Letter from the President:

I would like to begin by saying that I am deeply honored to serve as President of this great association. Since 1968 there have been some really talented, dedicated and experienced people that have served as Board Members and President of this association; very tough acts to follow. Over the past few years we have many new members that are probably not aware of the history of IHASS. I would like to recognize those active charter members that had the foresight and determination to get this association off the ground and built the foundation for what IAHSS represents today for all of us. The active Founding/Charter members of IAHSS (1968) are Russell Colling, Thomas Dailey, Raymond Johnson, and Thomas Kramer. Tom Kramer was instrumental in getting me involved with IAHSS over 30 years ago when we were both part of the Connecticut Chapter of IAHSS. Thank you all for the hard work and years of dedication you have given to this association, it is appreciated!

We’re off...2011 is underway and this is the first year that our volunteer leaders officially took office in January. What makes this association so great is our members and for our first time our membership has exceeded 1900 members. Our growth continues even though the economy has been ‘less than great’ for the past few years and monies are tight in everyone’s budget. The Board of Directors is focused on delivering the best products, services, and programs, for the best value possible to our membership. We recognize that a majority of our members come from rural/suburban areas and getting away from the facility to attend chapter meetings and educational programs can be expensive and time consuming. We are committed to exploring and using the best and the latest technologies to communicate and to deliver quality programs at reasonable cost to our members. This year there is a new Council on Membership/Regional Leadership which is being chaired by Bonnie Michelman which will focus on bringing value to the membership, identifying and reaching out for new members, member retention, and the ROI for all members. There is also a new Council on Advocacy which will be lead by Joe Bellino. This group will be the liaison between IAHSS and the federal, state and other healthcare regulatory agencies that impact healthcare security/safety issues. These are two timely and critical Councils and I want to thank Joe and Bonnie for stepping up once again for our association.

The ‘I’ in International is front and center again this year. In May the AGM will be in Toronto Canada and I encourage every member to make their best effort to be there.
The educational program, hotel, city and venue are exceptional; I hope you have your passport in hand and that you are planning to attend. The Toronto Chapter along with several other Canadian members has worked closely with Evelyn and Nancy to make this AGM the best one yet!

Over the past year we have made solid gains on the International front. Joe Bellino and I were in Australia at the end of 2010 and we met with several highly motivated Australians that are anxious to get a chapter started. Sincere thanks go out to Bruce Irvine IAHSS Regional Chairperson for Australia / New Zealand for spearheading this effort; we now have 4 active IAHSS members from this region. Efforts are still in the works to get a UK chapter started. There has been contact with a very high level government healthcare professional that has responsibility for safety, security and emergency preparedness in Saudi Arabia. We are discussing how we might get a Middle East chapter of IAHSS started as well.

In closing I would like to take this opportunity to recognize one special member who deserves our thanks and recognition in every possible way. I met Steve Gaunt many years ago when he was active in the El Paso TX chapter. Steve has always been a strong supporter of IAHSS and has served as a Chapter Officer in several different chapters, he is currently instrumental in getting the North New Jersey Chapter re activated, he has served on several IAHSS councils, committees, and task forces over the years and he has also served on the IAHSS Board of Directors. For many years Steve has also been serving with our US Military as a Chief Warrant Officer IV in the Army Criminal Investigative Division (CID) and he has been deployed on several long tours of duty in Iraq and Afghanistan. In spite of all this stress and being away from family and the USA Steve always comes back home, picks up the phone and says “what have I missed and how can I help IAHSS”. Holding Steve in the highest regard is easy; he is a hero and his service to our nation and IAHSS deserves our thanks and appreciation, well done Steve!

We have other members and some of our members have family members that are also serving in the military or have served in the military for their country and I ask that we keep them all in our thoughts and prayers and thank them for their service which too often goes unnoticed!

Jim Stankevich, CHPA
President

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**Executive Director’s Letter**

2011 already is a busy year! The volunteer work groups are in place and they have started developing needed materials for the Association. The new Council on Membership/Regionals and the Council on Advocacy are gearing up as is the new Taskforce on Physical Security and IT Security.

