act] Section 19).

As these drop-offs are a regular part of security work in emergency departments, that right means that NSW Health/local health districts have a duty to apply obvious and available risk controls to the situation; for instance, designing the emergency department with a seclusion room and constantly consulting, co-operating and co-ordinating, (WHS Act Section 46), with the NSW Police/local area command to ensure sufficient levels of police officers, so that security officers are not left having to deal with a potentially violent individual in an unsafe manner.

With respect to Section 19 (3) (f) & (g), it is also clear that security officers have the right to:

> *(f) the provision of any information, training, instruction or supervision that is necessary to protect all persons from risks to their health and safety arising from work carried out.*
>
> *(g) that the health of workers and the conditions at the workplace are monitored for the purpose of preventing illness or injury of workers arising from the conduct of the business or undertaking.*

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.

It is clear from *Section 19 (3) (f) & (g)* that *the provision of 'any information*' and that the '*conditions at the workplace are monitored'* requires a well-resourced feedback loop. As per WHS Act Section 46, NSW Health/local health districts, NSW Police/local area commands must be actively and systematically gathering data on the causes of violent behaviour in each and every emergency department and likewise then consulting security officers and their health and safety representatives.

In this Section 19 feedback loop regarding violent patients, NSW Health/local health districts must fully consult with the affected security officers with respect to WHS Act Sections 47, 48 and 49. It is often the case that the managers involved do not comply with their duties with respect to Section 48, as follows:

> ***48 Nature of consultation***
>
> *(1) Consultation under this Division requires:*
>
> *(a) that relevant information about the matter is shared with workers, and*
>
> *(b) that workers be given a reasonable opportunity:*
>
> *(i) to express their views and to raise work health or safety issues in relation to the matter, and*
>
> *(ii) to contribute to the decision-making process relating to the matter, and*
>
> *(c) that the views of workers are taken into account by the person conducting the business or undertaking, and*

(d) that the workers consulted are advised of the outcome of the consultation in a timely manner.

(2) If the workers are represented by a health and safety representative, the consultation must involve that representative.

As is clear from this section, the consultation processes arising from Section 48 are also iterative ones and are clearly linked to the provisions of Section 19 excerpted above.

With the foregoing consultation processes in mind, every local health district and local area command should be producing regular written reports on the hazards faced by their workers working in emergency departments, the hazards eliminated, and the risk controls applied to minimise those hazards that cannot be eliminated.

The HSU and our members are not aware of a best practice example where all these elements of hazard identification, risk management, consultation and reporting occur as an iterative process.

To ensure the safety of our emergency departments, all senior executives with WHS Act Section 27 duties of due diligence placed on them must act urgently ensure that the necessary financial resources are committed to change this parlous situation.

IRC Recommendations for Tweed Heads Hospital

Security officers at Tweed Heads hospital have been the subject of a number of assaults in recent months. In July this year they made it clear to management that they would no longer receive aggressive or violent patients from police or paramedics unless there was a minimum of two security officers present for the reception. This was done on the basis that the security officers had a genuine fear for their safety in the workplace should they be required to receive such patients alone. The dispute went to the Industrial Relations Commission.

The IRC ruled that it was in fact a safety dispute, and could not be heard. The Commissioner did, however, make a number of recommendations:

- That the parties meet early the next week to discuss safety issues.
- Management are to ensure that proper protocols are developed with police and ambulance as a matter of urgency to ensure there is as much forewarning as possible that a potentially violent and aggressive patient is being taken to the hospital and that the police or paramedics are to remain on site until there are two properly trained security staff present to receive the patient.
- That the two properly trained security staff can include a properly trained health and security assistant [HASA]. If no properly trained HASA is available, then a casual is to be called in and if no casual is available a security officer is to be called in on overtime.

Assuming such steps have a positive result in the Northern NSW Local Health District, there is no reason why they shouldn't be extended to apply to all of NSW Health.

It is this approach, and that of the Victorian committee recommendations, that the HSU sees as the most positive way ahead. A workforce of well-trained and resourced security staff, with properly defined powers, rules and practices, will promote the safety of patients, health workers and the public.