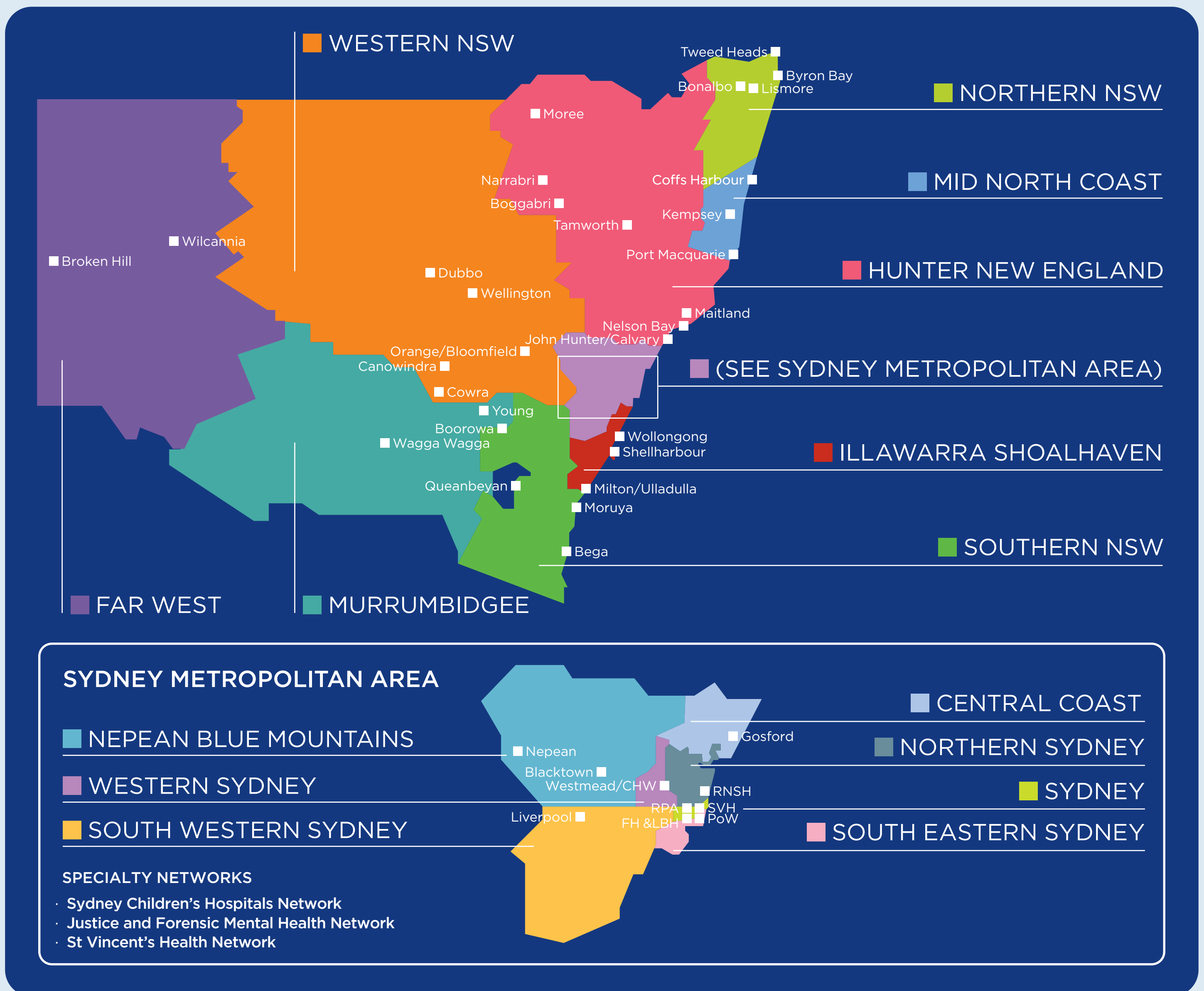
Improvements to security in hospitals

Final Report 2020

The Hon Peter Anderson AM

Hospitals visited

November 2018 to October 2019



1. Gosford Hospital
2. Nepean Hospital
3. Westmead Hospital
4. Children's Hospital Westmead (CHW)
5. St Vincent's Hospital (SVH)
6. Royal Prince Alfred Hospital (RPA)
7. Prince of Wales Hospital (POW)
8. Wollongong Hospital
9. Liverpool Hospital
10. Royal North Shore Hospital (RNSH)
11. Forensic Hospital (FH)
12. Long Bay Hospital (LBH)
13. Wellington Health Service
14. Dubbo Hospital
15. John Hunter Hospital (Newcastle)
16. Calvary Mater Hospital (Newcastle)
17. Tomaree Hospital (Nelson Bay)
18. Maitland Hospital
19. Queanbeyan Hospital
20. South East Regional Hospital (Bega)
21. Moruya – Eurobodalla Health Service
22. Milton Ulladulla Hospital
23. Shellharbour Hospital
24. The Tweed Hospital
25. Byron Central Hospital
26. Lismore Base Hospital
27. Bonalbo Multi Purpose Service
28. Wilcannia Multi Purpose Service
29. Broken Hill Health Service
30. Coffs Harbour Hospital
31. Kempsey Hospital
32. Port Macquarie Hospital
33. Wagga Wagga Health Service
34. Boorowa Multi Purpose Service
35. Young Health Service
36. Cowra District Hospital
37. Canowindra Soldier's Memorial Hospital
38. Orange Health Service
39. Bloomfield Hospital
40. Moree Hospital
41. Narrabri Hospital
42. Boggabri Multi Purpose Service
43. Tamworth Hospital
44. Blacktown Hospital

Stakeholder consultations

The following organisations or office holders have been formally consulted:

INTERNAL STAKEHOLDERS

- Security In Hospitals Working Party
- Security Managers Liaison Committee
- Dr Murray Wright, Chief Psychiatrist
- Dr Dominic Morgan, Chief Executive, NSW Ambulance
- HealthShare NSW
- Nursing and Midwifery Office
- Health Emergency Management Unit
- Health Infrastructure NSW
- Anne Marie Hadley, Chief Experience Officer

INTERSTATE HEALTH SERVICES

- Canberra Hospital ACT
- Royal Brisbane and Women's Hospital QLD
- Royal Melbourne VIC
- The Alfred Hospital VIC
- Footscray Hospital VIC

EXTERNAL STAKEHOLDERS

- Health Services Union (HSU)
- NSW Nurses and Midwives' Association (NSWNMA)
- Australian Medical Association (AMA)
- Australian Salaried Medical Officers Federation NSW (ASMOF)
- Australian Paramedic Association (NSW) (APA)
- NSW TAFE
- SafeWork NSW
- Deputy Commissioner Gary Warboys, Regional Field Operations NSW Police
- Deputy Commissioner Jeff Loy, Metropolitan Field Operations NSW Police
- Deputy Commissioner Mal Lanyon, Corporate Services NSW Police
- Assistant Commissioner Mark Walton, Commander of the Central Metropolitan Region NSW Police
- Assistant Commissioner Anthony Crandell, Education and Training Command NSW Police
- Commissioner Peter Severin, Corrective Services NSW
- Police Association of NSW
- Weapons, Tactics, Policy and Review, Operations Safety and Skills Command NSW Police
- People Development Command, Centre for Operational Safety Victoria Police
- Australian Security Industry Association Limited (ASIAL)
- Security Licensing and Enforcement Directorate NSW Police (SLED)
- Barrier Industrial Council (BIC)
- Australasian College for Emergency Medicine (ACEM)
- Western Sydney University
- Charles Sturt University

STATE MEMBERS OF PARLIAMENT

- Jenny Aitchison MP, Maitland
- The Hon. Kevin Anderson MP, Tamworth
- Clayton Barr MP, Cessnock
- Roy Butler MP, Barwon
- Yasmin Catley MP, Swansea
- Steph Cooke MP, Cootamundra
- Tim Crakanthorp MP, Newcastle
- Philip Donato MP, Orange
- Sonia Hornery MP, Wallsend
- Dr Joe McGirr MP, Wagga Wagga
- Greg Piper MP, Lake Macquarie
- Geoff Provest MP, Tweed
- Janelle Saffin MP, Lismore
- Paul Scully MP, Wollongong
- Tamara Smith MP, Ballina
- Wendy Tuckerman MP, Goulburn
- Anna Watson MP, Shellharbour

Improvements to security in hospitals

Introduction

Following publication in February 2019 of the Interim Report of my review into the safety of staff, patients and visitors in NSW public hospitals, I continued to review the security challenges facing hospitals in rural and regional areas, in accordance with Recommendation 4. I also investigated potential equipment options for hospital security staff and the security practices in hospitals in other States and Territories of Australia and New Zealand as foreshadowed by Recommendation 35.

This Final Report should be read in conjunction with the Interim Report (Appendix A).

At the end of this review, a total of 49 hospitals were visited from every Local Health District (LHD) and every type of facility, from major tertiary hospitals in metropolitan Sydney to four-bed multi purpose services in remote NSW, from Tweed Heads in the north to Moree in the north west, Broken Hill and Wilcannia in the far west, to Wagga Wagga in the south west and Bega in the south of the State.

During these visits, many hundreds of staff including security staff, nurses and doctors have been consulted. In response to an invitation from the Minister for Health and Medical Research, 17 Members of Parliament have also been consulted. Those members were from across the Government, Opposition, Shooters, Fishers and Farmers, the Greens and an Independent.

The issues encountered cannot be resolved with a one size fits all solution. Rather an amalgam of actions is required, the adoption of which will have a significant impact on improving the safety and security of patients, staff and others.

These are:
- Adoption of an adherence to the principle that "security is everyone's business"
- The "designing out of risk" where practicable
- The expansion of the Patient Experience in Emergency Departments program
- An expansion of diversionary programs away from the emergency department where appropriate, for patients who do not need to attend the emergency department and alternative care measures are available
- A focus on de-escalation rather than the concept of 'moving forward' as the first response
- A comprehensive range of measures around deterrence
- Communicating legislative base for security staff
- Better coordinated and prepared hospital security
- An understanding of, and commitment to, the policy that security staff are part of the clinical management team
- Above all, the absolute necessity for sound leadership and governance of the safety and security of the District/Network.

A number of these themes were discussed in the Interim Report. The approach I have taken with this report is to identify those recommendations from the Interim Report that require amendment, and new recommendations that I am making.

Finally, I note that action has commenced on implementing recommendations from the Interim Report.

Review Findings

The following considers each of the recommendations from the Interim Report to either confirm that the recommendation remains unchanged, or modify those where further visits and consultations have brought new information to light, and to make new recommendations.

Recommendations

CULTURE

1. A culture of safety and security to be mandated and clearly understood across the NSW health system based on the maxim that "security is everybody's responsibility".

CONFIRMED

Addressing security and staff safety risks in hospitals is not just an issue for security staff alone. On the contrary, solutions need to go beyond the security department and consider all facets from the way buildings are designed, the way staff interact with patients and visitors and how services are provided and models of patient care adopted.

Where good clinical management practices are in place, that has a flow on effect to security, as observed in certain locations.

Further, the approach to providing security cannot be a combative or offensive one. To borrow from a very experienced Security Officer, "we need to talk them down, not take them down". This is a simple expression of what effectively is the de-escalation policy that has been in place for some time.

2. That culture requires an understanding that staff and members of the public are entitled, both legally and morally, to the same protection as patients. Staff cannot work efficiently if they come to work fearful of being assaulted.

CONFIRMED

In furtherance of this recommendation the following is made:

Further Recommendation:

Appropriate warnings to be posted at hospitals and other health facilities in the community indicating that aggressive and/or violent behaviour will not be tolerated, and that police will be called and charges will be pursued. In addition 'exclusion notices' may be issued.

During the course of my visits I became aware of posters proclaiming both the need and responsibility to protect patients from harm. This is a laudable objective and one I totally support. Similarly, the safety of staff and others within our hospitals must be of equal importance.

The issue of staff safety is not simply a matter of moral responsibility it is also a legal one.

It must become clearly evident to any person entering hospital premises that physical and/or verbal abuse of staff, patients and members of the public will not be tolerated and action will be taken. Those actions include, inter alia: removal of the perpetrator from the hospital; notification to police and potential arrest and prosecution; and/or future exclusion from the premises unless in urgent need of medical attention.

The warnings need to be clear and indicate this is to protect patients and staff alike.

In some locations I visited, they have put in place an 'exclusion notice' issued by the Chief Executive of the LHD whereby a person can be excluded from attending the facility if they are violent or aggressive, unless they require urgent medical treatment. Based on anecdotal evidence, it would appear that such an 'exclusion notice' is viewed far more seriously than an Apprehended Violence Order (AVO). Also it does not require the police to do anything, nor does the matter have to go to court. The exclusion notice is not enforced if a person has a life threatening illness. The notices appear to be most effective against relatives and friends of a patient who are causing anxiety to staff through aggressive and threatening behaviour.

In Victoria, some hospitals have similar measures in place, including 'behaviour contracts' and 'not welcome notices'.

It should be noted that these policies should apply in other facilities that are not on the hospital campus, such as a community health centre. It may also be considered where community health staff are conducting home visits.

I note that a NSW Health staff safety public awareness campaign was developed for use on social media over the December 2019/January 2020 period to remind the community that aggression against hospital staff or paramedics is not acceptable.[1] I am supportive of such campaigns that communicate to the public that staff cannot work proficiently if they come to work fearful of being abused and/or assaulted.

3. ***An evaluation of the Nurse Safety Culture Co-ordinator positions funded in the 2017/18 Budget should be undertaken with a view to identifying opportunities to enhance the adoption of the culture referred to above.***

CONFIRMED

During my visits, I met a number of Nurse Safety Culture Co-ordinators. The work they are doing is impressive, and I note that an evaluation of the role is underway.

RURAL AND REGIONAL

4. ***The different challenges facing regional and rural hospitals should be the focus of a similar investigation to that undertaken so far by the Review.***

COMPLETED

1. www.health.nsw.gov.au/patients/Pages/staff-safety.aspx

Following the Interim Report, I visited a further 29 hospitals located in rural, remote and regional NSW between May and October 2019.

These locations face many challenges and these are discussed throughout the remainder of this report.

While the number of incidents that occur in these smaller facilities are generally far less than those that occur in bigger hospitals, when they do occur, they have a substantial impact on staff.

It became apparent when visiting regional and rural centres just how important the physical environment is in maintaining the safety of staff. Features such as perimeter controls, access controls between clinical and public areas and havens for staff to retreat to, provide the best opportunity to minimise risks to staff.

The issue of designing out risk is further discussed at Recommendation 17.

LEADERSHIP

5. ***The acceptance of, and adherence to, the principle that a staff safety culture is to be led by the Chief Executive of each organisation.***

   CONFIRMED – see Recommendation 11

6. ***Managers must ensure that the current culture of under-reporting of security type incidents ends. Staff are to be actively encouraged to enter all incidents into the current incident management system (IIMS). Staff are also to be advised of the efforts being made to upgrade the current system to the new ims+ to address the issues of concern.***

   CONFIRMED

   I am pleased to note that rollout of the new improved incident management system, ims+, commenced in November 2019 with a pilot at Western Sydney and Murrumbidgee LHDs. I am advised the system will then be progressively rolled out across NSW Health during the course of 2020. Once in place, this system should provide accurate information upon which staffing and rostering decisions can be made.

Further Recommendation:

Districts should note that they are required to comply with clause 34 of the Security Industry Regulation 2016 which requires that an incident register is kept by master licensees.

7. ***Managers and supervisors are to ensure compliance with the wearing of personal duress alarms where their use has been mandated. Where problems are identified regarding the use of a duress alarm then that matter is to be resolved urgently. Where a staff member requests, due to concerns for their individual safety, the issue of a duress alarm for use elsewhere in their place of work, then consideration should be given to the issue of same.***

   CONFIRMED

I also make the following recommendation with respect to duress alarms.

Further Recommendation:

Fixed duress alarms are to be located near the access door of a patient treatment room or staff only room, as well as at the rear of the room, so that staff can access the duress button and not get trapped.

It was brought to my attention during some of the visits that fixed duress alarms were installed in inappropriate locations or only at the rear of a room away from the exit door that could potentially cause entrapment of staff.

An issue raised particularly in rural areas related to the situation of staff working away from, and in some cases, a considerable distance away from the hospital regarding the provision of duress alarms and also position locators. Several concepts are in use including mobile phone apps and there would be merit in some form of exchange of information in this regard between LHDs.

Further Recommendation:

Local Health Districts/Specialty Networks share information in relation to the methods they use for staff working in the community and in particular working considerable distances away to communicate they require assistance and/or position locators.

8. ***All Local Health Districts and Specialty Networks are to have a system in place to ensure that clinical staff inform security staff when they become aware that a patient, who may present a behavioural challenge, is en route to the hospital.***

   CONFIRMED

   Refer to comments and recommendations under Recommendation 10.

9. ***Staff who have been threatened or assaulted resulting from a deliberate act of violence are to be encouraged and supported to report the assault to police and to request action be taken by the police against the perpetrator. Staff are to continue to be supported through any subsequent criminal justice proceedings. To this end, the member of staff is to be supported by another member of staff from the taking of statements through to attendance at court. Clearly this recommendation will be influenced by the clinical condition of the perpetrator. Representations should be made to permit staff of hospitals or other health facilities who are victims of assault to use the business address rather than their personal address when pressing charges or taking an AVO against an individual.***

   CONFIRMED with clarification of last sentence

   I am advised by the NSW Police Force that there is no requirement for a staff member to provide their personal address for an inclusion in an AVO. Therefore, this recommendation is amended as follows.

Amended Recommendation:

Staff who have been threatened or assaulted resulting from a deliberate act of violence are to be encouraged and supported to report the assault to police and to request action be taken by the police against the perpetrator. Staff are to continue to be supported through any subsequent criminal justice proceedings. To this end, the member of staff is to be supported by another member of staff from the taking of statements through to attendance at court. Clearly this recommendation will be influenced by the clinical condition of the perpetrator. *Local Health Districts/Specialty Networks should be aware that there is no requirement for staff of hospitals or other health facilities who are victims of assault to use their personal address rather than their business address when pressing charges or taking an AVO against an individual.*

My use of the word “deliberate” in Recommendation 9 in the Interim Report has been raised with me (and I continue to use it again in this Final Report).

What has to be clearly understood is that we are talking about the laying of a criminal prosecution against a person. In such a case the onus of proof beyond reasonable doubt never leaves the prosecution. Put at its simplest there are two basic proofs required in such a case. The first is the “actus reus” or the act itself. The second is the presence of “mens rea” or the guilty intent. The absence of the second will cause the prosecution to fail hence my use of the word “deliberate”.

It is my view that if the allegation is one of assault then a charge should be laid by police. Consideration should also be given by the LHD to issuing the perpetrator with an exclusion notice.

It is worth noting that “spitting” on someone is an assault and should be reported accordingly as this type of action will almost certainly be accompanied by some other form of threatening or offensive behaviour.

I strongly support the Government’s intention to introduce mandatory testing of people who bite or otherwise expose frontline workers to a risk of a blood borne virus such as HIV, hepatitis B or hepatitis C, and that refusal to comply with a mandatory testing order will be an offence.

10. The effectiveness of local liaison committees with police and other agencies are to be reviewed to ensure appropriate representation is present and that the meetings are held regularly. Any difficulties identified at the local level which are not resolved should be escalated in line with the NSW Health/NSW Police Force Memorandum of Understanding for further consideration.