IAHSS is moving ahead with a new logo, new marketing materials, and a new public relations campaign. Members will soon see the new brand as materials run out and are replaced.

IAHSS will be exhibiting at ISCWest in Las Vegas in April as part of our outreach program to improve the visibility of IAHSS.

The 43rd AGM is in Toronto in May and we hope you will join us. Start planning now and get your passport so you are ready! Explore all the travel options: flying, driving, Amtrak, or traveling with a group from your area. Porter Air has daily flights from several airports direct to Toronto Island airport, it is a great option and cost effective. Toronto is a beautiful city with something for everyone. Combine a superb educational program with networking with your peers and the wonderful venue to make this a must attend event. We hope to see you in Toronto.

Concerns or questions? Email me at **evelyn@iahss.org** and I’ll get back to you.

Always,

Evelyn Meserve, CHPA, HEM
Members of the International Association for Healthcare Security and Safety are familiar with the reconstitution of the Board of Directors based on the results of the annual election. Beginning 2011, the IHSS Foundation administrative year commences in January; following the lead of the IAHSS in moving the beginning of the year from July to January.

Departing the IHSS Foundation, having completed the most recent eighteen month term of appointment (accommodating to the cited change from the July to January date) are:

- William A. Famsworth, Jr., CHPA;
- Thomas A. Smith, CHPA, CPP; and
- Erin Downey, MPH, SCD.

Also ending her commitment as IAHSS Board of Directors Liaison to the IHSS Foundation, Bonnie S. Michelman, CHPA, CPP.

Each has made substantial contributions to the successes of the IHSS Foundation in implementing the recent reallocation of functions between the IAHSS and the IHSS Foundation.

The IHSS Foundation Board of Directors for the year 2011 is comprised of:

- Edwin W. Stedman, CHPA (2010-2011), President;
- Russell F. Jones, PhD, CHPA, CPP (2011-2012), Secretary;
- Lisa B. Pryse, CHPA, CPP (2010-2011) Treasurer;
- Ken Close, CHPA (2010-2011), Member;

Lisa B. Pryse, IAHSS Treasurer will represent the IAHSS on the IHSS Foundation Board of Directors.

As with all the international, regional and chapter officers of the IAHSS, the appointed members of the Board of Directors of the IHSS Foundation serve as unpaid volunteers. Board meetings are conducted monthly via teleconference, except for the single face-to-face meeting conducted in conjunction with the Annual General Meeting of the IAHSS, being held this year in Toronto, Ontario, Canada during the period 22-25 May 2011.

Similarly, administrative support is provided by the Executive Office, Chicago, Illinois staffed by:

- Evelyn F. Meserve, CHPA, Executive Director and
- Nancy Felesena, Executive Secretary.

The IAHSS and the IHSS Foundation, although sharing a single individual as Treasurer; each function with independent operating budgets.

In the previous Update Article the intent of the IHSS Foundation to support, fortify and complement the goals and objectives of the IAHSS through its programs was set forth. The use of key words in formulating Nominations for Recognition was noted.

The IHSS Foundation Recognition Program, as well as the Grant and Ken & Ellie Christian Scholarship, (Tuition Assistance) programs rely upon submission of Nominations / Applications which are consistent from one nominator/applicant to the next in order to provide for equality in review and evaluation by the Board of Directors. Concerns have been expressed relative to the cumbersomeness/complexities of the forms. None of the forms exceed five basic pages.

Page One (the face page) provides a listing of the information which the IHSS Foundation considers appropriate to adequately support the submission.

That information should be included as Exhibits attached to the nomination/application. The face page (to be included a Page One) serves as a check list for both the originator and the reviewer. For those nominations/applications of individuals (e.g., Literary Achievement; Medals of Valor, Merit, Distinction) as differentiated from entities (Program of Distinction, Chapter of Distinction), one of the included exhibits requested is the Curriculum Vitae of the nominee, thus obviating the need for a page in the nomination/application identifying the individual subject of the submission.

