Australasian College
for Emergency Medicine

34 Jeffcott Street West Melbourne Victoria 3003, Australia
+61 3 9320 0444 | admin@acem.org.au | ABN 76 009 090 715

Penalties for assaults on public officers
June 2020

Introduction

The Australasian College for Emergency Medicine (ACEM; the College) welcomes the opportunity to provide a written submission to the Queensland Sentencing Advisory Council (the Council) review of *existing penalties for assaults on police and other frontline emergency service workers, corrective services officers and other public officers*.

As the peak professional organisation for emergency medicine, ACEM is responsible for the training of emergency physicians and the advancement of professional standards in emergency medicine in Australia and New Zealand. The practice of emergency medicine is concerned with the prevention, diagnosis and management of acute and urgent aspects of illness and injury among patients of all ages presenting with a spectrum of undifferentiated physical and behavioural disorders.[1] ACEM has a vital interest in ensuring the highest standards of medical care are provided for all patients presenting to an emergency department (ED) and we have long advocated for a health system that provides a safe workplace.

FACEMs and trainees in EDs are on the front lines into the hospital and broader healthcare system. Although ACEM strongly supports legal protections provided to all healthcare staff working throughout Queensland's hospitals and EDs, we will not be commenting on the legal specifics of any existing or proposed change to the legal framework as this is beyond the scope of ACEM's expertise. The College considers that more can be done to reduce the likelihood of violence occurring in EDs and this forms the basis of our submission.

Consistent with the Terms of Reference (ToRs) we make the following submission on behalf of the Queensland membership of the College. Where relevant, we have provided answers to questions specifically raised in the Issues Paper.

1. Safety concerns in the ED

The safety of patients, visitors and staff in the ED is of primary concern to ACEM. While in the vicinity of the ED and the wider hospital, all people have a right to an environment safe from violence. The College's vision is that no staff, patients or accompanying persons suffer harm due to violent incidents in the ED.

The ED is well-recognised as a setting in which violence is more likely to occur. A survey of ACEM members found that 88% had been threatened by a patient in the past year and 43% had been physically assaulted in the past year.[2] More recently, our members report instances of being spat on by patients, which places them at high risk during a time of pandemic. At all times, the management of agitated or violent patients in the ED can be challenging and poses a safety risk to the individual patient, staff, other patients and people accompanying them.

Violence in EDs is under-reported due to perceptions among ED staff that it is an inherent part of the job. ED staff who are exposed to workplace violence also under-report incidents due to barriers associated with complex and lengthy reporting systems, lack of time, unclear policies and procedures, confidentiality issues, peer pressure, the stigma of victimisation, and fear of retaliation by hospital administrators. This culture of under-reporting suggests that the quantitative evidence on violence in EDs is limited and of poor quality. For instance, few studies have monitored trends in ED violence or evaluated the effectiveness of interventions over time. To understand the cumulative effects of violence on ED staff, as well as appropriate prevention and intervention strategies, instituting a culture of reporting is essential.[3]

[1] ACEM. Policy on standard terminology (P02). Melbourne: ACEM; 2014
[2] ACEM: *ACEM Workforce Sustainability Survey Report,* Melbourne: ACEM 2016
[3] ACEM: *P32: Violence in emergency departments, December 2017*. Melbourne: ACEM

Recommendation 1: A review of existing reporting policies and practices that results in better supports for ED staff to report violence to hospital administration, with all incidents investigated and reported to the police, as required.

Recommendation 2: All hospitals should provide appropriate psychosocial and legal support systems for ED staff during any investigation and/or legal proceedings related to incidences of violence.