CONFIRMED

The Health/Police Memorandum of Understanding (MOU) generally works well however ongoing oversight from a Health perspective is required.

In those places where there is an existing relationship between the LHD and/or the local management of an individual hospital and the Police Local Area Commander, the evidence is of a very effective outcome for all concerned. In some places newly attested probationary constables come to the local hospital to meet the staff they will be coming into contact with, and to also have an understanding of where particular services are located. This has proved to be very effective in establishing a positive

ongoing relationship and is worthy of implementation by all LHDs. It may well be useful to consider a similar approach with regard to Corrective Services NSW.

In addition to both the NSW Police Force and NSW Ambulance, Corrective Services NSW has become an important ‘player’ in terms of impact on many hospitals. The ongoing Section 33 trial has potentially introduced an additional layer of risk that requires consideration, from the perspective of hospitals receiving patients.

The Ministry of Health has developed a draft MOU with Corrective Services NSW which is currently subject to consultation. Once this is finalised, it will provide a formal mechanism for local meetings to occur.

It has also become apparent that Australian Border Force is also relevant insofar as the treatment of detainees in hospitals such as Fairfield and Liverpool is concerned.

The greatest difficulty arising from these interactions is that it is felt that other agencies do not readily appreciate that the security staff on duty (if such staff are rostered or available) are a finite resource which have been provided to meet the known security demands of that hospital on that day.

One initiative that would be of great assistance to the hospital (not just security staff) is if an agency bringing a person to the hospital could advise that hospital they are coming and the nature of any potential security/safety risks surrounding the person they are bringing in.

This is particularly important so that the hospital is ready for the arrival and the appropriate staff are present. This assists in ensuring that security staff (and others) do not have to be called to an event that has already “kicked off” (underway) but rather are present or on standby and able to reduce the volatility of the situation. It will also provide an early opportunity for the hospital to give some consideration to the requirement for extra staff should such a provision be possible.

At times there are sensitive and challenging situations within hospitals involving Family and Community Services (FACS) that would benefit from a more formal liaison between the hospital management and the local FACS management to ensure that staff are not at risk during such situations. Timely advice from FACS to a hospital should be standard procedure.

There are some hospitals in small country towns where there are no security staff and no, or limited, police presence. In the event of a serious incident or threat, this makes those places vulnerable.

Further Recommendations:

Police and paramedics should inform emergency department staff when bringing in patients with challenging behaviours who may pose a potential risk. To this end, the existing and all future MOUs with third party agencies should include provision for such information to be provided prior to arrival at the emergency department.

Where applicable, appropriate liaison should be established with both Corrective Services NSW and Australian Border Force to ensure effective processes, including early notification, are in place where patients are brought to hospitals from correctional facilities or elsewhere, and detention centres.

Local Health Districts/Specialty Networks should establish appropriate liaison with Family and Community Services (FACS) to ensure the safety of staff is maintained during any proposed interventions by FACS staff.

In some parts of the State where there is no established police presence, consideration should be given to discussions with Local Government NSW, the peak organisation representing the interests of NSW general and special purpose councils, with a view to identifying potential opportunities for support in certain security-related circumstances.

GOVERNANCE

11. ***Each Board of a Local Health District or Specialty Network is accountable for the security and safety of staff, patients and visitors. Consideration should be given to having security / staff safety as a standing agenda item for each Board meeting and, where they exist, each Board sub-committee dealing with audit, risk and compliance.***

    CONFIRMED

    There are some LHDs who may believe that it is not necessary to adopt my earlier "governance" recommendations regarding security. It is my very firmly held view that Chairs and/or Boards who choose to ignore those recommendations are placing themselves in a very exposed position in the event of a major incident.

    The NSW Health Corporate Governance and Accountability Compendium (May 2019) states very clearly that the 'primary responsibility for achieving a violence-free workplace for staff, patients and the public rests ultimately with the chief executive and the board of the public health organisation'.

    This recommendation does not place any great burden on either the Board or the Executive of a LHD. What it does do is ensure that those who need to be aware of incidents and staff safety concerns (or lack thereof) in order to discharge their governance functions, can do so.

    I have repeatedly pointed out in the many discussions I have held that in the event of a tragedy in a hospital arising from a security incident, the matter will become one for investigation by the Coroner. In that situation there is no doubt that the governance of the security of that facility will be the subject of close consideration, and most certainly there will be a requirement for certain people (other than those directly involved in the incident) to enter the witness box and explain what they and the organisation had done to try and prevent such a tragedy.

12. ***The required NSW Health Security Improvement Audit Program is to be fully resourced and implemented in each Local Health District and Specialty Network, and reported to the Board through the Board sub-committee dealing with audit, risk and compliance.***

    CONFIRMED

13. ***A central security audit function be established with appropriate resourcing to drive compliance and consistency of security policies and standards throughout NSW Health.***

CONFIRMED

It is understandable that LHDs wish to have policies that address local issues however it is vital that all staff are able to move between LHDs and not encounter policies which substantially diverge from those that have been issued by the Ministry of Health. It is logical that all LHDs generally comply with such policies and that any justifiable deviation from same are readily capable of being identified and understood by new staff in that LHD. It is noted that this unit is being established within the Ministry of Health.

I had the opportunity to meet with the Queensland Health Occupational Violence Strategy Unit which is undertaking a variety of initiatives and sharing approaches to staff safety and security across the health districts in that State, aimed at improving the safety of staff, patients and visitors. It is my view that NSW Health would benefit from a similar approach.

In furtherance to the above recommendation, the following is made:

Further Recommendation:

The central security audit function established within the Ministry of Health, should not be confined to one of audit but one of identifying and sharing best practice across the whole system to improve security.

14. ***Where there are both Security Officers and Health and Security Assistants (HASAs) in the one location, action must be taken to ensure both groups operate as one integrated team with a strong professional relationship and an ultimate single line of reporting within each Local Health District/Specialty Network.***

CONFIRMED with minor amendment

It is clear that the security function, including where there are both security officers and HASAs, within a LHD, should be conducted in an integrated and coordinated way across the District, and should ultimately report to a suitable position that can represent the security function at a senior executive level. This will ensure a consistency across the security landscape. It will also provide opportunities for security staff to work in other locations and provide career development.

It is noted that some LHDs are planning to introduce, or have introduced, a District-wide security governance model and have employed a District Security Manager. The Ministry of Health should seek advice from these LHDs on any evaluation of the approach and share that advice with other Districts.

In furtherance of the governance principles enunciated in the Review and personal observations, two recommendations are included below regarding the transfer of the security function from HealthShare NSW to the LHDs.

Further Recommendations:

That the security function within Hunter New England Local Health District transfer from HealthShare NSW to Hunter New England Local Health District.

That the security function at Royal North Shore Hospital transfer from HealthShare NSW to Northern Sydney Local Health District.

Implementation of these further recommendations will require discussions to be held and decisions to be made regarding how the transfer of functions occurs, and therefore would not realistically be able to occur before 1 July 2020.

15. ***Local Health Districts and Specialty Networks must determine security staffing levels based on an assessment of risk and implement demand driven rostering of security staff to address the identified risk, similar to how clinical staff are rostered.***

CONFIRMED – see comments under Recommendation 6

On a number of occasions it was put to me that there was a need for additional security staff either across the State or at a particular location. My response has been how many, where and based on what evidence? Too often the answer, if there was one, was the same number of additional staff on each shift, each and every day.

My very strongly held view is that if the recommendations contained in this Final Report were to be implemented, this would result in a reduction in both the number and intensity of adverse security events in hospitals (and health facilities). This would particularly apply in and around emergency departments.

16. ***Security staff should be positioned so that they are regularly visible in emergency departments, both in the treatment and waiting areas.***

CONFIRMED

At the time of writing this report, a three month trial of a security officer located in the emergency departments 24/7 at Gosford and Wyong hospitals is underway. The trial is subject to evaluation and the outcome should be communicated across LHDs.

There are already some locations that have security located within their emergency departments on a 24/7 basis. What I saw to be very effective was where HASAs were embedded in some of the busier rural locations, such as at Tweed Heads. This practice was welcomed by emergency department staff and HASAs alike where it was observed in operation. It was obvious that the HASAs involved were held in high regard both professionally and personally by their clinical colleagues. It allowed other security staff to undertake their duties and back up the HASAs in the event of an incident in the emergency department.

With respect to mental health, refer to my comments under Recommendation 24.

Further Recommendation:

Consideration should be given to embedding Health and Security Assistants (HASAs) in appropriate emergency departments and mental health facilities/units.

17. ***When planning new and redeveloped hospital and health facilities, due regard needs to be given to designing out risk and taking account of the views of clinical and security staff. This should include developing design guides that assist staff and architects to incorporate security into early planning stages.***

CONFIRMED

It should be standard practice that the Chief Executive of the LHD is provided with the recommended plan for the site to confirm the final layouts are safe and design out all possible risks where practicable.

Further Recommendations:

Prior to finalising plans for new or redeveloped hospitals and health facilities, confirmation should be sought from the Chief Executive of the Local Health District/Specialty Network that the design and layout of the facility has undergone a security review and meets all relevant NSW Health policies and the Australasian Health Facility Guidelines (AHFG). Where relevant NSW Health policies and AHFG requirements have not been applied, the Local Health District/Specialty Network Chief Executive should also be required to confirm that a documented risk assessment, meeting the requirements of work health and safety legislation, has been undertaken.

A review of the efficacy and governance of the current process of planning, designing and building health facilities (with particular regard to security) should be considered to ensure that the expertise and views of the facility users are taken into account.

The extensive program of capital works being undertaken or planned across NSW Health provides an opportunity to ensure that the design of these hospitals reduces risks to staff safety, effectively future proofing as far as possible all new and redeveloped hospitals.

Logic dictates that the issue of designing out risk must be at the forefront of consideration from the initial project briefing. It is noted that this is a core activity of architects and designers who work with users to design facilities with a particular model of care/service delivery intended. This means that all those involved including architects and project managers need to be aware of and understand the importance of, designing out risk at the start of the project so that security measures are included in the early schematic design.

Both the LHDs and Health Infrastructure must seek out and take advice from both clinical staff and staff with safety and security expertise nominated by the LHD/Network prior to any design work commencing, during the design process, before project documentation is concluded, during construction and commissioning and also in post occupancy evaluation.

The onus placed upon the Chief Executive of the LHD in being able to confirm the matters from the recommendation above is in furtherance of the governance responsibilities enunciated elsewhere in this report.

During my visits, I heard complaints from LHD staff regarding requests made to architects and/or designers being ignored. Two clear examples were in evidence:

i. Firstly the style of glass windows indicated in emergency department and other waiting rooms was often raised with me. There is a school of thought that there should be no such barrier between staff and the public in order to ensure a "welcoming" atmosphere and also to improve aesthetics.

   This Review rejects such an approach. The safety of staff is paramount and there have been too many incidents of spitting, assaults and throwing of objects, e.g. chairs. The design of many of the safety glass windows is unsatisfactory in that a person can gain access to staff because the width of the opening will permit a person to climb or reach through to the staffing area, or to spit on or at staff or grab papers and computer chords on the desk.

   There are excellent existing examples of appropriate safety glass windows that permit papers to be exchanged and ensure reasonable privacy for the person speaking to the staff member without placing the staff member in an exposed situation.

ii. Secondly, the location and access to Safe Assessment Rooms (SAR) requires a degree of standardisation. It is unreasonable to have a recalcitrant patient brought through the emergency department to a SAR when it should be accessible by paramedics and/or police directly from the outside. The access to the SAR from the outside should be by way of a door that is either the width of one and a half single doors or a double door. Attempting to take a person who is resisting through a single door substantially increases both the difficulty in doing so as well as creating an increased opportunity for injury to the person and/or staff.

Further Recommendations:

Barriers used at emergency department reception and triage desks and other waiting room/reception areas that have been determined to be at risk, should be of a safety glass design that does not allow a person to climb or reach through and grab at or potentially harm staff.

The width of entry/exit doors to Safe Assessment Rooms (or similar) should be a minimum of the width of one and a half doors. This design principle should be built into Health Infrastructure's Design Guidance Note for Safe Assessment Rooms.

See comments under Recommendation 23 regarding the new NSW Health Guideline for SARs released 9 January 2020.

The issue of facility lockdown capability is discussed further in this report under Recommendation 21.

The introduction of swipe cards for access to staff areas is to be commended. It is imperative that all staff understand the necessity to comply with the policies surrounding such cards, and ensure doors with swipe card readers are not kept ajar.

Further Recommendation:

Local Health Districts should conduct programs for all staff reinforcing the importance of the appropriate use of swipe cards.

STANDARDISATION

18. ***The security standards set out in the NSW Health security manual Protecting People and Property, and the related policies, should be adopted in every facility as written, and compliance is to be subject to audit.***

    CONFIRMED

19. ***A standardised "Code Black" procedure must be in place in all facilities, in line with that specified in Protecting People and Property, unless a particular localised variation can be justified. Regular practice drills should be undertaken so that everyone understands their roles and responsibilities and skills remain current.***

    CONFIRMED

Further Recommendations:

Consideration be given to introducing a 'potential' Code Black similar to the 'Controlled/Planned Code Grey' used in Victoria.

During a number of visits, it became obvious that there was an inconsistent approach to a Code Black response. At the commencement of each shift, personnel should be identified who will be required to attend a Code Black if called, and their roles should also be clearly defined and understood.

Hospitals in Victoria use two types of Code Grey for responding to incidents of aggression. In NSW, such incidents are referred to as Code Black. In addition to the reactive 'emergency' Code Grey, a 'controlled' or 'planned' Code Grey is a pre-emptive response that anticipates a potentially difficult/challenging situation and puts into place the necessary resources in the event the situation evolves. This has resulted in fewer emergency Code Greys.

There is benefit in adopting a potential Code Black (or other terminology deemed to be appropriate), along the lines of that used in Victoria, to differentiate the type of response required. In some cases management plans for particular individuals may be in place. There were a number of examples during my hospital visits across the State where this type of response already occurs informally.

The Interim Report recommends that security staff are notified when clinical staff are made aware that a patient who may present behavioural challenges is en route to hospital (Recommendation 8). It is this type of situation that would benefit from having a potential Code Black" response category. See my further comments under Recommendation 29

20. ***The use and effectiveness of current CCTV operations with particular reference to the prevention, response and evidentiary uses are to be subject to audit to ensure compliance with the NSW Health security standards for CCTV as set out in Protecting People and Property.***

CONFIRMED

> **Further Recommendation:**
>
> Local Health Districts/Specialty Networks consider establishing, where practical, an integrated district-wide CCTV operation with 24/7 observation monitoring. The Ministry of Health should consider trialling such an operation in two or more Districts.

The observation of such a CCTV operation in Brisbane extending over a very large geographical area with multiple campuses was impressive. It provided ongoing monitoring and enabled immediate observation of any area to which attention had been drawn. It was staffed by one security officer on a rotating basis.

Of similar interest is the fact that the CCTV coverage of the Nepean Clinical School in Derby Street Penrith opposite Nepean Hospital is operated by and from Sydney University Campus. Interestingly security from Nepean Hospital have no role in the event of an incident. The university calls the police.

I am aware that as part of a trial of proactive security measures, a trial is underway at Blacktown Hospital of 24/7 monitoring of CCTV screens. The trial is underway at the time of writing this report and the outcome of the trial should help inform action in relation to this recommendation.

21. ***Security audits are to include disaster planning, lockdown procedures and incident management protocols.***

CONFIRMED

I am aware of a revised structure within the Ministry of Health to focus on incident and emergency preparedness and response across the health system.

During my review I became aware of the very different approaches in LHDs regarding disaster management.

The ongoing provision of electronic means to lockdown all or parts of facilities is most welcome. This will reduce the risks for staff required to do manual lockdowns.

The practice of having a space in any facility that can be quickly adapted for use as a control room during an incident is prudent. By the same token if that space is located in an area which becomes the subject of a lockdown there needs to be an alternative space outside the lockdown zone readily available for use.

A control room is a separate facility to that operated by the police in such a situation. It is to enable communication within the LHD, contact with the Ministry of Health and of course effective liaison with police.

Further Recommendation:

Local Health Districts/Specialty Networks should review their disaster management staffing and protocols.

A review of facility lockdown capability should be undertaken along with an assessment of plans to establish local control centres if required in the event of a disaster or incident.

Security managers should be an integral part of incident and emergency/disaster planning and response.

22. ***Security Officers and HASAs should be part of a state-wide hospital security function enabling mobility through transfers and ongoing professional development.***

CONFIRMED – see comments under Recommendations 14 and 41

PATIENT CARE/MODELS OF CARE

23. ***The provision of a safe space in emergency departments (in the best interests of both patients and staff) is supported. Examples of such a space are "Safe Assessment Rooms" or "PANDA Units" (Psychiatric, Alcohol and Non-prescription Drug Assessment). Further analysis of the successful Behavioural Assessment Unit (BAU) pilot program at the Royal Melbourne Hospital is required with a view of possible adoption in some major emergency units.***

CONFIRMED

I note that a new NSW Health Guideline for SARs, developed by the Agency for Clinical Innovation, was released on 9 January 2020. The Guideline describes the appropriate use, governance and design of SARs in emergency departments. I note this document clearly states that SARs are not intended to be used for seclusion. A SAR is a room in the emergency department that is appropriate to assess a behaviourally disturbed patient or any other emergency department patient who requires a safe place away from the general emergency department bed area. See my comments under Recommendation 17 regarding design considerations. Any use or design of a SAR should be in accordance with this guideline. NSW Health policy *Management of patients with Acute Severe Behavioural Disturbance in Emergency Departments* also applies in this regard.

During my review, I had the opportunity to visit the Behavioural Assessment Unit (BAU) located in the emergency department at the Royal Melbourne Hospital, as discussed in the Interim Report. At The Alfred Hospital, a similar unit also located in the emergency department is referred to as Behaviours of Concern (BOC).

These models in Victoria have proven to be effective in safely managing patients who come into emergency departments with behavioural disturbances. Security staff are part of the clinical management team along with the doctors and nurses. The patient is assessed and treatment commenced in a timely manner, and the staff are not placed at risk because the patient is managed in a controlled environment.

BAU, BOC and PANDA units are a short stay unit in the emergency department where patients are admitted and continue to be cared for after they have been assessed in the emergency department until they are transferred to an appropriate ward or discharged.

Further to my recommendation in the Interim Report, I continue to support the consideration of the BAU/BOC model in some major emergency units.

Further Recommendation:

Consideration be given to developing and testing a locally adapted model similar to the BAU/BOC used in Victoria. In doing so, consideration may need to be given to opportunities within new or redeveloped hospital builds.

At Footscray Hospital in Victoria, an observation chart is used to document behaviours of concern to help staff identify changes in behaviour and potential situations that may escalate. This chart normalises the assessment of behaviours and is included as part of the routine observation process for all patients. The chart assists staff to identify actions that can be put in place to ensure the patient does not pose a threat to him/herself or staff or others. Such a chart would be worthy of consideration for use in NSW.

Further Recommendation:

A clinical tool/form should be developed that allows for the assessment and observation of deteriorating patient behaviour as part of routine observation rounds, in order to identify where intervention and management may be required.