Excepting the Literary Achievement nomination, Page Two provides for identification and supporting comments of the originator of the submission. The lead section of Page Five identifies the subject of the nomination; remainder of Page Five is reserved for use of the Board of Directors. Page Two of a nomination for Literary Achievement is specific to the literary work and its author(s).

Pages between Two and Five provide for comments supporting the submission - those of Chapter and Regional Chair-persons as well as colleagues and peers.

Concerns have also been expressed relative to the limited time provided for submissions between the year end and the deadline for submissions to receive consideration. That date is established in order to provide for adequate review, evaluation and rating of nominations by the Board of Directors prior to the Recognition Dinner at which presentations are to be made. Review of recent nominations reveals the deadline to be reasonable given submission content.
Although just a drill, the scenario of an active shooter within Scotland Memorial Hospital, Laurinburg, NC in December was reminiscent of an actual event that occurred several months earlier.

As part of its ongoing enhancement of security measures, Scotland Memorial participated in an active shooter drill in conjunction with the local police department in Laurinburg. In February 2010, the hospital’s emergency department experienced an actual shooting incident after a man, falsely identifying himself as a patient’s brother, entered the trauma room and shot the man in the chest. The shooter was arrested in the hospital parking lot, but the hospital still went into lockdown mode for several hours.

Dave Salzlein, Director of Financial Analysis at Scotland Memorial and overseer of the security department, says the drill is just part of the changes and improvements being made to security after the shooting. “This drill was coordinated with local police who were doing in-service on an active shooter,” he says. Already in place since the shooting are new rules regarding the number of visitors allowed for each ER patient—no more than two—and the use of wands, when warranted, for weapons detection on patients arriving who may have been involved in a violent act.

Elements of an Active Shooter Drill; Unarmed Security’s Role

The drill took place on an unused portion of the hospital’s third floor, says Salzlein. There, they were able to set up a scenario of a shooter. As part of the drill, the hospital went into lockdown, except for the emergency department. Salzlein says all patients, staff and visitors were notified in advance about the drill because no one would be allowed to leave or enter during that time.

The drill began, he says, with a nurse calling the switchboard to report a shooter on the premises, which then triggered the operator to contact police. The hospital’s internal security response, says Salzlein, involved officers securing both the perimeter and interior of the hospital, meeting police as they arrived and giving them maps of the building and information on the incident and then guiding them to the scene.

Security also set up areas for media, the emergency response team and even grief counseling, says Salzlein. “We tried to go through the process as comprehensively as possible,” he says.

While the shooting in February heightened everyone’s awareness, he says, hospital security already had many of these procedures in place. After the shooting, he says, they did take a second look at some of the communications methods “so we could gather additional information from staff witnesses,” he says. They also explored ways to get better information as events unfolded from the hospital’s CCTV system.

The Importance of Drilling with Police

Following the actual shooting, a consultant was brought in, says Salzlein, to do a survey of what had been and needed to be done. From that, he says, they made the appropriate staffing and security changes. Officers, however, still remain unarmed, he says, although they are equipped with tasers.

Continued on next page
Undertaking an active shooter drill with local police, he says, provides benefits to both organizations. “It gave local law enforcement the opportunity to get familiar with the inside of the hospital,” he says. “Most active shooter drills take place in schools, and this is a much different environment to train in.” Additionally, he says, the mass notification system differs between schools and hospitals, “so this lets law enforcement get better acquainted with our facility and what the response needs to be.”

COMMUNICATING WITH STAFF, PATIENTS AND VISITORS

For Scotland Memorial, the drill was another opportunity to test its response and learn from it. Salzlein deemed the exercise “very successful” and noted that as part of the drill, they had one of the key officers get “injured” so the scenario would be changed and officers would need to react to that. The event was recorded on the hospital’s CCTV system so tapes can be reviewed as part of the learning process.