Recommendation 3: Support systems should be in place for ED staff who are returning to work after experiencing workplace violence.[4]

2. Managing violent behaviour in the ED

ACEM acknowledges that restrictive practices (including sedation or physical restraint) are often needed to manage agitated or violent patients who pose a risk to themselves, staff or other patients and when all other de-escalation techniques have been unsuccessful.[5] Evidence also suggests that patients who are intoxicated with alcohol or other drugs are less likely to respond to verbal forms of de-escalation and are more likely to require sedation compared to patients with a sole diagnosis of mental illness.[6] [7]

ACEM emphasises that the use of restrictive practices in many circumstances is a symptom of system failure. Access block[8] and excessively long waits to be seen, assessed and admitted from the ED (if necessary) reduces the capacity for definitive care given the inability to provide safe, timely and high-quality care to the patient. This environment can further aggravate patient distress and increase the risk of behaviour escalating into violence, necessitating the use of restrictive practices where EDs are not staffed and resourced to provide clinical supervision of patients over prolonged periods of time.[9]

Whilst most jurisdictions have strong regulation of these practices, including exclusions on their use or special provisions for vulnerable groups (for example children and Aboriginal and Torres Islander peoples), the use of restrictive practices in the ED is not part of routine data collection. As such there is limited data to improve our understanding of the use of restrictive practices and the association with ED length of stay, impairing the potential for any progress towards reducing or eliminating the use of these practices.

In Victoria, researchers undertook an audit of patients who had attended four Victorian hospitals in 2016 to understand clinical practice when responding to behavioural emergencies, determined by a Code Grey (unarmed threat) being called.[10] This audit found that Code Greys were called for 1.49% of all patients, with restrictive interventions applied in 24.3% of such cases.[11] Importantly, where a Code Grey had been called, less than one in six patients were admitted to an inpatient bed, indicating that such presentations could have potentially been prevented through the provision of alternative and adequate community and crisis services.[12]

Recommendation 4: ACEM recommends that restrictive practices (sedation and restraint) in EDs are governed by clear clinical governance frameworks, standardised documentation tools and clear reporting pathways that allow for audits of their use and system improvement recommendations to be progressed to the relevant governance level

Recommendation 5: ACEM recommends that all security personnel working with the ED are appropriately resourced and trained in de-escalation techniques to reduce the need for restrictive practices and ensure patient and staff safety.

---

[4] As above.

[5] Knott, J., Gerdtz, M., Dobson, S., Daniel, C., Graudins, A., Mitra, B., Bartley, B. and Chapman, P. (2019) Restrictive interventions in Victorian emergency departments: A study of current clinical practice, *Emergency Medicine Australasia*

[6] Yap, C.L., Taylor, D. Kong, D.C.M., Knott, J.C., Taylor, S., Graudins, A., Keijzers, G., Kulawickrama, S., Thom, O., Lawton, L., Furyk, J., Finucci, D., Holdgate, A., Watkins, G., Jordan, P. (2019) Management of behavioural emergencies: a prospective observational study in Australian emergency department. *J Pharm & Prac*, 49 (4): 341-348.

[7] Braitberg, G., Gerdtz, M., Harding, S., Pincus, S., Thompson, M. and Knott, J. (2018) Behavioural assessment unit improves outcomes for patients with complex psychosocial needs, Emergency Medicine Australasia, 30:353-358.

[8] ACEM: *S127: Statement on Access Block, June 2017*. Melbourne: ACEM

[9] Kennedy MP. (2005) Violence in emergency departments: under-reported, unconstrained, and unconscionable. Med J Aust; 183(7):362–5.

[10] Knott, J., Gerdtz, M., Dobson, S., Daniel, C., Graudins, A., Mitra, B., Bartley, B. and Chapman, P. (2019) Restrictive interventions in Victorian emergency departments: A study of current clinical practice, *Emergency Medicine Australasia*

[11] Knott et al. (2019)

[12] Knott et al. (2019)

3. Other comments

Emergency departments provide an essential health service to the community at a time of health crisis; ACEM's view is we shouldn't have to turn them into fortresses to keep staff and patients safe. However, much more needs to be done to understand the causes of violence in emergency departments and to resource emergency departments to prevent violence and minimise its impact.

Thank you for the opportunity to provide a response to this important review. We welcome the opportunity to discuss this submission further, if provided. Please do not hesitate to contact ACEM via policy@acem.org.au.

Yours sincerely

Dr John Bonning
President

Dr Kim Hansen
Chair, Queensland Faculty