24. ***Urgent action is required to overcome delays in mental health assessments which see patients waiting hours for such an assessment, creating a situation not in the best interests of the patient and potential to cause significant security issues for those with challenging behaviours. The use of Nurse Practitioners and Clinical Nurse Consultants (Mental Health) should be considered in this regard.***

CONFIRMED

From the very commencement of the Review until its completion the dominant theme to emerge in discussions and during visits to metropolitan, regional and rural hospitals was the management of mental health patients.

It is obvious that just as an action undertaken by a person suffering from a mental illness may have nothing to do with the mental illness itself but rather drugs, alcohol or some other motivation, then so it is that matters of concern are erroneously “lumped under” the title of mental health.

Two particular problems were consistently raised with me no matter the type of hospital nor its geographical location. The first is the assessment of an apparent mental health patient. The second relates to the management of such a patient following an assessment that the patient requires acute care.

Clinicians repeatedly raised the issue of having to hold a patient in the emergency department for several hours awaiting a mental health assessment. Sedation could not be administered in case the awaited mental health expert arrived and the sedated patient could not then be assessed. This was despite the fact that in some locations a mental health nurse such as a Nurse Practitioner or Clinical Nurse Consultant had made an assessment of the patient, however the arrival of a Mental Health Registrar was necessary to confirm that assessment and determine suitability inter alia for admission to the mental health inpatient unit or discharge home. Leaving all other considerations aside, the impact of such a situation upon a clearly distressed patient, was to my mind indefensible. In some cases the eagerly awaited Registrar has to travel some considerable distance from a place where the Registrar's presence is constantly required.

No evidence has been produced to me during the review that could justify the current situation whereby Nurse Practitioners, Clinical Nurse Consultants and accredited persons are not able to make timely decisions regarding a patient.

It became my practice when visiting emergency departments to ask the emergency department doctor the following question:
"If a patient presents in the emergency department with an apparent heart attack, do you await the arrival of a cardiologist before commencing treatment?" The answer was invariably "No", to which I would then ask "So why do you do so if a patient presents with an apparent mental health episode?" The majority of the time the answer was "I don't!"

It is evident that in many locations the doctors in charge run their emergency departments based on their assessments and decisions irrespective of the medical illness involved. They do not countenance delay and act accordingly.

Similarly, the Mental Health Emergency Care – Rural Access Program (MHEC-RAP) in some rural LHDs provides access for staff in emergency departments to mental health assessment by Telehealth for hospitals in rural and remote areas that do not have on-site mental health clinicians. However, delays are often experienced with access to this service, with small hospitals having to hold a patient overnight in their emergency departments until a clinician is available in the morning to undertake the Telehealth assessment.

The fact remains that the problem of delay still exists in some locations and needs to be addressed. The presence of mental health clinicians in an emergency department is a positive thing and should be encouraged. In some locations their input is welcomed in determining the best course of action for patients.

I am aware of a pilot of a Nurse Practitioner-led model for people presenting with mental health conditions in the emergency departments at Royal Prince Alfred, Dubbo and Maitland Hospitals. This initiative is commended and the results of the pilot should be shared widely across the health system.

Further Recommendations:

The timely availability of MHEC-RAP (and similar programs) in rural areas be reviewed and consideration be given to ensuring that current delays in such assessments and decisions to admit or discharge the patient are reduced.

There should be greater utilisation of existing accredited persons under the *Mental Health Act 2007* who have the authority to either enact or lift a Schedule on a patient and enable timely access to appropriate care including admission decisions. In doing so, a review should be conducted of accredited persons across the NSW health system to identify and address any barriers to their use.

Immediate action should be taken to overcome the situation whereby Nurse Practitioners, Clinical Nurse Consultants and accredited persons are not able to make timely decisions regarding a patient in order to ensure patients are not experiencing unnecessary delays before receiving the appropriate treatment in the most appropriate location.

I refer to my comments at Recommendation 16, and the further recommendations proposing that HASAs are embedded in emergency departments and also in mental health units. There was certainly enough evidence to suggest that where this is in place, it works well. The HASAs are seen as part of the clinical management team and are on hand to respond to situations as required.

An issue raised regularly with me by both clinical and security staff arising from the retention of assessed mental health patients in emergency departments for many hours (and in some cases, days) relates to constant requests from the patients to be able to "have a smoke" and the tension that builds when such requests must be refused. It would be helpful if there were opportunities for such patients to have secure access to fresh air; however that is almost impossible to achieve. The No Smoking policy must be complied with, however in some places the issue is being dealt with by the supply of nicotine replacement options. This would assist in alleviating tension and anxiety and reduce the possibility of a situation escalating.

Further Recommendation:

In those locations where assessed mental health patients (or other patients for that matter) are delayed in emergency departments for lengthy periods, they be offered (where medically appropriate) access to nicotine replacement options when they raise the issue of a desire to smoke.

It would be remiss of me not to record how unhelpful it was from a security point of view, to encounter in some situations anecdotal evidence of a less than optimal relationship between emergency department staff and mental health staff. This is not generally the case where mental health staff are based in emergency departments, where both professional and personal relationships are built.

From a governance perspective it is the LHD which has both the opportunity and responsibility to ensure that this potentially problematic issue is being addressed by requiring regular consultation between emergency department and mental health leadership under the auspices of the LHD.

Further Recommendation:

Each Local Health District/Specialty Network regularly convene meetings with both emergency department and mental health clinicians to ensure a positive and ongoing interaction.

I refer to my comments under Recommendations 23 regarding safe spaces in emergency departments to assess those patients with behavioural concerns, and Recommendation 25 which discusses diversionary programs away from the emergency department and improved access to timely mental health assessments for patients. The adoption of these measures would contribute to safer environments for staff and also for patients.

25. There is sufficient positive feedback to justify further consideration of possible expansion of mental health initiatives such as: Operation Pacer in the St George Local Government area; PEAMHATH (Police Early Access to Mental Health Assessment via Telehealth) in Hunter LHD; Resolve Program in Nepean Blue Mountains and Western NSW LHDs; and MHAAT (Mental Health Acute Assessment Team) in Western Sydney LHD.

CONFIRMED

Further Recommendations:

Consideration be given to expanding the PACER (Police, Ambulance Clinical Early Response) program in metropolitan locations.

Consideration also be given to piloting and evaluating Police Ambulance Early Access to Mental Health Assessment via Telehealth (PAEAMHATH) in two rural locations.

During my visits, I witnessed or was advised of various models for mental health patients that had been developed locally with police and paramedics that divert patients away from the emergency department and fast track access to appropriate services.

It was very pleasing to see that PACER won a 2019 NSW Health Award for *Excellence in the Provision of Mental Health Services*. It was also a finalist for the 2019 Premier's Award for *Tackling Longstanding Social Challenges*.

PACER is a collaboration between police, ambulance and the mental health services where a mental health Clinical Nurse Consultant works as part of a team with police to better respond to mental health crises in the community. It offers on-scene and also telephone assistance in the community. It was piloted within the St George Mental Health Service from January to June 2019 and has been extended.

Another model is the PAEAMHATH in the Hunter area where iPads were provided to police and paramedics, so they can access mental health triage and support for consumers at the scene of the emergency. This has considerable support from police and ambulance services as well as mental health staff as it can avoid unnecessary presentations to the emergency department and lengthy transport to hospital for patients, and for police and paramedics who are diverted away from their local area to undertake such transports. This program is particularly beneficial in rural areas.

There are also examples of other initiatives in other LHDs. Such programs can provide better access to assessments and services for patients leading to better outcomes, and avoid prolonged delays and stays in emergency departments, which improves the experience for the patient and reduces the risk of behaviours escalating.

I am aware of and commend work that has been undertaken by the Ministry of Health looking at co-responder models where mental health, police and ambulance services work in collaboration to provide improved pathways and access to appropriate care for persons experiencing mental health crises in the community. It is these types of models that can make a difference not only to the care of patients, but also to the safety of patients and staff.

26. There is a need to reduce stress and improve the waiting experience for people in an emergency department waiting room. Strategies to improve the experience of patients while waiting at an emergency department should be evaluated and where they are found to have had a positive impact on the patient/carer experience and staff safety, consideration should be given to resourcing their expansion across NSW Health. The broader implementation of these successful initiatives, when coupled with mobile security staff frequently moving through the waiting room, will have significant benefits for the operation of an emergency department.

CONFIRMED

Hospitals, in particular emergency departments, are suffering from the transference of the anger and incivility present and increasing within the general community. Hospitals as a sanctuary and a place for care and compassion are unable to use the sort of security screening measures evident in courthouses, airports, government buildings and places of public entertainment (eg sporting venues and concerts).

It is therefore necessary to introduce and extend a suite of measures that will assist in reducing the stress in and around emergency departments for patients, staff and members of the public. NSW Health incident data suggests that the majority of aggressive incidents against staff occur in the wards as opposed to emergency departments. Events taking place in emergency department waiting rooms and treatment areas receive most of the public attention because of the intense and unexpected nature of the incidents. There is therefore a necessity to focus on initiatives specifically applicable to emergency departments and waiting rooms.

Initiatives to reduce tension in emergency department waiting rooms are already proving valuable. The trial of the NSW Health Emergency Department Patient Experience program (otherwise known as the concierge program) has clearly established its worth, winning a 2019 NSW Premier's Award for Providing World Class Customer Service. The program was piloted in four emergency departments up until June 2019 and 17 more emergency departments have since implemented the initiative[2]. The Patient Experience officer is a proactive measure that helps patients, their families and visitors know where to go when they arrive, what to expect during their time in the emergency department, when they are likely to be seen and if there are any delays, as well as providing access to refreshments, wi-fi and mobile device charging stations. I was impressed with the 'Welcome to ED' video animation that is sent to the mobile devices of patients/families on arrival at the emergency department. The videos are available in nine languages and explain what to expect during their visit.

Anecdotal evidence indicates not only a reduction of angst in the waiting room among patients, family and friends but also reduces the anxiety of patients when reaching treatment. Further expansion is strongly recommended.

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[2]Hospitals participating in the Patient Experience program at the time of writing this report are Blacktown, Lismore, Nepean Liverpool, Royal North Shore, Ryde, Sydney Children's Hospital, The Children's Hospital at Westmead, Broken Hill, Wagga Wagga, Griffith, Deniliquin, Royal Prince Alfred (Camperdown), Concord, Westmead, Fairfield, Bathurst, Gosford, Wyong, John Hunter (Newcastle), Shoalhaven Hospitals

The designing out of risk in emergency departments is of considerable importance. The NSW Health *Emergency Department Patients Awaiting Care* policy sets out measures to improve the experience of people waiting in emergency departments, and this policy should be followed across all NSW emergency departments.

The presence of both hospital security officers and HASAs within and moving through emergency departments and waiting rooms coupled with evidence of the presence of CCTV cameras is a clearly effective set of preventative measures. In this regard, refer to my comments on the trial of proactive security measures currently underway at Gosford and Wyong as discussed under Recommendation 16.

27. At times, a patient's condition may require a 1:1 security presence to assist in protecting staff, the patient and property. This is a security function and should never be confused with the individual patient specials (or 'specialling') required to be undertaken by clinical staff.

CONFIRMED

Further Recommendation:

The nomenclature of "clinical specialling" and "security specialling" is to be adopted to distinguish between a patient requiring clinical supervision and a patient requiring security supervision.

While supportive of the concept of "1:1 security presence", I have not encountered support for the use of this term during the course of the review. The continued confusion surrounding the use of the word "specialling" needs to be overcome as soon as possible. The recommendation provides a simple way to achieve a proper identification and understanding of two very different activities.

As discussed at Recommendation 24, the retention of patients in emergency departments following an assessment that the patient requires an acute bed is a problem across the State. Each patient so assessed requires a security special on a 24/7 basis with that security presence either being provided from the LHD's own security staff – in most instances on overtime – or by licensed security staff supplied by a security company.

Utilising health security staff can lead to burn-out where it occurs on a regular basis. The costs associated with this issue are substantial and would more than cover the engagement of part-time and casual LHD security staff to undertake the task in many locations. This is not a matter confined to metropolitan hospitals alone.

Further Recommendation:

The use of security specials by each Local Health District be urgently reviewed to ensure the most cost effective provision of same.

28. In future, where a 1:1 security presence is required, that role must be referred to as '1:1 security support' and not as a 'special'. Protecting People and Property should be updated to ensure the role and responsibilities of security staff during episodes of 1:1 security support are set out.

CONFIRMED with amendment to the title

Amended Recommendation:

In future, where a 1:1 security presence is required, that role must be referred to as '*security specialling'* and not as a 'special'. Protecting People and Property should be updated to ensure the role and responsibilities of security staff during episodes of '*security specialling*' are set out.

CAPABILITY

29. All staff who work in an area where there is risk of assault/violence are required to undertake security/safety training in a timely manner, and the skills learned should be practised regularly. The training of staff should be subject to audit and the results reported to the Chief Executive and to the Board (or equivalent) through the Board sub-committee dealing with audit, risk and compliance.

CONFIRMED

In discussions with staff across the range of hospitals visited during the review, a number of matters of concern became evident. These concerns were as follows;

- A number of staff had not undergone the Violence Prevention Management (VPM) training
- Those who had undergone the training had not practised the skills since the training was completed
- There were some staff who, having completed the training, indicated that in the event of an incident taking place requiring the use of "take down" skills, the staff would not participate in such take down. Interestingly the reason for non-participation was not philosophical but rather a concern for their own safety
- There were also staff who advised that they were unable to undergo the training due to the length of time involved in such training and the budgetary impact of same (in particular the full 4 day VPM training program)
- The requirement for staff in rural areas to travel considerable distances to undergo the training
- The reluctance of some doctors to participate in the training and/or the utilisation of the training in take downs.

A resulting action of the 12 Point Plan on Hospital Security (2016), saw a suite of VPM training resources developed for staff working in emergency departments, including a one day version of the four day VPM training that focuses on a multidisciplinary approach to the physical safety and restraint skills required in the emergency department. This recognised that the existing four day VPM training required a considerable 'off the job training' time commitment, and it was primarily focussed on situations that may arise in mental health units. The emergency department VPM training package has a range of resources, including videos that are designed to encourage practice and drills in the workplace. From my visits and consultations, these resources are not being widely used.

An accurate picture of the implementation of training should be obtained as to which staff have completed the required training, which staff have not completed the required training and on how many occasions since the training was completed that it has been refreshed.

The clear issue of concern regarding the training was overwhelmingly that to release staff for a number of days to undergo the training had significant staffing and budgetary implications.

Logically, in rural and regional areas, instead of requiring a number of staff to travel a considerable distance to the trainer, the trainer should travel to the place of employment of the staff and train them there. This also has the advantage where various types of staff can be trained together, at their place of work where they may be required to respond together to certain situations.

Evidence exists to strongly support a requirement for Code Blacks to be regularly rehearsed as a multidisciplinary/inter-professional team so that staff who work together can practise their skills together and more importantly build a rapport and cohesion with others who may be involved in an incident with them. Such rehearsal also provides the opportunity for other staff not involved in the Code Black to understand what needs to happen to fill the gap created by other staff members participating in the Code Black.

The regular rehearsal of Code Blues (clinical emergency) was an accepted fact across the system which begs the question why not have regular rehearsals of Code Blacks? A full multidisciplinary response supported by security staff is necessary to ensure the safety of the patient, the staff and others during any Code Black event.

I noted that all staff respond to a Code Blue event but this is not always the case with Code Blacks. The review became aware that the reluctance of staff to become involved in an incident was based on a concern for that staff member's safety. This is understood and it must be stated that a staff member, confronted with such a situation is justified in feeling apprehensive, irrespective of their role. Any person who does not feel some apprehension is either foolish or deluding themselves. The reality is that a team, properly trained and rehearsed, is more likely to avoid injury. It is important that all staff understand that physical intervention in a situation should not necessarily be the first response. Both logic and policy dictate that every effort should be made to calm the situation, i.e. de-escalate, before taking other defensive action.

The basic premise of the policy regarding hospital security staff is that they must be part of a clinical management team and that team is led by a clinician. It is recommended that discussions be held with the Australian Medical Association (AMA) and Australian Salaried Medical Officers Federation of NSW (ASMOF) to ensure the understanding, acceptance and participation of doctors in a Code Black and in the required VPM training.

Similarly, medical, nursing and allied health colleges should be requested to include a module for their students making them aware of their responsibilities for their own safety and for those with whom they work. An excellent example of this approach is the virtual reality training that the School of Nursing at the University of Newcastle provides with regards to aggression. The use of simulated training such as this would be a model worthy of consideration.

It must however be stressed that a range of other activities that have been and are being introduced will assist in reducing the intensity of an incident. These include initiatives previously discussed in this report such as the Patient Experience program, diversionary programs, proactive presence of security staff in emergency departments and proactive monitoring of CCTV. These can all assist in reducing the intensity of a situation in many circumstances. On those occasions, where a situation becomes inflamed, it must be remembered that strength comes from leadership, numbers and training, not size.

This approach recognises that one size does not fit all and allows a local risk assessment to guide the decisions. Regular rehearsals of what has been learnt should occur and debriefing from actual

incidents should be reviewed to enable staff to learn from practical experiences and potentially determine how such a situation might be dealt with in the future.

Further Recommendations:

An audit and assessment of violence prevention training, participation, availability of refresher training and location of training should be undertaken. This should include the maintaining of a register of staff who have completed the training.

A comprehensive review of occupational violence training provided to staff is required. This should include a review of the volume, content and composition of all training provided.

The use of simulated training regarding staff safety and security, particularly for clinical staff, is strongly supported and should be considered.

Training should be a blended approach between online and face to face with any physical training being delivered as near as practicable to the work location of the person undergoing the training.

All staff who have undergone training must be provided with regular local drills and opportunity to practice the physical skills required to maintain their safety during a restraint.

Medical, nursing and allied health colleges should be requested to include a module for their students making them aware of their responsibilities for their own safety and for the safety of those with whom they work.

Local Health Districts/Specialty Networks should ensure that during orientation for trainees/students participating in clinical placements, they are acquainted with the practical application of the concept of security and safety being part of the role of the clinical management team.

ROLE AND POWERS OF SECURITY STAFF

30. ***Security staff should not be referred to as "guards". They should be referred to as security officers or security staff.***

    CONFIRMED

31. ***The following statement from Information Sheet 1 – Role of security staff working in NSW Health, should be promulgated to all health staff: "In all cases security staff should work as part of a team, in collaboration with other staff, to assist with managing patients, to provide assistance to visitors, and to assist with protecting staff and securing the assets of the Agency."***

    CONFIRMED – see Recommendation 32

32. ***Clinicians must be informed of, and understand, the role and responsibilities of security staff. They must take action to integrate them into the multi-disciplinary team and include them in team discussions that discuss security/staff safety such as safety huddles and incident debriefs.***

    CONFIRMED

During some visits it was a matter of concern that security staff were not being included in safety huddles nor were they participating in incident debriefs. Debriefings in particular are important for everybody to learn from an incident that has taken place.

Further Recommendation:

That action be taken to ensure that all staff are aware that security staff are part of the clinical management team and are to be treated as such.

Note: This policy has not been understood or implemented in many places. In those places where it is practised it has proven to be extremely successful and beneficial to all concerned.

I note that as part of work undertaken in response to the 12 point plan, additional online training modules for staff have been developed. These include modules for all staff about the role of security staff, and more detailed ones specifically for security staff about their roles and responsibilities.

33. There should be a 'Part' of the Health Services Act dealing with hospital security and safety setting out the duties, powers, rights and responsibilities of security staff and any related matters that arises from this review that support safety in hospitals. This should also enable resolution of situations regarding the transport of patients from one part of a hospital campus to another where there is a public road between the two facilities.