Officers taking part in the drill were the regular contingent who would be on duty that day, says Salzlein, to make it as realistic as possible. “We are planning another drill in six months,” he says, in which the scenario will be changed and any revisions to security policy and procedures following this drill will have been incorporated.

One of the biggest keys in undertaking such a drill, says Salzlein, is to communicate properly with staff and the community at large that this was just an exercise. Patients, staff and visitors were reminded 30 minutes before the drill began about the lockdown, he says, to help alleviate any confusion or stress. “Overall, people were very receptive and it did get a good response,” he says.

FOR FURTHER INFORMATION, CONTACT:
Dave Salzlein, Director of Financial Analysis, Scotland Memorial Hospital, 500 Lauchwood Dr., Laurinburg, NC 28352. Phone: 910-291.7000.
The International Association for Healthcare Security & Safety (IAHSS) is proud to unveil a new, more polished logo! The new logo is Phase One of the rollout of IAHSS’ new corporate look, bringing us in line with the proactive sensibilities of IAHSS’ membership. “A great many number of ideas were looked at before we could even begin to narrow our choices,” says IAHSS Executive Director Evelyn Meserve. “We eventually got it down to three, and then, finally, we selected the one that we really felt best represented the organization’s modern focus.” IAHSS was formed in 1968 by a forward-looking group of healthcare security professionals. The mission of IAHSS, leading excellence in healthcare security, safety and emergency management, is now implemented worldwide, and IAHSS’ new logo reflects the urbane, visionary nature of its membership.

“Healthcare workers are more likely to be attacked than prison guards or police officers.”


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IN BRIEF:

VIOLENCE

HOSPITAL EVALUATES SAFETY FOLLOWING ER ‘SUICIDE’ SHOOTING
SUMTER, SC. Potential safety changes are being considered following a shooting at Tuomey Hospital in which a man entered the nurses’ station in the emergency room and shot himself in the head with a handgun. The incident occurred around 11 p.m. on Feb. 11 in front of several staff members. According to news reports, the man wasn’t considered a threat to patients or staff. However, the hospital is conducting an investigation to determine if any further safety measures need to be put into place. The victim, who survived the shot, was airlifted to another hospital.

SECURITY, EMERGENCY PERSONNEL SUBDUE PATIENT WHO ASSAULTED NURSES
BRIDGEPORT, CT. Security and police were needed to subdue a car fire victim after he allegedly attacked nurses examining him at Bridgeport Hospital. The 39-year-old man had earlier been found at the scene of a car fire and was brought to the hospital for smoke inhalation treatment. During his exam, news reports say the man violently threw a nurse out of his room after he began to act strangely during the procedure. Hospital security and police tackled the suspect and cuffed him. He was later charged with second-degree breach of peace, assault on emergency personnel and interfering with an officer.

EMPLOYEE STABS SUPERVISOR TO DEATH IN HOSPITAL BOILER ROOM
BETHESDA, MD. A maintenance worker at Suburban Hospital was arrested and charged with the murder of his boss in connection with the New Year’s Day stabbing incident in the hospital’s boiler room. The 40-year-old victim was stabbed at least 70 times, according to news accounts. The victim was on the phone at the time of the incident, allowing a friend to overhear demands for money and screams. The friend called the man’s parents, who in turn contacted hospital security and police. The alleged assailant had previously been found not guilty in the shooting death of a Washington, DC, man.

HOSPITAL PATIENT TRIES TO STRANGLE DOCTOR WITH HIS STETHOSCOPE
BANGOR, ME. Hospital security and police were called in to subdue an unruly emergency room patient who tried to strangle a doctor with his own stethoscope. The 55-year-old man was being examined when he became combative and tried to wrap the stethoscope around the doctor’s neck, according to news accounts. A police detective who was working a hired shift at Eastern Maine Medical Center and hospital security combined to subdue the patient. Reports note that at one point during the incident, the man “stood in a defensive posture and then shoved a security (officer) out of the way.” The man was charged with assault on emergency medical personnel and simple assault for shoving the security officer.