CONFIRMED with amendment

The first sentence that "*there should be a 'Part' of the Health Services Act dealing with hospital security and safety setting out the duties, powers, rights and responsibilities of security staff and any related matters that arises from this review that support safety in hospitals"* is confirmed and should be pursued.

Amended Recommendation:

There should be legislative change to:

- insert a new 'Part' into the Health Services Act dealing with hospital security and safety, recognising the duties, powers, rights and responsibilities of security staff and any related matters that arise from this review that support safety in hospitals
- ensure there are no legal barriers hampering transport of patients from one part of a hospital to another, where the hospital campus is on two sites.

34. The re-introduction of "special constables" is not supported.

CONFIRMED

From time to time the Review was confronted with the suggestion that hospital security staff should be special constables. On every occasion, the person raising the issue was asked to explain the benefits that would flow to security staff from its re-introduction. In the main the response was usually that hospital security staff needed to have a 'power of arrest". On each occasion the current law was explained and is set out below.

Broadly speaking, the current Section 100 of the *Law Enforcement (Powers and Responsibilities) Act of 2002 generally follows the intent of the provision's predecessor Section 352 (1) of the Crimes Act of 1900.*

Section 100 states:

(1) A person (other than a police officer) may, without warrant, arrest a person if:
  - (a) the person is in the act of committing an offence under any Act or statutory instrument, or
  - (b) the person has just committed any such offence, or
  - (c) the person has committed a serious indictable offence for which the person has not been tried.

(2) A person who arrests another person under this section must, as soon as is reasonably practicable, take the person, and any property found on the person, before an authorised officer to be dealt with according to the law.

The NSW Parliament passed the NSW Police Legislation Amendment (Special Constables) Bill in 2013 to abolish the Special Constables status that was bestowed on certain employees, including Special Constables in hospitals. The legislation attracted bipartisan support.

I am advised that only a very small number of NSW Health security staff ever held special constable status, or carried batons and handcuffs. In practice, the only additional powers this status conferred on the NSW Health security staff who held special constable status were that they could search an individual without his/her consent and detain an individual on suspicion of a crime.

Training of hospital security staff must ensure they are clearly aware of their powers. Regard must be had to the recommendations dealing with Recommendation 33.

35. In relation to the issue of defensive type equipment for security staff, further investigation of options and practices in other jurisdictions is required to assess the suitability of any such equipment in the healthcare environment that does not compromise staff or patient safety.

The review visited the following hospitals/services interstate:

- The Royal Melbourne Hospital
- Western Health Footscray Hospital
- The Alfred Hospital, Melbourne
- Royal Brisbane and Women's Hospital (Metro North Hospital & Health Service) Brisbane
- Queensland Occupational Violence Strategy Unit
- Canberra Hospital
- Victoria Police

The Review wrote to each State/Territory health department in Australia and New Zealand seeking advice about what Personal Protective Equipment (PPE) is being utilised by security staff within that jurisdiction. Responses varied from provision of standard safety glasses, plastic gloves and face shields/masks through to capsicum foam, batons, mechanical wrist restraints, anti-stab vests, slash proof gloves and body-worn cameras.

Before proceeding to further recommendations, attention is drawn to the Interim Report. The subject of equipment for security staff, particularly the provision of defensive equipment, is a vexed one, and it remains so. By way of explanation, I reproduce my comments from the Interim Report.

By far the most vexed issue considered is that of what equipment should be issued to security staff. The current situation is that security staff are issued with protective eyeglasses and gloves. This reality is not understood by some non-security staff in the system.

There is almost universal opposition to the issue of batons and handcuffs to security staff. This opposition includes many security staff themselves. Opposition ranges from the possibility that a baton could be taken off a security officer and used as a weapon against staff. Another objection relates to the creation of an offensive rather than a defensive perception i.e. non-threatening.

Throughout the consultations and visits undertaken, I regularly raised the following worst case scenario and requested a response.

> *A person enters the waiting room of an ED and commences to cause a disturbance for whatever reason. Staff, patients and members of the public of all ages in the ED waiting room are concerned or more likely fearful.*
>
> *Quite properly all staff involved, including security, will then implement the policy and training they have received in order to de-escalate the situation. For whatever reason the situation worsens dramatically and police are called. It may be a hospital that does not have a 24 hours police presence nearby. Conversely it could be an extremely busy Local Area Command (LAC) who are unable to respond immediately.*

There are recent examples of persons being armed with a knife or machete in an ED that fortunately, have not manifested into a worst case scenario and the situation has been managed by security and other staff, and police.

To return to the question I posed, no one has been able to provide an acceptable answer. Obviously if the situation can be de-escalated, that is the preferred outcome. However it does not always happen nor are the police always able to arrive swiftly.

Obviously it is preferable to have patients, staff and the public remove themselves from the scene of the threat – this may not always be possible or realistic.

In the absence of a clear answer, I have considered various items of equipment as discussed below:

<u>The items below are considered not suitable:</u>

- **HANDCUFFS –** The traditional police metal handcuffs are not supported.
- **BATONS –** Batons including the retractable baton used by police are not supported. They can be used against staff if they lose possession of it. The baton is perceived as an aggressive item and may cause a situation to escalate simply by its presence or production.
- **TASERS –** Inappropriate for use in a hospital by hospital staff.
- **BOLO WRAP –** Inappropriate for use in a hospital by hospital staff.
- **STAB PROOF VESTS** – Stab vests, in all forms, are not supported.
- **CAPSICUM SPRAY –** Not supported in a hospital setting. Spray impacts adversely on other staff and members of the public in the vicinity when the spray is activated.

<u>The following items are considered suitable for use as standard issue, following a trial:</u>

- **SLASH AND HYPODERMIC RESISTANT GLOVES –** Are in use elsewhere as a means to provide some form of defensive protection against sharp implements.

- **FLEXIBLE CUFFS –** A single plastic flexible cuff tie could be carried discretely and could be used as a temporary measure where the restraints currently used in hospitals are neither available nor appropriate. Flexible cuffs should only be used to restrain a person's hands in front of them.

The following items are considered suitable to trial as items of "last resort":

- **CAPSICUM FOAM –** A strictly controlled trial of the use of this foam should be undertaken. The use of the foam for defensive purposes only would be recordable and accountable. The foam would be discreetly carried and only produced/used in situations where staff are in imminent danger and cannot withdraw from the situation and no other reasonable method is at hand to defend themselves and/or other staff/members of the public.
- **CONTROL STICK** – The Control Stick (in its pen-sized form only) provides an appropriate back-up or adjunct to something like capsicum foam by way of a trial as noted above.

It must be understood that the items considered above as suitable for trial, are tools to be used as a defensive mechanism only and not offensively and only as a last resort when there is no opportunity to isolate and withdraw. Strict conditions regarding the use of such items prior to the trial must be developed, strictly adhered to, and clearly understood. These should include secure storage, signing out and signing in of equipment.

The following is for further consideration following evaluation of the current trial:

- **PERSONAL BODY CAMERA –** The use of such cameras is currently the subject of a NSW trial involving paramedics. Their use should be further considered following evaluation of that trial.

Further Recommendations:

Subject to appropriate trials and development of policies regarding their use, standard equipment, in addition to the current equipment (safety glasses, gloves), should include slash and hypodermic resistant gloves, and flexi cuffs.

Given the very strong advice received that two pieces of equipment are necessary in case the first item deployed does not succeed, the use of capsicum foam and the control stick are recommended to be trialled as equipment of last resort where there are no other means at hand for staff to defend themselves and/or other staff/members of the public.

Capsicum foam and the control stick are only to be used in circumstances where:

- Their use is consistent with policy, where neither is for the purpose of moving forward but rather as a deterrent in dissuading an advancing threat placing the safety of staff at an unreasonable risk of harm
- Where isolate and withdraw practices have failed or are not available
- Where a warning of use has been issued before use as a final de-escalation strategy
- Consistent with all the above, the last resort is to deploy one or both of the defensive measures
- Any use is the subject of reporting and review
- Any misuse is to be considered as serious misconduct.

It is strongly recommended the foam and control stick be only available to the most senior and appropriately trained security officer at that time on each shift. I do not recommend nor do I support the general issue of either pieces of equipment to all security staff.

The trial of equipment should also evaluate the clinical suitability of use of these equipment in a clinical environment.

An assessment about the use of body worn cameras by security staff should be made following the evaluation of the current trial of body worn cameras for paramedics.

In making these recommendations, I see the use of capsicum foam only occurring after warning the person to stay back (or leave if they wish) and that provided they do so, staff will not move towards them. However, should the person move aggressively towards staff, they will be sprayed with the capsicum foam and if necessary the control stick and/or flexi-cuff used to restrain them, pending arrival of the police.

It is strongly emphasised that the use of capsicum foam and/or control stick is predicated on the basis of their use only as a last resort.

Offensive implements and knives

The review found that the prevalence across the State of patients and others being in possession of knives and similar implements, including syringes (unless for a medical reason), more than justifies a legislative indication of the condemnation of and deterrence from such possession. The provision should apply whether the person brought the object to the hospital or health facility or acquired it in the facility.

A person in lawful custody found to be in possession of a razor or other cutting weapon without lawful purpose (the proof of which lies upon the accused) faces imprisonment or a monetary penalty. This is where the person has been arrested by police and provides a sanction post an event. (See Section 547D of the Crimes Act 1900).

What is needed is a deterrent to the bringing of such implements to any hospital or health facility.

The Summary Offences Act 1988 Sections 11B, 11C and 11E provides the basis for such a deterrent. Section 11B (1) states “A person shall not, without reasonable excuse (proof of which lies on the person), have in his or her custody an offensive implement in a public place or a school.” Maximum penalty: 50 penalty units or imprisonment for 2 years.

An offensive implement is defined Section 11B (3) as
(a) anything made or adapted for use for causing injury to a person, or
(b) anything intended, by the person having custody of the thing, to be used to injure or menace a person or damage property.

Section 11C (1) states “A person must not, without reasonable cause (proof of which lies on the person) have in his or her custody a knife in a public place or school.”
Maximum penalty: 20 penalty units or imprisonment for 2 years, or both.

Section 11B (3) provides that “However, it is not a reasonable excuse for the purposes of this section for a person to have custody of a knife solely for the purpose of self defence or the defence of another person.”

It is my view that the difficulty arises in Section 11B (2) which states “Without limitation, it is a reasonable excuse for the purpose of this section for a person to have custody of a knife, if (a) the custody is reasonably necessary in all the circumstances for any of the following:” It then proceeds to list some seven (i-vii) circumstances.

The seven circumstances referred to in Section 11B (2) may well be reasonable for a “public place”, however they do not, in my view, have validity in a hospital setting. It is for this reason that only i, vi and vii should be applicable to possession in a hospital as defined in Section 3.

The provisions of Section 11E (1) are also relevant. It states “A person who, without reasonable excuse (proof of which lies on the person) (a) uses a knife, or (b) carries a knife that is visible, in the presence of any person in a public place or school in a manner that would be likely to cause a person of reasonable firmness present at the scene to fear for his or her personal safety is guilty of an offence. Maximum penalty: 50 penalty units or imprisonment for 2 years.”

A definition of “hospital” appears in Section 3 of the Act as does a definition of a “public place”. Although a separate definition for a hospital is provided there can be no doubt that a “hospital” is a “public place” within the meaning of the Act in general and Sections 11B, C and E in particular.

This is not simply a symbolic gesture. Countless examples of the type of offensive implements and knives etc that have been confiscated by security staff across the State were brought to the attention of the review. The general public need to understand that such possession in a hospital is completely unacceptable and needs to be addressed.

This recommendation dealing with legislation must be considered in conjunction with the Review’s findings and recommendations dealing with matters such as search, arrest and equipment as a comprehensive way of confronting this scourge. It is also worth emphasising in the warnings referred to in Recommendation 49 that the possession of knives etc is totally unacceptable.

Further Recommendation:

Consideration should be given to a provision within the Summary Offences Act 1988 whereby only “reasonable excuses” i, vi, vii, as provided in Section 11C(2) shall be applicable to a matter involving possession in a hospital as defined in Section 3.

Assault

I note that action from the Hospital Security 12 Point Plan (2016) and the Parliamentary Inquiry into Violence Against Emergency Services Personnel (2016) resulted in the amendment to Section 21(A)(2) of the Crimes (Sentencing Procedure) Act 1999 in June 2018 to allow the Court to also consider a victim’s occupation as a worker in a hospital, such as security staff, as an aggravating factor in sentencing. This amendment was made to remove doubt about the scope of the existing provision that referred to a ‘health worker’.

CRIMES (SENTENCING PROCEDURE) ACT 1999
Section 21A(2)
Aggravating, mitigating and other factors in sentencing
(2) **Aggravating factors** The aggravating factors to be taken into account in determining the appropriate sentence for an offence are as follows—
(a) the victim was a police officer, emergency services worker, correctional officer, judicial officer, council law enforcement officer, health worker, teacher, community worker, or other public official, exercising public or community functions and the offence arose because of the victim's occupation or voluntary work
(l) the victim was vulnerable, for example, because the victim was very young or very old or had a disability, because of the geographical isolation of the victim or because of the victim's occupation (such as a **person working at a hospital (other than a health worker**), taxi driver, bus driver or other public transport worker, bank teller or service station attendant)

These provisions apply to all NSW Health staff, contractors and volunteers.

Search
Hospitals would be much safer places for staff and visitors alike if security arrangements existed such as those at courthouses, airports and many other public buildings. It is of course out of the question to have patients and visitors enter via walk-through security scanners and other security measures that exist in those other places.

It is currently permissible to conduct a search of a person in a hospital with their consent (or without their consent in certain circumstances related to mental health patients).

The importance of this particular issue of the power to search is reinforced by the contents of that part of this report dealing with "Offensive Implements and Knives". The issue of a power to search was regularly raised with me during my many visits and also in submissions.

My initial reaction to the problem was to give considerable thought to recommending a right to search without consent in particular circumstances such as where a reasonable suspicion existed. On reflection, I came to the view that a better understanding and effective usage of the current laws and health policies could lead to a significant improvement in the current totally unacceptable situation regarding the possession of knives and other offensive implements in hospitals. This is equally applicable to unacceptable behavior.

In considering the current laws it is vital that regard is had to the provisions of the Summary Offences Act 1988 which are detailed in the section entitled "Offensive Implements and Knives". To my mind these provisions, subject to the recommended legislative change, should be the basis for dealing with the situation where police attend the hospital.

The other important piece of legislation is the Inclosed Lands Protection Act 1901. This needs to be considered in conjunction with the policies in this regard issued by NSW Health and in particular Information Sheet 2 issued by NSW Health in September 2017, entitled "Escorting an Individual from NSW Health Hospital Premises".

Section 3 of the Inclosed Lands Protection Act 1901 provides a definition of a hospital and also provides that a hospital falls within the definition of "prescribed premises".

Section 4(1) creates an offence if a person, without lawful excuse (proof of which lies upon the person), enters into inclosed lands without the consent of the owner, occupier or person apparently in charge of those lands or who remains on those lands after being requested by the owner, occupier or person apparently in charge of those lands to leave those lands. The penalty in the case of "prescribed premises" is a maximum of ten penalty units.

Section 4A (1) provides that any person who remains on premises after being asked to leave and while remaining upon those lands conducts himself or herself in such a manner as would be regarded by reasonable persons as being, in all the circumstances, offensive is liable, in the case of prescribed premises, to a maximum penalty of twenty penalty units.

It is however Section 4B (1) that is of considerable importance to the issue under consideration. It provides that a person is guilty under this section if the person commits an offence under Section 4 in relation to Inclosed Lands on which any business or undertaking is conducted and while on those lands does certain things set out in the nine clauses to sub-section (1).

The three clauses of most relevance are:

(a) Interferes with, or attempts or intends to interfere with, the conduct of the business or undertaking

(b) Does anything that gives rise to a serious risk to the safety of the person or any other person on those lands

(e) without reasonable excuse, possesses, places or uses any net, trap, snare, poison, explosive, ammunition, knife, hunting device or hunting equipment.

The penalty for an offence other than agricultural land is a maximum of fifty penalty units.

It is of utmost importance that conditions of entry are posted at public entry points to the hospital. This is similar to the signs shops are required to exhibit for similar purposes regarding bag searches. The conditions of entry must indicate that:

- weapons, illegal drugs and alcohol are not to be brought into the facility;
- the relevant health facility reserves the right to search persons who are reasonably suspected of having brought such an item into the facility;
- any person refusing such a search will be asked to leave the premises and may be removed if such a request is refused.

Put simply if there is a reasonable suspicion that a person has brought such an item into the facility then the consent of that person to a search should be sought. In the event the person refuses to consent to a search, that person should be required to leave the facility or may be removed from the premises and escorted to the boundary of the premises.

In this way safety can be maintained preferably without physical confrontation, resulting in the person leaving the premises or submitting to the search. Obviously the presence of police considerably alters the way in which this type of incident can be dealt with.

A matter requiring attention relates to the requirement for "the owner, occupier or person apparently in charge of those lands" to make a request for a person to leave the premises. Currently the LHD/ Network can, through the Chief Executive, authorise individual staff members to take action under the Act on behalf of the LHD/Network. It is my understanding that there is no uniform approach taken to the issuance of such authorisations.

The person making the demand for a person to leave has to be present to make such a demand. If there is any appreciable delay in the authorised person arriving at the scene, either from outside the premises or from elsewhere on what may be a very large campus, then it is possible the incident may escalate. The answer is to ensure that an authorised person is readily available at all times. This could be achieved by ensuring that at least one member of the Code Black Team on each shift is so authorised. This makes particular sense if the recommendation regarding the establishment of a "Potential Code Black" is implemented.

The legislation referred to above and policy mechanisms already exist to deal with this important issue regarding powers that staff need to deal with a variety of security situations. It is therefore necessary to reinforce the existence and content of both to all those who may become involved in such a situation in order to remove the current uncertainty.

Further Recommendations:

A review of the location and content of all "conditions of entry" signs be undertaken by Local Health Districts and Specialty Networks.

The current authorisation under the Inclosed Lands Protection Act be reviewed to ensure appropriate coverage for each facility.

The policies, documentation and training relating to powers of search and removal of persons from NSW Health premises be reviewed and reinforced with all relevant staff.

In an ideal world it would be assumed that persons being brought to a hospital or health facility by police, paramedics or corrections officers have already been searched. The reality is that this is not always the case and health staff are placed in a potentially dangerous situation should such a person be armed with a knife or other weapon.

Further Recommendations:

Where a patient arrives under the provisions of the Mental Health Act 2007 or the Mental Health (Forensic Provisions) Act 1990, it should be mandatory for staff to record if a search has been conducted by the transporting agency.

For any patient, Health staff must understand they are within their rights to ask a transporting agency (that has existing powers to conduct searches) to search a patient on arrival at the hospital/health facility and a record of such a search should be kept.

Arrest

There is no doubt that hospital staff and in particular those performing security duties have, in the absence of the police, a power of arrest under Section 100 of the Law Enforcement (Powers and Responsibilities) Act 2002.

We have seen reported in the media, several examples of members of the public performing a citizen's arrest in recent months. In order to overcome the current uncertainty in the minds of many hospital security staff, it would be appropriate for a provision to be inserted in the relevant legislation clearly enunciating the fact that such staff who have effected a citizen's arrest, which is reasonable in all the circumstances, shall be afforded the necessary legislative protection.

Further Recommendation:

In order to overcome the current uncertainty in the minds of many hospital security staff, it would be appropriate for a provision to be inserted in the relevant legislation clearly enunciating the fact that staff who have effected a citizen's arrest, which is reasonable in all the circumstances, shall be afforded the necessary legislative protection.

The enactment of such a provision will ensure that staff are not placed in a potentially dangerous position due to their hesitancy concerning their rights to act.

The Review has spent a considerable amount of time contemplating a recommendation that legislation be introduced, similar to that in Victoria, which imposes a mandatory minimum custodial sentence for assaults upon police and health workers. The provision of substantial penalties in legislation has no deterrent effect if those responsible for the abhorrent crimes do not receive appropriate penalties. It is incumbent upon all parts of the legal process to make it abundantly clear to the community that the abuse and assault of hospital and health workers is unacceptable and will not be tolerated. Until those who engage in this unacceptable behaviour are left in no doubt that they will be both prosecuted and appropriately punished no significant positive impact will be had on the unacceptable level of such behaviour in our hospitals and health centres. Reluctantly I have chosen not to so recommend.

A full explanation of how the Victorian mandatory sentencing provisions operates can be found in the judgment of His Honour Judge Tinney, delivered in December 2019 in the Appellate jurisdiction of the County Court of Victoria in DPP –v- Haberfield.

PROFESSIONALISATION OF SECURITY WORKFORCE

36. It must be recognised that the role hospital security staff undertake is unique to the health environment and is significantly different from any other security role.

CONFIRMED

The principal determinant of this uniqueness is the fact that security staff are clinician controlled and are an integral part of the clinical management team.

37. A new subclass covering "Hospital Security" should be introduced to Class 1 licences under the Security Industry Act. A modification to the Section 36 requirement in the current security industry legislation, mandating wearing of the licence be sought failing which an exemption should be sought under Section 36(2) from the Commissioner of Police.

NOT CONFIRMED/RECOMMENDATION TO BE REPLACED

Since my Interim Report I had further opportunity to meet with the Security Licensing Enforcement Directorate (SLED) of the NSW Police Force with respect to this recommendation. For a variety of sound reasons, this was not supported by SLED.

Only those roles where the primary purpose of the role is to carry on security activities generally require a SLED security licence. In rural and regional areas there are many challenges, and a significant one is attracting suitable staff who have a security licence to work in a hospital clinical environment. These areas tend to have HASAs employed to cover security needs, although the larger rural centres such as Coffs Harbour, Lismore, Tamworth, Tweed Heads and Wagga Wagga also have security officer staff. In the majority of cases, particularly in smaller rural locations, HASAs are predominantly engaged in patient support activities and are not undertaking security activities such as patrolling, monitoring CCTV, or maintaining key control processes and are only required to respond to aggressive or threatening incidents involving patients or others on occasion, along with other staff as part of the clinical management team. Regardless of whether an individual is employed as a security officer or as a HASA whose role entails little security work, a Class 1A licence is required.

Removal of a requirement for a security license for HASAs in instances where their role does not involve significant security activities, in regional and rural facilities, may create opportunities for attracting a broader candidate pool to fill HASA roles in these facilities.

Any security staff exempted under such a provision would still be required to undergo all the security training mandated by the Ministry of Health. Such officers would also be encouraged to consider undertaking the SLED Class 1A licence for their future career opportunities both within the NSW Health security function and within the broader security industry.

Replacement Recommendation:

Application be made to the Security Licensing Enforcement Directorate (SLED) to exempt certain HASAs and certain casual staff from the requirement to have a Class 1A Security Licence. The interaction with SLED with respect to the recommendation, should be undertaken by the Ministry of Health.

With respect to the second sentence of the recommendation from the Interim Report regarding the wearing of the licence, the advice received from SLED indicates that they will not agree to the modification sought however they did clarify that the licence can be worn attached to the waist or above so long as it is clearly visible. The principle reason for rejection of this recommendation was because of issues of impersonation that have taken place.

38. ***All security staff uniforms should consist of dark trousers/pants, white shirt with the inclusion of words/logo that identify them as "hospital security". The wearing of combat boots, appointments belts, or any other equipment or apparel that give the appearance of police or military uniforms are not supported.***

CONFIRMED with clarification as follows

Further Recommendation:

Security staff (particularly HASAs) should be offered the opportunity to wear white polo shirts rather than white business shirts, provided that the words “hospital security” appear thereon.

A number of security staff (particularly HASAs) expressed the view that a business shirt would be restrictive in the performance of their duties, hence the preference for a polo type shirt.

A white polo shirt will distinguish HASAs from other non-security staff who currently also wear the pistachio coloured polo shirts. It was put to me that white will show the dirt and day to day marks from activities that the staff are involved in, more so than pistachio, which to my mind does not, when properly considered, succeed as an argument. Any such change should be done by way of replacement at the time current shirts are due to be replaced, not as an immediate new issue.

39. ***HASAs should wear the same uniform as security officers so that they are clearly identifiable to staff, patients and visitors. The exception is where they are embedded in a location requiring them to wear similar uniform to other staff e.g. acute mental health unit.***

    See Recommendation 38.

40. ***The title of HASAs should be changed to Security and Health Assistants (SHAs) to more accurately reflect the primacy of their security role, as set out in the award.***

    TO BE DEFERRED – Implementation of this recommendation is to be deferred pending outcome of Recommendation 37.

41. ***Security staff and HASAs currently undertake the SLED qualification prior to being licensed, the TAFE*** **Security in the Health Environment** ***course, and the violence prevention and management program. This training should be formally assessed against nationally recognised competency standards so that the training undertaken is formally recognised. This would provide the basis for regular assessment of the competencies required and also facilitate a professional development pathway for those seeking advancement. It will also provide an opportunity to introduce topics such as mental health, paediatrics and customer focus.***

    CONFIRMED

    The Queensland Occupational Violence Strategy Unit has developed a series of fact sheets/information sheets for security staff about clinical conditions to assist them when responding to situations in the course of their security duties. The information sheets provide information about clinical conditions such as dementia and delirium, eating disorders, and other behaviours that may be displayed by patients. In some cases these were accompanied by information sessions led by clinical staff. Development of similar resources for security staff in NSW would be worthwhile.

Further Recommendation:

A series of educational material/ online modules should be developed on clinical conditions as a resource for security staff, to provide guidance and understanding when responding to particular situations in the clinical environment, for example drug and alcohol, mental health, community health, aged care and paediatrics.

42. ***That NSW Health seek to recruit security staff beyond the traditional methods and that an approach be made to universities such as Western Sydney, Charles Sturt and Macquarie as sources for potential security staff.***

CONFIRMED

Both Charles Sturt and Western Sydney Universities have indicated support and willingness to be involved in such a recruitment strategy.

43. ***Districts/Networks should establish a pool of casual security staff, similar to that for teachers, to enable suitable staff to be identified at short notice.***

CONFIRMED - See comments under Recommendation 37

I note that this is already underway in some Districts. The following is also made in furtherance of the above.

Further Recommendation:

In establishing casual pools, Local Health Districts/Specialty Networks must have processes in place to identify those individuals in the casual pool who are available to escort patients on intra-hospital transports or to undertake security observations (security specialling).

There is a drain on security staff resources in a hospital when existing security staff, including HASAs, are required to accompany patients with behavioural disorders from one hospital to another. This is particularly difficult and time consuming in rural areas due to the tyranny of distance. Likewise, where security staff are tasked to undertake a security special of a patient with behavioural disturbance, it takes them away from their usual duties and impacts on the availability of security resources at that site. Having a ready casual pool that can be drawn on to undertake these activities will improve this situation.

44. ***A "Tool box" be developed to assist in having useful interview and scenario questions available to facilitate the identification of suitable security staff.***

CONFIRMED

JUSTICE HEALTH AND FORENSIC MENTAL HEALTH NETWORK

45. ***The collaborative model currently operating at the Long Bay Hospital is to be commended. It is evident that the clinical and correctional staff work very well together in a very challenging environment.***

    CONFIRMED

46. ***A significant divergence of opinion apparently exists between staff at the Forensic Hospital as to the most appropriate "security" measures that should be introduced. Indeed the vehemently expressed views by staff, with whom the matter of security was discussed at the time of the visit, are diametrically opposed to the position that had been put to me by the union. Expressions such as "I will resign if security are brought in" seem to indicate a significant divergence of opinion amongst staff.***

    NOTED

47. ***Having become aware of certain measures proposed by management of the Forensic Hospital it is believed that those measures should be given the opportunity to be tested. Support for that course of action is predicated on the basis of constant monitoring during the next six months, with a view to further consideration of the matter at that time.***

    CONFIRMED

    Monitoring has indicated that the plans that have been put in place are working effectively.

RESOURCING

48. ***All Local Health Districts and Specialty Networks consider the recommendations from this report and any resourcing implications and make a submission to the Ministry of Health regarding resource requirements.***

    CONFIRMED - To be considered further in light of the findings of the Final Report.

REPORT IMPLEMENTATION

There is an imperative that action is taken to improve security and staff safety. There is no one size fits all solution and a suite of measures as proposed in this report must be taken. A system-wide approach, commitment and leadership are required.

> **Further Recommendation:**
>
> A governance structure should be established to provide monitoring and oversight to ensure the recommendations in this report are addressed and where practicable, implemented, reporting quarterly to the Secretary and Minister for Health.

Interim Report Recommendation	Final Report Recommendation
CULTURE	
1. A culture of safety and security to be mandated and clearly understood across the NSW health system based on the maxim that "security is everybody's responsibility".	Confirmed
2. That culture requires an understanding that staff and members of the public are entitled, both legally and morally, to the same protection as patients. Staff cannot work efficiently if they come to work fearful of being assaulted.	Confirmed **Further Recommendation:** 49. Appropriate warnings to be posted at hospitals and other health facilities in the community indicating that aggressive and/or violent behaviour will not be tolerated, and that police will be called and charges will be pursued. In addition 'exclusion notices' may be issued.
3. An evaluation of the Nurse Safety Culture Co-ordinator positions funded in the 2017/18 Budget should be undertaken with a view to identifying opportunities to enhance the adoption of the culture referred to above.	Confirmed
RURAL AND REGIONAL	
4. The different challenges facing regional and rural hospitals should be the focus of a similar investigation to that undertaken so far by the Review.	Completed
LEADERSHIP	
5. The acceptance of, and adherence to, the principle that a staff safety culture is to be led by the Chief Executive of each organisation.	Confirmed (see Rec 11)
6. Managers must ensure that the current culture of under-reporting of security type incidents ends. Staff are to be actively encouraged to enter all incidents into the current incident management system (IIMS). Staff are also to be advised of the efforts being made to upgrade the current system to the new ims+ to address the issues of concern.	Confirmed **Further Recommendation:** 50. Districts should note that they are required to comply with clause 34 of the Security Industry Regulation 2016 which requires that an incident register is kept by master licensees.

Interim Report Recommendation	Final Report Recommendation
7. Managers and supervisors are to ensure compliance with the wearing of personal duress alarms where their use has been mandated. Where problems are identified regarding the use of a duress alarm then that matter is to be resolved urgently. Where a staff member requests, due to concerns for their individual safety, the issue of a duress alarm for use elsewhere in their place of work, then consideration should be given to the issue of same.	Confirmed **<u>Further Recommendation</u>:** 51. Fixed duress alarms are to be located near the access door of a patient treatment room or staff only room, as well as at the rear of the room, so that staff can access the duress button and not get trapped. 52. Local Health Districts/Specialty Networks share information in relation to the methods they use for staff working in the community and in particular working considerable distances away to communicate they require assistance and/or position locators.
8. All Local Health Districts and Specialty Networks are to have a system in place to ensure that clinical staff inform security staff when they become aware that a patient, who may present a behavioural challenge, is en route to the hospital.	Confirmed
<u>Amended Recommendation:</u> 9. Staff who have been threatened or assaulted resulting from a deliberate act of violence are to be encouraged and supported to report the assault to police and to request action be taken by the police against the perpetrator. Staff are to continue to be supported through any subsequent criminal justice proceedings. To this end, the member of staff is to be supported by another member of staff from the taking of statements through to attendance at court. Clearly this recommendation will be influenced by the clinical condition of the perpetrator. Local Health Districts/Specialty Networks should be aware that there is no requirement for staff of hospitals or other health facilities who are victims of assault to use their personal address rather than their business address when pressing charges or taking an AVO against an individual.	Confirmed as amended

Interim Report Recommendation	Final Report Recommendation
10. The effectiveness of local liaison committees with police and other agencies are to be reviewed to ensure appropriate representation is present and that the meetings are held regularly. Any difficulties identified at the local level which are not resolved should be escalated in line with the NSW Health/NSW Police Force Memorandum of Understanding for further consideration.	Confirmed **Further Recommendations:** 53. Police and paramedics should inform emergency department staff when bringing in patients with challenging behaviours who may pose a potential risk. To this end, the existing and all future MOUs with third party agencies should include provision for such information to be provided prior to arrival at the emergency department. 54. Where applicable, appropriate liaison should be established with both Corrective Services NSW and Australian Border Force to ensure effective processes, including early notification, are in place where patients are brought to hospitals from correctional facilities or elsewhere, and detention centres. 55. Local Health Districts/Specialty Networks should establish appropriate liaison with Family and Community Services (FACS) to ensure the safety of staff is maintained during any proposed interventions by FACS staff. 56. In some parts of the state where there is no established police presence, consideration should be given to discussions with Local Government NSW, the peak organisation representing the interests of NSW general and special purpose councils, with a view to identifying potential opportunities for support in certain security-related circumstances.
GOVERNANCE	
11. Each Board of a Local Health District or Specialty Network is accountable for the security and safety of staff, patients and visitors. Consideration should be given to having security / staff safety as a standing agenda item for each Board meeting and, where they exist, each Board sub-committee dealing with audit, risk and compliance.	Confirmed

Interim Report Recommendation	Final Report Recommendation
12. The required NSW Health Security Improvement Audit Program is to be fully resourced and implemented in each Local Health District and Specialty Network, and reported to the Board through the Board sub-committee dealing with audit, risk and compliance.	Confirmed
13. A central security audit function be established with appropriate resourcing to drive compliance and consistency of security policies and standards throughout NSW Health.	Confirmed **Further Recommendation:** 57. The central security audit function established within the Ministry of Health, should not be confined to one of audit but one of identifying and sharing best practice across the whole system to improve security
14. Where there are both Security Officers and Health and Security Assistants (HASAs) in the one location, action must be taken to ensure both groups operate as one integrated team with a strong professional relationship and an ultimate single line of reporting within each Local Health District/Specialty Network.	Confirmed **Further Recommendations:** 58. That the security function within Hunter New England Local Health District transfer from HealthShare NSW to Hunter New England Local Health District. 59. That the security function at Royal North Shore Hospital transfer from HealthShare NSW to Northern Sydney Local Health District.
15. Local Health Districts and Specialty Networks must determine security staffing levels based on an assessment of risk and implement demand driven rostering of security staff to address the identified risk, similar to how clinical staff are rostered.	Confirmed – see comments under Rec 6
16. Security staff should be positioned so that they are regularly visible in emergency departments, both in the treatment and waiting areas.	Confirmed **Further Recommendation:** 60. Consideration should be given to embedding Health and Security Assistants (HASAs) in appropriate emergency departments and mental health facilities/units.

Interim Report Recommendation	Final Report Recommendation
17. When planning new and redeveloped hospital and health facilities, due regard needs to be given to designing out risk and taking account of the views of clinical and security staff. This should include developing design guides that assist staff and architects to incorporate security into early planning stages.	Confirmed **Further Recommendations:** 61. Prior to finalising plans for new or redeveloped hospital and health facilities, confirmation should be sought from the Chief Executive of the Local Health District/Specialty Network that the design and layout of the facility has undergone a security review and meets all relevant NSW Health policies and the Australasian Health Facility Guidelines (AHFG). Where relevant NSW Health policies and AHFG requirements have not been applied, the Local Health District/Specialty Network Chief Executive should also be required to confirm that a documented risk assessment, meeting the requirements of work health and safety legislation, has been undertaken. 62. A review of the efficacy and governance of the current process of planning, designing and building health facilities (with particular regard to security) should be considered to ensure that the expertise and views of the facility users are taken into account. 63. Barriers used at emergency department reception and triage desks and other waiting room/reception areas that have been determined to be at risk, should be of a safety glass design that does not allow a person to climb or reach through and grab at or potentially harm staff. 64. The width of entry/exit doors to Safe Assessment Rooms (or similar) should be a minimum of the width of one and a half doors. This design principle should be built into Health Infrastructure's Design Guidance Note for Safe Assessment Rooms. 65. Local Health Districts/Specialty Networks should conduct programs for all staff reinforcing the importance of the appropriate use of swipe cards.

Interim Report Recommendation	Final Report Recommendation
STANDARDISATION	
18. The security standards set out in the NSW Health security manual Protecting People and Property, and the related policies, should be adopted in every facility as written, and compliance is to be subject to audit.	Confirmed
19. A standardised "Code Black" procedure must be in place in all facilities, in line with that specified in Protecting People and Property, unless a particular localised variation can be justified. Regular practice drills should be undertaken so that everyone understands their roles and responsibilities and skills remain current.	Confirmed **Further Recommendations:** 66. Consideration be given to introducing a 'potential' Code Black similar to the "Controlled/Planned Code Grey" used in Victoria. 67. During a number of visits, it became obvious that there was an inconsistent approach to a Code Black response. At the commencement of each shift, personnel should be identified who will be required to attend a Code Black if called, and their roles should also be clearly defined and understood.
20. The use and effectiveness of current CCTV operations with particular reference to the prevention, response and evidentiary uses are to be subject to audit to ensure compliance with the NSW Health security standards for CCTV as set out in Protecting People and Property.	Confirmed **Further Recommendation:** 68. Local Health Districts/Specialty Networks consider establishing, where practical, an integrated district-wide CCTV operation with 24/7 observation monitoring. The Ministry of Health should consider trialling such an operation at two or more Districts.
21. Security audits are to include disaster planning, lockdown procedures and incident management protocols.	Confirmed **Further Recommendations:** 69. Local Health Districts/Specialty Networks should review their disaster management staffing and protocols.