ISOLATION OF PSYCH PATIENT SOUGHT AFTER RAPE OF SEDATED PATIENT
CINCINNATI, OH. Officials at University Hospital were reviewing safety and security protocols as well as taking measures to isolate a patient in the psychiatric ward after he allegedly raped another psychiatric patient while she was sleeping. Both individuals were patients on the psychiatric ward at the time. The victim was sleeping because of heavy medication. The 30-year-old man, who has a criminal past and was in state prisons twice in the past year; contended the sex was consensual. “We acknowledge and accept our responsibility and obligations to provide a safe and secure environment for our patients, and we will take the steps necessary to fulfill those obligations,” said Dr. W. Brian Gilber, the hospital’s president and CEO, in a statement to the press.

HOMELESS WOMAN SHOOTS SELF IN HOSPITAL BATHROOM
WHITEHAVEN, TN. A 57-year-old woman died from a self-inflicted gunshot wound in the bathroom at Methodist South Hospital. The woman, who had been released from the hospital earlier in the day on Jan. 12, remained in the emergency room waiting for more than 16 hours before the incident occurred. According to news reports, when police arrived to speak with her about going to a shelter because
she was homeless, she excused herself to use the restroom. Officers heard the shots shortly thereafter. Reports note the woman had been evicted from a home eight days earlier and had also allegedly threatened another woman with a gun.

**HOSPITAL REVIEWS SECURITY AFTER LATEST SHOOTING INCIDENT**

**ALBUQUEQUE, NM.** University of New Mexico Hospital officials are reviewing security and response procedures following an incident in which a visitor fired a gun on the pediatrics floor. A UNM Health Sciences spokesperson told a local TV station that hospital officials and all those who were involved or responded to the Jan. 3 incident were meeting to create a timeline of events and look at any security changes they feel should take place. The hospital does have 45 security officers on staff, but none is allowed to carry a gun. According to police reports, a man visiting his girlfriend, who was a patient, began assaulting her. When the woman’s family intervened, the altercation moved into a hallway where the boyfriend fired a shot before fleeing the building. The hospital, its parking garage, and both the central and north UNM campuses were locked down while police hunted unsuccessfully for the suspect. This is not the first time someone has made it into UNM Hospital with a gun. In June 2010, a man in the lobby of the emergency room was fiddling with a gun in his front pocket when it went off. Bullet fragments hit six people. UNM says it will consider the idea of metal detectors, at least in the emergency room.

**OFF-DUTY POLICE OFFICER USES TASER TO SUBDUE PATIENT**

**BEDFORD, TX.** An off-duty police officer working at Texas Health Harris Methodist Hospital Hurst-Euless-Bedford responding to a report of “a violent situation” was reported by police to have “used his taser to restrain a patient so he could be restrained by the hospital staff.” When the officer arrived, “there had been two hospital employees that had been assaulted” by the patient, said a Bedford police spokesman. The officer used a technique called a “drive stun,” in which an electric charge is administered but the projectiles of the taser aren’t fired. Citing privacy laws, hospital officials would not give details of the incident beyond issuing a statement that “this was a licensed police officer who was in the hospital assisting with security. Our assumption was that he did what he believed to be appropriate and correct.”

**PATIENT CHARGED WITH STABBING SECURITY OFFICER NUMEROUS TIMES**

**ST. LOUIS, MO.** A 61-year-old man has been charged with first-degree assault and armed criminal action after police reported he stabbed a security officer at St. Alexius Brothers Hospital when he was brought to the hospital for an evaluation. When he was asked to change his clothes, he allegedly lunged at the security officer, stabbing him under the armpit, causing a puncture wound several inches deep, and slashed him numerous times on his body, according to the indictment.