Interim Report Recommendation	Final Report Recommendation
	70. A review of facility lockdown capability should be undertaken along with an assessment of plans to establish local control centres if required in the event of a disaster or incident. 71. Security managers should be an integral part of incident and emergency/disaster planning and response.
22. Security Officers and HASAs should be part of a state-wide hospital security function enabling mobility through transfers and ongoing professional development.	Confirmed – see comments under Recommendations 14 and 41
PATIENT CARE / MODELS OF CARE	
23. The provision of a safe space in emergency departments (in the best interests of both patients and staff) is supported. Examples of such a space are "Safe Assessment Rooms" or "PANDA Units" (Psychiatric, Alcohol and Non-prescription Drug Assessment). Further analysis of the successful Behavioural Assessment Unit (BAU) pilot program at the Royal Melbourne Hospital is required with a view of possible adoption in some major emergency units.	Confirmed **Further Recommendations:** 72. Consideration be given to developing and testing a locally adapted model similar to the BAU/BOC used in Victoria. In doing so, consideration may need to be given to opportunities within new or redeveloped hospital builds. 73. A clinical tool/form should be developed that allows for the assessment and observation of deteriorating patient behaviour as part of routine observation rounds, in order to identify where intervention and management may be required.
24. Urgent action is required to overcome delays in mental health assessments which see patients waiting hours for such an assessment, creating a situation not in the best interests of the patient and potential to cause significant security issues for those with challenging behaviours. The use of Nurse Practitioners and Clinical Nurse Consultants (Mental Health) should be considered in this regard.	Confirmed **Further Recommendations:** 74. The timely availability of MHEC-RAP (and similar programs) in rural areas be reviewed and consideration be given to ensuring that current delays in such assessments and decisions to admit or discharge the patient are reduced. 75. There should be greater utilisation of existing accredited persons under the Mental Health Act 2007 who have the authority to either enact or lift a

Interim Report Recommendation	Final Report Recommendation
	Schedule on a patient and enable timely access to appropriate care including admission decisions. In doing so, a review should be conducted of accredited persons across the NSW health system to identify and address any barriers to their use. 76. Immediate action should be taken to overcome the situation whereby Nurse Practitioners, Clinical Nurse Consultants and accredited persons are not able to make timely decisions regarding a patient in order to ensure patients are not experiencing unnecessary delays before receiving the appropriate treatment in the most appropriate location. 77. In those locations where assessed mental health patients (or other patients for that matter) are delayed in emergency departments for lengthy periods, they be offered (where medically appropriate) access to nicotine replacement options when they raise the issue of a desire to smoke. 78. Each Local Health District/Specialty Network regularly convene meetings with both emergency department and mental health clinicians to ensure a positive and ongoing interaction.
25. There is sufficient positive feedback to justify further consideration of possible expansion of mental health initiatives such as: Operation Pacer in the St George Local Government area; PEAMHATH (Police Early Access to Mental Health Assessment via Telehealth) in Hunter LHD; Resolve Program in Nepean Blue Mountains and Western NSW LHDs; and MHAAT (Mental Health Acute Assessment Team) in Western Sydney LHD.	Confirmed **Further Recommendations:** 79. Consideration be given to expanding the PACER program in metropolitan locations. 80. Consideration also be given to piloting and evaluating Police Ambulance Early Access to Mental Health Assessment via Telehealth (PEAMHATH) in two rural locations
26. There is a need to reduce stress and improve the waiting experience for people in an emergency department waiting room. Strategies to improve the experience of patients while waiting at an emergency department should be evaluated and where they are found to have had a positive impact on the patient/carer experience and staff safety,	Confirmed

Interim Report Recommendation	Final Report Recommendation
consideration should be given to resourcing their expansion across NSW Health. The broader implementation of these successful initiatives, when coupled with mobile security staff frequently moving through the waiting room, will have significant benefits for the operation of an emergency department.	
27. At times, a patient's condition may require a 1:1 security presence to assist in protecting staff, the patient and property. This is a security function and should never be confused with the individual patient specials (or 'specialling') required to be undertaken by clinical staff.	Confirmed **Further Recommendations:** 81. The nomenclature of "clinical specialling" and "security specialling" is to be adopted to distinguish between a patient requiring clinical supervision and a patient requiring security supervision. 82. The use of security specials by each LHD be urgently reviewed to ensure the most cost effective provision of same.
Amended Recommendation: 28. In future, where a 1:1 security presence is required, that role must be referred to as 'security specialling' and not as a 'special'. Protecting People and Property should be updated to ensure the role and responsibilities of security staff during episodes of 'security specialling' are set out.	CONFIRMED with amendment to the title
CAPABILITY	
29. All staff who work in an area where there is risk of assault/violence are required to undertake security/safety training in a timely manner, and the skills learned should be practised regularly. The training of staff should be subject to audit and the results reported to the Chief Executive and to the Board (or equivalent) through the Board sub-committee dealing with audit, risk and compliance.	Confirmed **Further Recommendations:** 83. An audit and assessment of violence prevention training, participation, availability of refresher training and location of training should be undertaken. This should include the maintaining of a register of staff who have completed the training.

Interim Report Recommendation	Final Report Recommendation
	84. A comprehensive review of occupational violence training provided to staff is required. This should include a review of the volume, content and composition of all training provided. 85. The use of simulated training regarding staff safety and security, particularly for clinical staff, is strongly supported and should be considered. 86. Training should be a blended approach between online and face to face with any physical training being delivered as near as practicable to the work location of the person undergoing the training. 87. All staff who have undergone training must be provided with regular local drills and opportunity to practice the physical skills required to maintain their safety during a restraint. 88. Medical, nursing and allied health colleges be requested to include a module for their students making them aware of their responsibilities for their own safety and for those with whom they work. 89. Local Health Districts/Specialty Networks should ensure that during orientation for trainees/students participating in clinical placements, they are acquainted with the practical application of the concept of security and safety being part of the role of the clinical management team.
ROLE AND POWERS OF SECURITY STAFF	
30. Security staff should not be referred to as "guards". They should be referred to as security officers or security staff.	Confirmed
31. The following statement from Information Sheet 1 – Role of security staff working in NSW Health, should be promulgated to all health staff: "In all cases security staff should work as part of a team, in collaboration with other staff, to assist with managing patients, to provide assistance to visitors, and to assist with protecting staff and securing the assets of the Agency."	Confirmed – see Recommendation 32

<table>
<tr><th>Interim Report Recommendation</th><th>Final Report Recommendation</th></tr>
<tr><td>32. Clinicians must be informed of, and understand, the role and responsibilities of security staff. They must take action to integrate them into the multi-disciplinary team and include them in team discussions that discuss security/staff safety such as safety huddles and incident debriefs.</td><td>Confirmed

<u>Further Recommendation</u>:

90. That action be taken to ensure that all staff are aware that security staff are part of the clinical management team and are to be treated as such.</td></tr>
<tr><td><u>Amended Recommendation</u>:

33. There should be legislative change to:
• insert a new ‘Part’ into the Health Services Act dealing with hospital security and safety, recognising the duties, powers, rights and responsibilities of security staff and any related matters that arise from this review that support safety in hospitals
• ensure there are no legal barriers hampering transport of patients from one part of a hospital to another, where the hospital campus is on two sites.</td><td>Confirmed with amendment</td></tr>
<tr><td>34. The re-introduction of “special constables” is not supported.</td><td>Confirmed</td></tr>
<tr><td>35. In relation to the issue of defensive type equipment for security staff, further investigation of options and practices in other jurisdictions is required to assess the suitability of any such equipment in the healthcare environment that does not compromise staff or patient safety.</td><td>Completed

<u>Further Recommendations</u>:

91. Subject to appropriate trials and development of policies regarding their use, standard equipment, in addition to the current equipment (safety glasses, gloves), should include slash and hypodermic resistant gloves, and flexi cuffs.

92. Given the very strong advice received that two pieces of equipment are necessary in case the first item deployed does not succeed, the use of capsicum foam and control stick are recommended to be trialled as equipment of last resort where there are no other means at hand for staff to defend themselves and/or other staff/ members of the public.</td></tr>
</table>

Interim Report Recommendation	Final Report Recommendation
	93. Capsicum foam and the control stick are only to be used in circumstances where: • Their use is consistent with policy where neither is for the purpose of moving forward but rather as a deterrent in dissuading an advancing threat placing the safety of staff at an unreasonable risk of harm • Where isolate and withdraw practices have failed or are not available • Where a warning of use has been issued before use as a final de-escalation strategy • Consistent with all the above, the last resort is to deploy one or both of the defensive measures • Any use is the subject of reporting and review • Any misuse is to be considered as serious misconduct. 94. It is strongly recommended the foam and control stick be only available to the most senior and appropriately trained security officer at that time on each shift. I do not recommend nor do I support the general issue of either pieces of equipment to all security staff. 95. The trial of equipment should also evaluate the clinical suitability of use of these equipment in a clinical environment. 96. An assessment about the use of body worn cameras by security staff should be made following the evaluation of the current trial of body worn cameras for paramedics. 97. Consideration should be given to a provision within the Summary Offences Act 1988 whereby only “reasonable excuses” i, vi, vii, as provided in Section 11C(2) shall be applicable to a matter involving possession in a hospital as defined in Section 3.

Interim Report Recommendation	Final Report Recommendation
	98. A review of the location and content of all "conditions of entry" signs be undertaken by Local Health Districts and Specialty Networks. 99. The current authorisation under the Inclosed Lands Protection Act be reviewed to ensure appropriate coverage for each facility. 100. The policies, documentation and training relating to powers of search and removal of persons from NSW Health premises be reviewed and reinforced with all relevant staff. 101. Where a patient arrives under the provisions of the Mental Health Act 2007 or the Mental Health (Forensic Provisions) Act 1990 it should be mandatory for staff to record if a search has been conducted by the transporting agency. 102. For any patient, Health staff must understand they are within their rights to ask a transporting agency (that has existing powers to conduct searches) to search a patient on arrival at the hospital /health facility and a record of such a search should be kept. 103. In order to overcome the current uncertainty in the minds of many hospital security staff it would be appropriate for a provision to be inserted in the relevant legislation clearly enunciating the fact that staff who have effected a citizen's arrest which is reasonable in all the circumstances shall be afforded the necessary legislative protection.
PROFESSIONALISATION OF SECURITY WORKFORCE	
36. It must be recognised that the role hospital security staff undertake is unique to the health environment and is significantly different from any other security role.	Confirmed

Interim Report Recommendation	Final Report Recommendation
Replacement Recommendation: 37. Application be made to the Security Licensing Enforcement Directorate (SLED) to exempt certain HASAs and certain casual staff from the requirement to have a Class 1A Security Licence. The interaction with SLED with respect to the recommendation, should be undertaken by the Ministry of Health.	Recommendation as replaced and reworded confirmed
38. All security staff uniforms should consist of dark trousers/pants, white shirt with the inclusion of words/logo that identify them as "hospital security". The wearing of combat boots, appointments belts, or any other equipment or apparel that give the appearance of police or military uniforms are not supported.	CONFIRMED with clarification **Further Recommendation:** 104. Security staff (particularly HASAs) should be offered the opportunity to wear white polo shirts rather than white business shirts, provided that the words "hospital security" appear thereon.
39. HASAs should wear the same uniform as security officers so that they are clearly identifiable to staff, patients and visitors. The exception is where they are embedded in a location requiring them to wear similar uniform to other staff e.g. acute mental health unit.	See Recommendation 38
40. The title of HASAs should be changed to Security and Health Assistants (SHAs) to more accurately reflect the primacy of their security role, as set out in the award.	TO BE DEFERRED – Implementation of this recommendation is to be deferred pending outcome of Recommendation 37
41. Security staff and HASAs currently undertake the SLED qualification prior to being licensed, the TAFE Security in the Health Environment course, and the violence prevention and management program. This training should be formally assessed against nationally recognised competency standards so that the training undertaken is formally recognised. This would provide the basis for regular assessment of the competencies required and also facilitate a professional development pathway for those seeking advancement. It will also provide an opportunity to introduce topics such as mental health, paediatrics and customer focus.	Confirmed **Further Recommendation:** 105. A series of educational material/ online modules should be developed on clinical conditions as a resource for security staff, to provide guidance and understanding when responding to particular situations in the clinical environment, for example drug and alcohol, mental health, community health, aged care and paediatrics.

Interim Report Recommendation	Final Report Recommendation
42. That NSW Health seek to recruit security staff beyond the traditional methods and that an approach be made to universities such as Western Sydney, Charles Sturt and Macquarie as sources for potential security staff.	Confirmed
43. Districts/Networks should establish a pool of casual security staff, similar to that for teachers, to enable suitable staff to be identified at short notice.	CONFIRMED - See comments under Recommendation 37 **Further Recommendation:** 106. In establishing casual pools, Local Health Districts/Specialty Networks must have processes in place to identify those individuals in the casual pool who are available to escort patients on intra-hospital transports or to undertake security observations (security specialling).
44. A "Tool box" be developed to assist in having useful interview and scenario questions available to facilitate the identification of suitable security staff.	Confirmed
JUSTICE HEALTH & FORENSIC MENTAL HEALTH UNIT	
45. The collaborative model currently operating at the Long Bay Hospital is to be commended. It is evident that the clinical and correctional staff work very well together in a very challenging environment.	Confirmed
46. A significant divergence of opinion apparently exists between staff at the Forensic Hospital as to the most appropriate "security" measures that should be introduced. Indeed the vehemently expressed views by staff, with whom the matter of security was discussed at the time of the visit, are diametrically opposed to the position that had been put to me by the union. Expressions such as "I will resign if security are brought in" seem to indicate a significant divergence of opinion amongst staff.	Noted
47. Having become aware of certain measures proposed by management of the Forensic Hospital it is believed that those measures should be given the opportunity to be tested. Support for that course of action is	Confirmed - Monitoring has indicated that the plans that have been put in place are working effectively

Interim Report Recommendation	Final Report Recommendation
predicated on the basis of constant monitoring during the next six months, with a view to further consideration of the matter at that time.	
RESOURCING	
48. All Local Health Districts and Specialty Networks consider the recommendations from this report and any resourcing implications and make a submission to the Ministry of Health regarding resource requirements.	
IMPLEMENTATION	
	New Recommendation: 107. A governance structure should be established to provide monitoring and oversight to ensure the recommendations in this report are addressed and where practicable, implemented, reporting quarterly to the Secretary and Minister for Health.

APPENDIX A

Interim Report

Improvements to security in hospitals

Peter Anderson
February 2019

Improvements to security in hospitals

Introduction

My appointment to lead a review into the safety of staff, patients and visitors in NSW public hospitals was announced by the Hon Brad Hazzard, Minister for Health, on 16th November 2018. The Terms of Reference, attached at Annexure A, required a report by February 2019.

The process adopted in order to meet the timeline for reporting in February was to convene the Working Party, meet with the identified stakeholders and visit several hospitals to meet staff and inspect the facilities. Initially, the hospital visits were to be undertaken prior to Christmas with the exception of the Forensic Hospital which was to be done in January. It was intended that the stakeholders interviewed would submit a formal response to the Review by 10th January 2019 to enable the report to be completed.

The Security in Hospitals Working Party comprised the following:

Peter Anderson	Chair
Phil Minns	Deputy Secretary, People, Culture and Governance
Dr Teresa Anderson	Chief Executive, Sydney Local Health District
Scott McLachlan	Chief Executive, Western NSW Local Health District
Gary Forrest	Chief Executive, Justice Health and Forensic Mental Health Network
Ross Judd	Security Manager, St Vincent's Hospital
Rodney Scott	Security Manager, Wagga Wagga Health Service
Sarah Marmara	Principal Project Officer, System Purchasing Branch NSW Ministry of Health

Attendees – NSW Ministry of Health	
Annie Owens	Executive Director, Workplace Relations
Sharon Litchfield/ Melissa Collins	Director, Industrial Relations and HR Policy
Michelle O'Heffernan	Principal Policy Officer, Workplace Relations
Fiona McNulty	Project Officer, Office of Deputy Secretary PCG

The issues being raised during both the stakeholder consultations and the hospital visits caused a reconsideration of the process being undertaken.

As a consequence further visits and consultations were undertaken during January. This meant that a major hospital in each of the eight local health districts (LHDs) comprising the Sydney metropolitan, Central Coast and Illawarra regions plus the two specialist networks have been visited. Specifically they were: Gosford; Nepean; Westmead; Children's Hospital, Westmead; St Vincent's; Royal Prince Alfred; Prince of Wales, Wollongong; Royal North Shore; and Forensic Hospital. A major (Dubbo) and smaller (Wellington) hospital in the Western NSW LHD were also visited.

Time constraints have prevented the Review from comprehensively considering both the general and specific security issues relevant to regional and country LHDs. It is true that some security issues cross both metropolitan and regional boundaries however the unique challenges confronting regional and country hospitals deserve special consideration in their own right.

The Working Party has met on four occasions and has provided invaluable input into the review.

STAKEHOLDER CONSULTATIONS

The following organisations or office holders have been formally consulted:

- NSW Nurses and Midwives' Association
- Health Services Union
- Australian Medical Association – NSW Branch
- Australian Salaried Medical Officers' Federation (ASMOF) NSW
- Australian Paramedic Association (NSW)
- NSW Health Security Managers Liaison Committee
- Dominic Morgan, Chief Executive, NSW Ambulance
- Commissioner Peter Severin, Corrective Services NSW
- Acting Commissioner Gary Worboys and Deputy Commissioner Jeff Loy – NSW Police Force
- Assistant Commissioner Anthony Crandell, Commander, NSW Police Educational Services
- Police Association of NSW
- Weapons, Tactics, Policy and Review Unit of NSW Police Operational Safety & Skills Command
- Australian Security Industry Association Limited (ASIAL)
- NSW TAFE
- SafeWork NSW

STAKEHOLDER SUBMISSIONS

The following organisations or office holders provided a written submission:

- NSW Nurses and Midwives' Association
- Health Services Union
- Australian Salaried Medical Officers' Federation (NSW)
- Australian Paramedic Association
- SafeWork NSW
- Justice Health & Forensic Mental Health Network
- Barrier Industrial Council (BIC)

A number of private submissions have also been received and considered from a range of individuals both within and from outside the NSW Health system.

From the outset I advised everyone with whom I met that I wished them to be frank in their discussions otherwise everyone would be wasting their time. Where assertions were made that required "testing" that was done and on many occasions documentary supporting evidence for certain matters was requested and received.

PREVIOUS INQUIRIES AND REPORTS

I wish to make it clear that with regard to many of my findings and recommendations they are in part based on what is already happening in one or more places depending upon the particular issue.

A substantial amount of policy documents, reports and briefing papers were made available to me by the NSW Ministry of Health. Every request for additional information was promptly acceded to by the Ministry.

I deliberately refrained from reading the following documents until January to see whether I was forming some of the same conclusions to be found in those reports:

- BRI Report – NSW Health Emergency Department Security Review 2016
- Violence in Healthcare Taskforce Report Victoria 2016
- Occupational Violence against Healthcare Workers Victoria 2015
- Occupational Violence Prevention Hospital and Health Services Taskforce Report Queensland 2016

Significantly the broad thread of these reports remain the focal point for the matters being raised with me by the stakeholders consulted and during the visits to the hospitals.

Over the last three years an enormous amount of effort has been expended in promulgating a myriad of policies and initiatives dealing with the issue of safety and security, resulting from the 12 point plan on hospital security developed in February 2016, and those recommendations relating to hospitals from the Inquiry into violence against emergency services personnel. In light of this significant and ongoing effort it is a matter of considerable concern that the objectives underlying this work have not been consistently achieved across the NSW Health system.

Improvements to security in hospitals

Review Findings

The NSW health system has always been extremely complex and has undergone a variety of changes with regard to both administration and the provision of clinical services over the past three decades.

From an administrative perspective the most significant of these changes was the devolution of responsibility to local health districts and speciality networks. This means that when looking at security across the state, what becomes apparent is the variation in the way security is managed in local health districts and specialty networks and the way security practices and policies are interpreted and put in place. This is further compounded by the separation and variation that exists within the districts themselves. The fundamental difficulty in this regard is that there is no standardisation of the approach to security.

Providing security in hospitals requires a wider approach than just that of an individual hospital. There needs to be relationships within a hospital, with other hospitals and health facilities in a district, and those relationships should also stretch across districts to neighbouring hospitals and facilities. Relationships with such agencies as NSW Ambulance, the NSW Police Force, Corrective Services NSW and Australian Border Force, are equally as important.