**POLICE CALLED WHEN PATIENT FIRES STARTER PISTOL IN ROOM**

**YUKON, OK.** Police have arrested a man accused of firing a starter pistol inside of a hospital room. The patient, taken to Integris Canadian Valley Hospital after complaining of chest pain, was in a room when hospital security heard what sounded like a single gunshot, according to press reports. When officers entered his room, they found a handgun on the floor. They secured the gun, which fired only blanks, and called Yukon police who arrested the patient on an outstanding warrant. Charges relating to the incident have not yet been filed.

**CANCER CENTER HIT BY $4,000,000 EMPLOYEE ‘CARTRIDGE’ THEFT SCAM**

**NEW YORK, NY.** A former receiving clerk at Memorial Sloan-Kettering stole nearly $4 million from the cancer center in a massive scheme that involved ordering unnecessary printer cartridges and reselling them, authorities said. The proceeds from the scam were used to fund a lavish lifestyle that allowed the $37,000-a-year clerk to move from a Bronx housing project to a luxurious high-rise in the suburbs. The clerk, 32, has been charged with grand larceny and criminal possession of stolen property. He allegedly began his scheme in 2004. He reportedly instructed delivery drivers to call him when they were close to the site where he worked so he could personally receive the packages, officials said. He was caught on surveillance video taking the parcels -- which never went through the mailroom -- to a garbage area.

continued on next page
JOHNS HOPKINS EMPLOYEE INDICTED IN $600,000 PATIENT ID THEFT OPERATION

BALTIMORE, MD. An employee at Johns Hopkins Hospital allegedly provided stolen names, social security numbers and addresses from patients for a theft ring that used the information to obtain credit and then made purchases totaling more than $600,000. The female employee, who worked at Johns Hopkins for 18 months, had access to personal information from patients or their guardians. Along with four others, the woman was indicted on fraud and identity theft charges.

MEDICAL CENTER EMPLOYEES VICTIMIZED BY ‘OFFICE CREEPERS’

ATLANTA, GA. Northeast Georgia Medical Center was among the facilities victimized by thieves best known for sneaking into offices while people are at lunch and stealing and using credit cards from their desks. These so-called “office creepers,” according to newspaper accounts, hit between noon and 1:30 p.m. The medical center was allegedly hit by two women, one of whom was wearing medical scrubs. The duo have been connected to similar crimes in DeKalb, Gwinnett and north Fulton counties, the Hall County Sheriff’s Office said. A reward is being offered to help catch the two women.

HEALTH SYSTEM CAMERAS FAIL DURING $18,000 PHARMACY THEFT

MIAMI, FL. The decision by Jackson Health System to not reveal the status of its video surveillance system has drawn criticism from the public and generated requests for a report on how many cameras aren’t functioning properly. The surveillance system’s failure to record an $18,000 theft from the hospital’s pharmacy spurred the probe. Jackson is the third largest health system in the country and the largest hospital in the southern United States. A chairperson on the committee reviewing the problem told the media that security managers were concerned a public report might reveal a weakness in the system that would be helpful to thieves. Public Health Trust members were told some cameras provide surveillance, but don’t record, while others may be broken and that fixing the problem could be expensive.

HOSPITAL BEEFS UP EXTERIOR SURVEILLANCE SYSTEM TO REDUCE THEFTS

WEST SUFFOLK, UK. Bury St. Edmunds Hospital has received 27 new CCTV cameras on its grounds and parking lots as part of an effort to cut down on thefts. The hospital already has 32 cameras inside, but had just one exterior camera. The West Suffolk Hospital NHS Trust funded the additions. Additionally, the site’s police community support officer post has been extended another two years. Her job includes patrolling the hospital grounds and reviewing security around the site. There were 77 thefts at the hospital last year through early 2011, including within the emergency room, on the wards and in the parking lot. Items taken ranged from a wedding ring and cash to laughing gas and a stretcher.