With the increase in global security threats in recent years, we have witnessed unprecedented levels of cooperation between organisations involved in security both at the domestic and international level. Here in Australia substantial improvements have been achieved within and between organisations having a security focus.

Similar consultation and co-operation is required across the board in the NSW health system with regard to security services.

All this is occurring at a time of ever-increasing hospital presentations creating challenges in emergency departments (EDs) and wards. These challenges range from: addressing the demand for acute and sub-acute mental health services; drug (particularly ice) and/or alcohol affected people; hospital services for the escalating numbers of aged and ageing persons; and, meeting the result of ever increasing anger-related presentations as well as treating weapon-inflicted injuries.

Any delays in the timely movement of patients through EDs can increase the pressures on EDs. However where it impacts on patients with behavioural disturbances who of necessity are awaiting assessment and having to undergo stays in busy EDs, then this leads to an increasing security risk.

This is best illustrated by the increasing use of the incorrectly titled security "specials" whereby a 1:1 security presence with a patient is required due to a patient's behaviour. In Victoria and in South Australia they are referred to a 'sitters'. In the health system the use of the term "special" always refers to a clinician providing specific care to a patient. The use of security officers to be positioned on a 1:1 basis near a patient should not be referred to as "specials".

A major problem that has been identified relates to the process when a person arrives at an ED and whose behaviour is a matter for concern. The person may have been a "walk-in" or been brought to the hospital by police, ambulance or corrective services. If the person is suffering injury then obviously the injury needs attention. The person may also or alternatively be exhibiting significant behavioural issues which create a potentially dangerous security/safety situation.

The necessity for a coordinated and health-focussed security focus and service across the state has never been more self-evident.

CULTURE OF SAFETY AND SECURITY

It is evident from all the consultation and observation that there needs to be a clearly understood and mandated culture of safety and security across the health system.

Security is everybody's business and everybody's responsibility. It must permeate the organisation from the top down i.e. it must be led by the Chief Executive and acceptance of and adherence to the culture cannot be left to the individual. Above all there cannot be different views across local health districts and speciality networks. There is a compelling case for the Master Licence to be held by the Chief Executive (as it is in some LHDs) with the opportunity to appoint a "close associate" under the provisions of Section 5 of the Security Industry Act 1997.

All staff must be involved in the promotion of and adherence to the new culture. It is all about eliminating risk where that is possible. In this regard it was of some concern to hear on more than one occasion that the security suggestions by clinical (and other) staff were disregarded in planning new facilities.

Basic security is as simple as ensuring that "swipe" doors are not propped open or used to allow members of the public to access parts of facilities they are not entitled to use. Attempting to undertake a lockdown of part or all of a hospital becomes that much more difficult if staff continue to do things such as those referred to above and observed during many visits.

Equally it is also about extremely busy people ensuring that things are not left lying around even for a few minutes which could be accessed by people who might misuse them or use them as a weapon.

GOVERNANCE

Above all it needs to be understood that security is not a “facilities” matter it is a “governance” matter. To this end the issue of security should be a standing agenda item for all boards and, where they exist, sub-committees dealing with risk, audit and/or compliance. It matters not if there is a nil report to boards or sub-committees, assuming there is nothing to report, it does however establish a commitment to the process and sets an example for all others in the system.

The greatest threats to an effective security system is complacency.

It must be clearly understood by all that adopting policies and then failing to implement those policies is indefensible. It is best exemplified by the situation where security manuals are interpreted and applied differently. Evidence to the Review suggested that there was a lack of uniformity with regard to a Code Black.

Arguments opposing standardisation of matters such as these beggar belief.

One of the most worrying matters relates to the wearing or rather non-wearing of duress alarms. Several reasons were given as to why this occurs. Problems identified by staff need to be addressed in a timely manner so that the duress alarms can serve the purpose for which they were recommended and purchased.

Similarly, if an item, such as a security door, requires repair or replacement that action should be undertaken as soon as possible. If that action is to be delayed for budgetary or some other reason, such as contractor delays, then that delay and the reason for such delay needs to be signed off by the Chief Executive and noted by the Board.

CCTV exists in a number of locations. The issue remains how many are constantly monitored? Are all systems effective from an evidentiary perspective? It also raises the question of district-wide coverage from both a total security perspective generally and a CCTV viewpoint in particular.

As it was my intention that any recommendations to be made by the Review would be evidence-based, I sought information as to the capacity of the Incident Information Management System (IIMS) system to provide specific information as to: time; day of the week; type of event; and other relevant information upon which to base specific recommendations particularly as to staffing levels. I was advised that the current system was unable to provide that information however I was briefed on the considerable work that had been undertaken to upgrade the IIMS system. This included a proposed pilot scheme for the new upgraded incident management system, known as ims+, to be conducted in this year (2019) with the intention of a full rollout of the upgraded system by late 2020.

In almost every consultation I have undertaken, I have been advised that there is a “culture” of under-reporting in IIMS of incidents relating to violence and aggression against staff, particularly in EDs. Data suggests the number of recorded incidents of

this type in EDs averaged barely one per day. It was consistently contended that ED staff did not input into IIMS (for a variety of reasons) whereas staff in mental health and wards generally did. This response was so widespread that it made reliance on the current IIMS statistics problematic.

This is in no way to downplay the substantial number of incidents in non-ED locations but rather to point out it would be prudent not to rely on those figures as the basis for immediate specific decisions.

It was disturbing to say the least to hear during my hospital visits from experienced doctors and nurses about the increase in aggressive and violent behaviour that they are experiencing, and the apprehension this brings.

There was also some reluctance on the part of clinical staff to become involved in any physical “takedowns” of patients.

Adoption of and adherence to a culture of safety and security would of necessity require all staff to input all appropriate matters into IIMS. Conversely it is necessary that at the very least the new ims+ enables a speedy inputting of an incident, identification of the person making the entry and follow up of the incident being reported.

UNDERSTANDING THE ROLE OF SECURITY OFFICERS

There is a clear lack of understanding of the powers and responsibilities of security officers. As a consequence security officers are regularly being asked (or directed) to do things that are outside their role, responsibility and powers. To a very great extent this problem could be best handled by adopting the “clinically-led” team approach (which includes security) that has been proven to work so well in some places.

For such an approach to work effectively it falls to medical staff in particular to fully appreciate their own role in the security effort and to ensure that all those who are likely to be confronted with a security incident (including security officers) are aware of each other’s responsibilities and above all to work as a team. In the same way any debriefing held subsequent to an “event” should involve all relevant personnel involved in the event including security.

It is also both counter-productive and in my view unsustainable for clinical staff to become aware that a potentially “difficult” situation may be about to arise and not to immediately inform security who may be required to attend.

It is in everyone’s interest to have early warning and identification of a potential problem. The existence of a sound and proven “team” approach will almost certainly contribute to the way in which volatile situations can be effectively handled in a less volatile manner.

POLICE LIAISON

A Zero Tolerance approach must be adopted regarding criminal offences committed against patients, staff and members of the public in or on health facilities.

There is an understandable reluctance for staff to become involved in the criminal justice process as a witness. The reality is that unless action is taken against offenders they will continue to offend. Courts should be given the opportunity to impose an effective deterrent against such behaviour. This alerts the general public that offences against hospital staff will not be tolerated.

Any staff member who is such a witness should be encouraged and supported in assisting the police. This should include the staff member being accompanied during the taking of a statement by the police, whether at the hospital or at the police station, and also being accompanied if attending court. Any reluctance on the part of police to charge such offenders should be the subject of discussion at the local police liaison committee or formalised to the Commissioner of Police.

These committees work extremely well in some places and less so in others. The relationship between the Chief Executive and the Local Area Commander is the key. All LHDs should review the operation of such committees in their district and maximise their effectiveness. Districts where a particular hospital services a number of Police Local Area Commands (LACs) can be challenging but nevertheless important in achieving a coordinated process.

PATIENT CARE/MODELS OF CARE

One the most challenging matters considered by the Review relates to the regularly occurring scenario where a person is brought to an Emergency Department (ED) and causes major problems and concern due to their behaviour. It may be due to illness, drugs, alcohol, mental health some other cause. The behaviour can cause considerable distress to other patients, relatives, staff and members of the public.

In situations where a mental health assessment is required, and the patient presents with challenging behaviours, there can be lengthy delays on occasions of up to several hours awaiting that assessment. During this period the person cannot be sedated as an assessment cannot then be undertaken while that person is under sedation. During this lengthy wait, the challenging behaviour can escalate and security risks are heightened.

All this is, in theory, taking place adjacent to other patients in the ED some of whom may be paediatric patients.

Psychiatric Emergency Care Centres (PECCs) have been established at a number of hospitals. Other locations have adopted a slightly different approach.

I was advised on several occasions (from different sources) of the establishment of a Behavioural Assessment Unit at the Royal Melbourne Hospital. The objective of the unit was, as reported in Emergency Medicine Australia, to "assess the impact of a new model of care for patients presenting to the ED with acute behavioural disturbance."

The Research concludes "A unit specifically designed to improve the care of patients requiring prolonged ED care due to mental illness and/or intoxication reduces the time spent in the ED and the use of some restrictive interventions. We recommend this model of care to EDs that care for this complex and challenging group of patients." A further observation was that "we observed fewer Code Grey events and episodes of mechanical restraint and therapeutic sedation."

Further consideration is required of the potential for the current trial in some selected EDs to improve the patient experience whereby there are dedicated staff whose role is to keep patients and their families up to date on their treatment plan while they are waiting. It is also necessary to consider an extension of the Nurse Practitioner and Clinical Nurse Consultant roles in addressing delays in EDs for particular circumstances whereby escalation of difficult situations can be averted or minimised.

SECURITY STAFF

In addressing the Terms of Reference a major focus must of necessity be on security staff in the hospital system.

There has been a multitude of suggestions regarding the issue and viewpoints range from one extreme to another.

Security staff include Security Officers, Health and Security Assistants (HASAs) and private/contracted security personnel.

What the hospital system **does not** require are security staff that:

- Do not understand that their role is not that of a nightclub bouncer and building guard
- Have a "punitive" attitude to their role
- Do not understand that their role is one of being part of a clinically-led team
- Do not have a commitment to the policy of de-escalation as the first response
- Think it is acceptable to sit down and spend time on their mobile phones
- Want to be quasi police in either appearance, attitude or performance
- Need to be special constables.

What the hospital system **does** require are security staff that:

- Understand that hospital security is significantly different from any other security role
- Are covered by their own "Part" of the relevant legislation i.e. Health Services Act
- Have a Health related "subclass introduced to Class 1 licences under the Security Industry Act. A modification to the Section 36 requirement re wearing of licence to be advocated or an exemption sought under Section 36(2) from the Commissioner of Police.
- Perform their role as part of a clinically-led team approach including the active participation of security in the clinical consultation team and being involved in debriefings
- Receive support from clinicians and others in the system in the discharge of their duties
- Form part of a state wide career structure that enables security staff to have effective mobility between locations
- Security officers and HASAs become part of the same structure with a single line of reporting
- That HASAs wear the same security uniform as security officers
- The title of HASAs be changed to Security and Health Assistants (SHAs) to more accurately reflect their role as detailed under the Award
- Have standardised core competencies that are reviewed annually together with an appropriate program of professional development
- In the discharge of their duties, exemplify a commitment to a "customer focus" while at the same time establishing their presence as a proactive deterrent. This will involve a subtle, but more obvious, presence encouraging interaction with patients, staff and the public as they move around a hospital.

Recruitment and retention

Consistent concerns were expressed regarding the difficulties being experienced in recruiting and retaining security staff. What is required is the right skill set, life experience, confidence and interpersonal skills. It has also been suggested that a "tool box" be developed to assist by having useful interview and scenario questions.

It would be remiss of me not to mention my perception of the great difficulty in recruiting people for a position that by definition is both security and cleaning etc. The situation in the non-metropolitan areas where the dual role is helpful is understood, however the situation in the metropolitan areas is not quite so clear cut.

It is recommended that an approach be made to universities that have substantial student bodies in undergraduate and postgraduate programs, particularly in criminology, policing and security studies. Such universities include Western Sydney University, Charles Sturt University and Macquarie University. Several thousand

students are so engaged and are looking for career opportunities both during their studies and on graduation.

The recruitment of 15 security staff in 2016, whereby candidates without a security licence were selected on their capabilities and their potential to work as hospital security staff, is a recruitment model worthy of further consideration. NSW Health sponsored these 15 staff to complete the four week vocational training, *Certificate II in Security Operations*, to obtain their security licence, following which they were placed in employment.

Security Uniform

The issue of a standard uniform for all security staff has been the subject of considerable divergence of opinion with the majority clearly coming down on the side of the current dark trousers/pants, practical shoes and white shirt with the word “security” embroidered thereon.

The majority view of white shirt with dark trousers/pants is therefore supported with one minor but nevertheless significant change. In order to ensure a clear differentiation between security personnel working in the hospital system and others such as those in shopping centres, nightclubs and the like, the following change is strongly suggested i.e. the word “hospital” in the same size lettering to be added to the word “security” on all uniforms. This small measure clearly reinforces the concept that security is part of the hospital itself and adds to the customer focus approach to be projected.

Consideration was given to using the word “health” in preference to “hospital”, however I am convinced that the word “hospital” has, compared to “health,” a more positive connotation that adds to the concept of customer focussed and professional security staff.

In considering the issue of uniform two very different approaches to uniform were encountered. The unique approach adopted regarding security uniforms in Sydney LHD has some merit and the arguments in support and the response to that “uniform” are understood. Although an attractive uniform, I did find it a little difficult to identify the “security” aspect of the uniform when viewed from a distance. I note that there is nothing but praise for the work done by security staff at Sydney LHD. Nevertheless it is felt that a standard approach is warranted.

The second example was Northern Sydney LHD. At the outset I wish to stress that I received nothing but praise for the work being done by the security staff. Indeed it was gratifying to hear of the extremely successful de-escalation approach they employed. The visual aspect however is one of concern. The vest, “appointments” type belt, “combat” boots and trousers/pants project a clear policing appearance and I found it somewhat confronting in the hospital setting. It must be re-stated that it is readily apparent that the excellent outcomes they achieve are due to the way they discharge their duties not because of the way they are currently dressed.

Equipment for security staff

By far the most vexed issue considered is that of what equipment should be issued to security staff. The current situation is that security staff are issued with protective eyeglasses and gloves. This reality is not understood by some non-security staff in the system.

There is almost universal opposition to the issue of batons and handcuffs to security staff. This opposition includes many security staff themselves. Opposition ranges from the possibility that a baton could be taken off a security officer and used as a weapon against staff. Another objection relates to the creation of an offensive rather than a defensive perception i.e. non-threatening.

Throughout the consultations and visits undertaken, I regularly raised the following worst case scenario and requested a response.

> *A person enters the waiting room of an ED and commences to cause a disturbance for whatever reason. Staff, patients and members of the public of all ages in the ED waiting room are concerned or more likely fearful.*
>
> *Quite properly all staff involved, including security, will then implement the policy and training they have received in order to de-escalate the situation. For whatever reason the situation worsens dramatically and police are called. It may be a hospital that does not have a 24 hours police presence nearby. Conversely it could be an extremely busy Local Area Command (LAC) who are unable to respond immediately.*

There are recent examples of persons being armed with a knife or machete in an ED that fortunately, have not manifested into a worst case scenario and the situation has been managed by security and other staff, and police.

To return to the question I posed, no one has been able to provide an acceptable answer. Obviously if the situation can be de-escalated, that is the preferred outcome. However it does not always happen nor are the police always able to arrive swiftly.

Obviously it is preferable to have patients, staff and the public remove themselves from the scene of the threat – this may not always be possible or realistic.

Advocates of capsicum spray fail to accept that the nature of the spray is such that it can spread far and wide causing difficulties for others through secondary exposure, including potentially harming not only the person it is being used on but others in the vicinity.

It should be noted that Victoria Police announced in 2013 (as reported in the Age of 22nd September, 2013) that they were moving away from capsicum spray to a *“capsicum streamer”* which has a much narrower target range than the spray. It is of even more interest that Victoria Police had already introduced a *“capsicum foam”* in 2004 for use in areas such as hospitals and trains.

Earlier this year (according to the ABC) the Victorian Government provided stab-proof vests for security staff in hospitals starting with high risk areas.

In December 2018 the ABC reported that the West Australian Health Department had called tenders for the provision of *"body armour vests"* to protect hospital and security staff from "bullets, blades and spikes".

The tender document referred to above states that the vests must: "*offer protection from multiple threats, including ballistic projectiles and will incorporate a high level of stab and slash protection from common sharp objects, including steak knives, screw drivers and other pointed and serrated objects."* The vests would also need provision for the attachment of capsicum spray and body-worn cameras.

This subject warrants further investigation to ensure that staff are properly protected from harm while also ensuring that the safety of staff, patients and visitors is not compromised.

Rights and responsibilities of security staff

A consistent theme from stakeholders and the hospitals related to confusion in both theory and practice as to the rights, powers and responsibilities of hospital security officers. The point should also be made that they should not be referred to as *"guards"* but either security officers or security staff. The word *"guard"* has a connotation that does not fit with the role in hospitals.

It is also clear there is considerable uncertainty in the minds of security staff. It is true that there are legislative provisions that empower hospital security staff. The common law also provides for certain situations. The reality is that security staff are uncertain of their legal position and this can be easily remedied so that they are able to discharge their duties confident in what the law is.

The most effective way to achieve this is to set out the duties, powers and responsibilities for security officers in one place i.e. a specific Part in the Health Services Act.

Another issue is exemplified by the situation at Royal Prince Alfred Hospital where some buildings are separated from others by Missenden Road. In practical terms this creates very real difficulties in terms of patient management and the powers of security staff. A simple solution would be to provide the opportunity for the curtilage of a site to be declared by way of a gazetted regulation as a "hospital" for the purposes prescribed.

Professionalisation of security staff

A constant theme to emerge was that hospital security staff are different from other security staff. Any proper examination of their role clearly endorses that proposition. This reality leads to the conclusion that the current licensing regime under the Security Industry Act 1997 does not reflect the true nature of the work of hospital security staff.

All hospital security staff including HASAs must hold a Class 1 licence under the Act. Class 1 licences are divided into 6 subclasses:

- Class 1A - Unarmed Guard
- Class 1B - Bodyguard
- Class 1C - Crowd Controller
- Class 1D - Guard Dog Handler
- Class 1E - Monitoring Centre Operator
- Class 1F - Armed Guard

All holders of operator licences must be employed by the holder of a Master licence.

There are those who may argue that a Class 1A covers the role of hospital security. This is not reflected in the various duties undertaken by hospital security staff and has a completely different focus to that envisaged by Class 1A.

Action should be taken to have a Class 1G subclass created specifically for hospital security. It should specify the competencies and training applicable to the hospital security role.

An issue of concern to many security staff relates to the provision of Section 36 of the Security Industry Act requiring the holder of a class 1 licence to wear the original licence so that it is clearly visible. It is proposed that such requirement be removed for hospital security or failing that an exemption be sought for hospital security staff from the Commissioner of Police under the provisions of section 36(2) due to the special nature of the licensee's duties.

What has become clear is that hospital security staff need some career structure. This would reduce problems associated with "mobility" within the hospital system. There needs to be some consideration of a program of professional development and potential performance recognition.

Above all the current system whereby a hospital security staff applicant has to have gained their class 1 licence from the Security Licensing and Enforcement Directorate (SLED) at their own expense and in their own time. They then, after appointment, have to attend and undergo the three day TAFE course together with NSW Health's Violence Prevention and Management training.

A small group should be authorised to undertake a review of all the training currently undertaken by hospital security staff. The objective would be to achieve an outcome whereby all the training undertaken might result in a recognised "Certificate" and establish a pathway whereby that qualification could be upgraded or enhanced.

Improvements to security in hospitals

Recommendations

CULTURE

1. A culture of safety and security to be mandated and clearly understood across the NSW health system based on the maxim that “*security is everybody’s responsibility*”.
2. That culture requires an understanding that staff and members of the public are entitled, both legally and morally, to the same protection as patients. Staff cannot work efficiently if they come to work fearful of being assaulted.
3. An evaluation of the Nurse Safety Culture Co-ordinator positions funded in the 2017/18 Budget should be undertaken with a view to identifying opportunities to enhance the adoption of the culture referred to above.

RURAL AND REGIONAL

4. The different challenges facing regional and rural hospitals should be the focus of a similar investigation to that undertaken so far by the Review.

LEADERSHIP

5. The acceptance of, and adherence to, the principle that a staff safety culture is to be led by the Chief Executive of each organisation.
6. Managers must ensure that the current culture of under-reporting of security type incidents ends. Staff are to be actively encouraged to enter all incidents into the current incident management system (IIMS). Staff are also to be advised of the efforts being made to upgrade the current system to the new ims+ to address the issues of concern.
7. Managers and supervisors are to ensure compliance with the wearing of personal duress alarms where their use has been mandated. Where problems are identified regarding the use of a duress alarm then that matter is to be resolved urgently. Where a staff member requests, due to concerns for their individual safety, the issue of a duress alarm for use elsewhere in their place of work, then consideration should be given to the issue of same.
8. All Local Health Districts and Specialty Networks are to have a system in place to ensure that clinical staff inform security staff when they become aware that a patient, who may present a behavioural challenge, is en route to the hospital.

9. Staff who have been threatened or assaulted resulting from a deliberate act of violence are to be encouraged and supported to report the assault to police and to request action be taken by the police against the perpetrator. Staff are to continue to be supported through any subsequent criminal justice proceedings. To this end, the member of staff is to be supported by another member of staff from the taking of statements through to attendance at court. Clearly this recommendation will be influenced by the clinical condition of the perpetrator. Representations should be made to permit staff of hospitals or other health facilities who are victims of assault to use the business address rather than their personal address when pressing charges or taking an AVO against an individual.
10. The effectiveness of local liaison committees with police and other agencies are to be reviewed to ensure appropriate representation is present and that the meetings are held regularly. Any difficulties identified at the local level which are not resolved should be escalated in line with the NSW Health/NSW Police Force Memorandum of Understanding for further consideration.

GOVERNANCE

11. Each Board of a Local Health District or Specialty Network is accountable for the security and safety of staff, patients and visitors. Consideration should be given to having security / staff safety as a standing agenda item for each Board meeting and, where they exist, each Board sub-committee dealing with audit, risk and compliance.
12. The required NSW Health Security Improvement Audit Program is to be fully resourced and implemented in each Local Health District and Specialty Network, and reported to the Board through the Board sub-committee dealing with audit, risk and compliance.
13. A central security audit function be established with appropriate resourcing to drive compliance and consistency of security policies and standards throughout NSW Health.
14. Where there are both Security Officers and Health and Security Assistants (HASAs) in the one location, action must be taken to ensure both groups operate as one integrated team with a strong professional relationship and a single line of reporting within each Local Health District/Specialty Network.
15. Local Health Districts and Specialty Networks must determine security staffing levels based on an assessment of risk and implement demand driven rostering of security staff to address the identified risk, similar to how clinical staff are rostered.
16. Security staff should be positioned so that they are regularly visible in emergency departments, both in the treatment and waiting areas.

17. When planning new and redeveloped hospital and health facilities, due regard needs to be given to designing out risk and taking account of the views of clinical and security staff. This should include developing design guides that assist staff and architects to incorporate security into early planning stages.

STANDARDISATION

18. The security standards set out in the NSW Health security manual *Protecting People and Property,* and the related policies, should be adopted in every facility as written, and compliance is to be subject to audit.
19. A standardised “Code Black” procedure must be in place in all facilities, in line with that specified in *Protecting People and Property*, unless a particular localised variation can be justified. Regular practice drills should be undertaken so that everyone understands their roles and responsibilities and skills remain current.
20. The use and effectiveness of current CCTV operations with particular reference to the prevention, response and evidentiary uses are to be subject to audit to ensure compliance with the NSW Health security standards for CCTV as set out in *Protecting People and Property*.
21. Security audits are to include disaster planning, lockdown procedures and incident management protocols.
22. Security Officers and HASAs should be part of a state-wide hospital security function enabling mobility through transfers and ongoing professional development.

PATIENT CARE/MODELS OF CARE

23. The provision of a safe space in emergency departments (in the best interests of both patients and staff) is supported. Examples of such a space are “Safe Assessment Rooms” or “PANDA Units” (Psychiatric, Alcohol and Non-prescription Drug Assessment). Further analysis of the successful Behavioural Assessment Unit (BAU) pilot program at the Royal Melbourne Hospital is required with a view of possible adoption in some major emergency units.
24. Urgent action is required to overcome delays in mental health assessments which see patients waiting hours for such an assessment, creating a situation not in the best interests of the patient and potential to cause significant security issues for those with challenging behaviours. The use of Nurse Practitioners and Clinical Nurse Consultants (Mental Health) should be considered in this regard.

25. There is sufficient positive feedback to justify further consideration of possible expansion of mental health initiatives such as: Operation Pacer in the St George Local Government area; PEAMHATH (Police Early Access to Mental Health Assessment via Telehealth) in Hunter LHD; Resolve Program in Nepean Blue Mountains and Western NSW LHDs; and MHAAT (Mental Health Acute Assessment Team) in Western Sydney LHD.
26. There is a need to reduce stress and improve the waiting experience for people in an emergency department waiting room. Strategies to improve the experience of patients while waiting at an emergency department should be evaluated and where they are found to have had a positive impact on the patient/carer experience and staff safety, consideration should be given to resourcing their expansion across NSW Health. The broader implementation of these successful initiatives, when coupled with mobile security staff frequently moving through the waiting room, will have significant benefits for the operation of an emergency department.
27. At times, a patient's condition may require a 1:1 security presence to assist in protecting staff, the patient and property. This is a security function and should never be confused with the individual patient specials (or 'specialling') required to be undertaken by clinical staff.
28. In future, where a 1:1 security presence is required, that role must be referred to as '1:1 security support' and not as a 'special'. *Protecting People and Property* should be updated to ensure the role and responsibilities of security staff during episodes of 1:1 security support are set out.

CAPABILITY

29. All staff who work in an area where there is risk of assault/violence are required to undertake security/safety training in a timely manner, and the skills learned should be practised regularly. The training of staff should be subject to audit and the results reported to the Chief Executive and to the Board (or equivalent) through the Board sub-committee dealing with audit, risk and compliance.

ROLE AND POWERS OF SECURITY STAFF

30. Security staff should not be referred to as "guards". They should be referred to as security officers or security staff.
31. The following statement from Information Sheet 1 – Role of security staff working in NSW Health, should be promulgated to all health staff: "*In all cases security staff should work as part of a team, in collaboration with other staff, to assist with managing patients, to provide assistance to visitors, and to assist with protecting staff and securing the assets of the Agency*."

32. Clinicians must be informed of, and understand, the role and responsibilities of security staff. They must take action to integrate them into the multi-disciplinary team and include them in team discussions that discuss security/staff safety such as safety huddles and incident debriefs.
33. There should be a ‘Part’ of the Health Services Act dealing with hospital security and safety setting out the duties, powers, rights and responsibilities of security staff and any related matters that arises from this review that support safety in hospitals. This should also enable resolution of situations regarding the transport of patients from one part of a hospital campus to another where there is a public road between the two facilities.
34. The re-introduction of “special constables” is not supported.
35. In relation to the issue of defensive type equipment for security staff, further investigation of options and practices in other jurisdictions is required to assess the suitability of any such equipment in the healthcare environment that does not compromise staff or patient safety.

PROFESSIONALISATION OF SECURITY WORKFORCE

36. It must be recognised that the role hospital security staff undertake is unique to the health environment and is significantly different from any other security role.
37. A new subclass covering “Hospital Security” should be introduced to Class 1 licences under the Security Industry Act. A modification to the Section 36 requirement in the current security industry legislation, mandating wearing of the licence be sought failing which an exemption should be sought under Section 36(2) from the Commissioner of Police.
38. All security staff uniforms should consist of dark trousers/pants, white shirt with the inclusion of words/logo that identify them as “hospital security”. The wearing of combat boots, appointments belts, or any other equipment or apparel that give the appearance of police or military uniforms are not supported.
39. HASAs should wear the same uniform as security officers so that they are clearly identifiable to staff, patients and visitors. The exception is where they are embedded in a location requiring them to wear similar uniform to other staff e.g. acute mental health unit.
40. The title of HASAs should be changed to Security and Health Assistants (SHAs) to more accurately reflect the primacy of their security role, as set out in the award.

41. Security staff and HASAs currently undertake the SLED qualification prior to being licensed, the TAFE *Security in the Health Environment* course, and the violence prevention and management program. This training should be formally assessed against nationally recognised competency standards so that the training undertaken is formally recognised. This would provide the basis for regular assessment of the competencies required and also facilitate a professional development pathway for those seeking advancement. It will also provide an opportunity to introduce topics such as mental health, paediatrics and customer focus.
42. That NSW Health seek to recruit security staff beyond the traditional methods and that an approach be made to universities such as Western Sydney, Charles Sturt and Macquarie as sources for potential security staff.
43. Districts/Networks should establish a pool of casual security staff, similar to that for teachers, to enable suitable staff to be identified at short notice.
44. A “Tool box” be developed to assist in having useful interview and scenario questions available to facilitate the identification of suitable security staff.

JUSTICE HEALTH AND FORENSIC MENTAL HEALTH NETWORK

45. The collaborative model currently operating at the Long Bay Hospital is to be commended. It is evident that the clinical and correctional staff work very well together in a very challenging environment.
46. A significant divergence of opinion apparently exists between staff at the Forensic Hospital as to the most appropriate “security” measures that should be introduced. Indeed the vehemently expressed views by staff, with whom the matter of security was discussed at the time of the visit, are diametrically opposed to the position that had been put to me by the union. Expressions such as “I will resign if security are brought in” seem to indicate a significant divergence of opinion amongst staff.
47. Having become aware of certain measures proposed by management of the Forensic Hospital it is believed that those measures should be given the opportunity to be tested. Support for that course of action is predicated on the basis of constant monitoring during the next six months, with a view to further consideration of the matter at that time.

RESOURCING

48. All Local Health Districts and Specialty Networks consider the recommendations from this report and any resourcing implications and make a submission to the Ministry of Health regarding resource requirements.

Terms of reference

Improvements to Security in Hospitals

1. Introduction

1.1 The Ministry of Health (the Ministry) is engaging a consultant (the Consultant) to identify and consider whole of NSW Health strategies for security in hospitals (including those in the Justice Health and Forensic Mental Health Network) to ensure staff, patients and visitors are kept safe from violence and aggression (the Project).

2. Background

2.1 In January 2016, a violent incident occurred in the emergency department of Nepean Hospital when a police officer and a member of the security staff were shot by a patient who seized the police officer's gun.

2.2 In February 2016 a Roundtable was convened and involved unions, frontline staff and managers. *A 12 Point Security Action Plan on Hospital Security* was developed and endorsed by the then Health Minister (**Attachment 1**).

2.3 Action has been taken to implement all actions within the *12 Point Security Action Plan on Hospital Security*, noting that some actions, such as embedding a stronger work, health and safety culture and rolling out the new incident management reporting system (ims+) are of a long term nature.

2.4 Action 3 from the *12 Point Security Action Plan on Hospital Security* required an audit of 20 emergency departments (the remainder of the emergency departments completed a security self-assessment). Every emergency department then developed a plan (the Remedial Action Plan) to address areas of non-compliance identified through the external or the self-assessment.

2.5 Every emergency department also implemented actions arising from the recommendations from the external ED audit report (the Implementation Plan).

2.6 In February 2018 the Government submitted its response to the *Legislative Assembly Committee of Law and Safety – Report of the Inquiry into Violence Against Emergency Services Personnel*. A number of the recommendations reflected and reinforced the value of the work that was already underway as part of the *12 Point Security Action Plan on Hospital Security*.

2.7 Recent incidents at Blacktown Hospital, where a nurse was stabbed after a patient gained access to an unsecured staff meal room, and Nepean Hospital, where a person adjacent to the entrance of the emergency department wielded a knife, have further highlighted the risks present for staff, patients and visitors when exposed to individuals exhibiting threatening or disturbed behaviours

3. Scope and purpose of the Project

The Consultant will, in undertaking the Project, have regard to but will not be limited by the matters listed below:

3.1 Consider the impact of the *12 Point Security Action Plan on Hospital Security* in setting a framework for improving hospital security.

3.2 Invite submissions from relevant stakeholders, including but not limited to the Health Services Union, the NSW Nurses and Midwives' Association, Australian Salaried Medical Officers' Federation and the Australian Medical Association.

3.3 Consider any additional state-wide strategies that are required to achieve further improvements to security in NSW hospitals (including those in the Justice Health and Forensic Mental Health Network), with a particular emphasis on any changes required to NSW Health policies, practices and legislation.

3.4 NSW Health and its staff acknowledge that the responsibility for public safety always remains the role of NSW Police. Nevertheless the future role of NSW Health security staff and contractors will be examined.

3.5 Have regard to previous inquiries and reports and the decisions taken by Government and NSW Health in response.

3.6 Have regard to the relevant best practices in other Australian and NZ health jurisdictions and the appropriateness or otherwise for their adoption in NSW.

3.7 Specifically consider the effectiveness of the TAFE/NSW Health training program on security and safety that has been implemented under the 12 point action plan.

3.8 Recommendations are to take account of the fact that NSW Health retains as its core function the provision of health services to promote, protect, develop, maintain and improve the health and wellbeing of individuals. Care still needs to be provided to people who are coping with serious illness and injury which may impact on behaviour, while ensuring that the workplace is safe for staff, patients and members of the public.

4. Key deliverable and work product, completion timeframe and key contacts

4.1 The Project requires that the Consultant provides a report addressing the specified scope and purpose.

4.2 The Project Report will contain recommendations, with commentary on the rationale for each recommendation.

4.3 The Consultant will be supported throughout the Project by an internal Departmental Working Party and appropriate administrative support provided by the Ministry of Health.

4.4 The Project Report will be submitted to the Secretary of the NSW Health by no later than **Wednesday 14 February 2019**. Any potential slippage in the timeframe for submission of the Report should be advised at the earliest possible opportunity.

5. Policy Context

5.1 The Consultant will have due regard to the following relevant NSW Health Policy Directives:

- Protecting People and Property NSW Health Policy and Standards for Security Risk Management in NSW Health Agencies (the Security Manual)
- PD2018_013 Work Health and Safety Better Practice Procedures
- PD2015_001 Preventing and Managing Violence in the NSW Health Workplace - A Zero Tolerance Approach
- PD2017_043 Violence Prevention & Management Training Framework for NSW Health Organisations
- PD2012_035 Aggression, Seclusion & Restraint in Mental Health Facilities in NSW
- PD2015_004 Principles for the Safe Management of Disturbed and/or Aggressive Behaviour and the Use of Restraint
- Memorandum of Understanding – NSW Health and NSW Police Force (2018)
- PD2010_024 Fire Safety in HealthCare Facilities
- PD2014_004 Incident Management Policy
- PD2015_043 Risk Management - Enterprise-Wide Risk Management Policy and Framework - NSW Health
- GL2015_007 Management of patients with Acute Severe Behavioural Disturbance in Emergency Departments
- GL2013_002 Management of NSW Police Force Officers' Firearms in Public Health Facilities and Vehicles
- GL2006_014 Aged Care – Working with People with Challenging Behaviours in Residential Aged Care Facilities

Action Plan arising from Security Roundtable

Attachment 1

1. Deliver an intensive program of multi-disciplinary training of ED staff including nursing, security and medical staff in managing disturbed and aggressive behaviour and ensure each member of the multi-disciplinary team is clear about their respective roles.

2.
   - Deliver a program to engender a stronger workplace health and safety culture and ensure all staff, including junior doctors, nurse graduates and other rotating staff are adequately inculcated into the safety culture
   - Ensure clinical unit and hospital managers are specifically trained to understand and give effect to their Workplace Health and Safety obligations and ensure their local workplaces have a zero tolerance to violence

3. Undertake a detailed security audit of the following EDs:
   - Bankstown Lidcombe Hospital
   - Blacktown Hospital
   - Blue Mountains Hospital
   - Byron District Hospital
   - Calvary Mater
   - Cooma Hospital
   - Hornsby Ku-ring-gai Hospital
   - John Hunter Hospital
   - Nepean Hospital
   - Orange (noting co-location with Bloomfield)
   - Prince of Wales
   - Royal Prince Alfred
   - Royal North Shore
   - Shoalhaven
   - St Vincent's Hospital Sydney
   - Tweed Heads Hospital
   - Wagga Wagga Rural Referral Hospital
   - Wellington Hospital
   - Wollongong Hospital
   - Wyong Hospital

   The audit will cover compliance with policy and mandatory training requirements, adequacy of ED design in managing aggressive patients, adequacy of security staff numbers, hospital liaison with local police on incident response to acts of physical aggression in EDs, and handover by police of physically aggressive individuals requiring treatment.

   The audit will recommend any strengthening of policies and procedures needed for EDs, in particular to adequately respond to behaviours of individuals, affected by alcohol or drugs, including psycho stimulants such as "ice", presenting at EDs.

4. Establish a working group to recommend strategies to increase the professionalisation of NSW Health security staff and how best to integrate their roles in a multidisciplinary response to patient aggression.

5. Partner with TAFE to train existing security staff in a security course purpose designed for the health environment.

6. Sponsor the recruitment of a new intake of trainees to qualify as security staff through the health specific course and recruit and train further staff following consideration of the results of the security audit.

7. Establish a Reference Group of expert clinicians to develop specific patient management and treatment pathways, including disposition and transport options, for patients presenting to EDs under the influence of psycho-stimulants such as “ice”, both for immediate management and longer term referral and treatment.

8. Immediately examine availability of Mental Health and Drug & Alcohol resources including the use of telehealth options for rural and regional areas for patients presenting to EDs under the influence of psycho-stimulants such as “ice”, both for immediate management and longer term referral and treatment.

9. Work with NSW Police to ensure arrangements adequately and consistently cover liaison, firearms safety, handover and incident response involving aggressive individuals presenting at public hospitals including pursuing prosecution of offenders.

10. Examine whether legislative changes are required:

    - to make clear that a victim’s status as a health worker, which is already an aggravating factor when sentencing an offender convicted of assault, covers hospital security staff.

    - to provide adequate legal protection to security staff who act in good faith and under the direction of health professionals, who require assistance in order to render lawful medical treatment or care of patient.

11. Identify the circumstances in which security staff are able to exercise power to remove from public hospital premises individuals who are not patients and who are acting aggressively or who are otherwise causing disruption.

12. Improve incident management reporting systems to ensure they are user friendly, well utilised and provide transparent management and feedback loops to staff making the reports.