EMPLOYEE FAILS TO FOLLOW PROTOCOL; PATIENT JEWELRY REPORTED MISSING

AURORA, CO. A patient in the emergency room at Medical Center of Aurora says her jewelry went missing after she was asked to remove it, according to news reports. Although a hospital spokesperson says there is no evidence of theft, she acknowledged that protocol wasn’t followed in this instance, despite the woman being told be the nurse that the jewelry would be given to security and locked up. The hospital says the employee responsible for securing the items would be counseled on proper procedures.

OVERNIGHT THEFT AT HOSPITAL NETS LARGE HAUL OF DRUGS

TORONTO, ONTARIO. Hospital security cameras were being reviewed and security officers questioned about who was working after the theft of several different drugs at Toronto General Hospital. The drugs were taken in a 12-hour period overnight and included 12 packs of Acetaminophen-Caffeine-Codeine, four bottles of Codeine syrup, eight vials of Fentanyl, 14 vials of Hyfromorphine, 17 vials of Meperidine, 21 vials of Morphine, 18 packs of Avitan, four packs of Delatenstryl and 10 to 15 vials of Versed, according to police.
STORE CAMERA ID’S EMPLOYEE CASHING STOLEN HOSPITAL GIFT CARDS
EVANSTON, IL. A mail room employee at NorthShore Evanston Hospital has been charged with stealing $2,500 worth of American Express gift cards from the hospital. Police said the theft occurred in December and the employee was caught on camera using one of the gift cards at a pharmacy in Highland Park. Hospital security reportedly noticed the cards were missing, and reported it to Evanston Police triggering an investigation which resulted in the arrest.

RURAL HOSPITAL LIMITS ACCESS FOLLOWING SAFETY ASSESSMENT
COOKEVILLE, TN. Cookeville Regional Medical Center, located in Middle Tennessee, 100 miles east of Nashville, has limited after-hours visiting to a single access point after deciding to lock the main entrance doors overnight to enhance overall security, according to press reports. The doors to the North patient tower are closed from 9 p.m. to 5 a.m. and visitors during those hours must enter through the emergency room entrance instead. After-hours visitors are being asked to sign in at the emergency room information desk. The change was identified during a recent safety assessment that included the Cookeville Police Department. Signs were posted at the main hospital entrance announcing the change, and maps were also printed to aid visitors around the campus. Additional security personnel were posted to help with the transition as well. CEO Bernie Mattingly was quoted as saying “If you read the papers or listen to the news at night, hospitals are increasingly becoming places where incidents happen... these are things that larger metropolitan hospitals have had in place for years, and unfortunately, it’s time we do the same.”

FAKE BOMB PUTS HOSPITAL IN EMERGENCY RESPONSE MODE
HARRISBURG, PA. Emergency responders and hospital administrators at Harrisburg Hospital took emergency measures after a package feared to be a bomb was discovered in a first floor rest room near a security desk. According to news accounts, the device, which turned out to be a battery charger wrapped in duct tape, was brought to the hospital’s attention through a 911 call to Dauphin County. Emergency responders and hospital administration scrambled to take measures to protect people at the hospital, including altering activities in the emergency room while a bomb-sniffing dog from the Capitol Police and a state police bomb squad responded. The fake bomb was removed under what police described as “continued threat protocol” and the emergency room was searched to make sure there were no other devices. The individual who made the 911 call called back to say the bomb was fake and that he was ready to turn himself in and was then arrested.

EXPLOSIVE DEVICE FOUND IN CLOTHES OF PATIENT INJURED IN AUTO ACCIDENT
LIBERTY, MO. Police are investigating a report that a man being treated at Liberty Hospital was found to have a suspicious device in his clothing. According to press reports, a 19-year-old man from Holt was involved in a rollover accident. Hospital security informed officers that after moving the man into the emergency room, medical staff located suspicious items concealed in his clothing. These included a suspected explosive device, pills, marijuana and drug paraphernalia. The suspicious items had been moved to the hospital ambulance bay when officers arrived. “They observed a cylindrical-shaped item, about 6 inches long, covered in yellow tape, with a small green fuse,” according to a news release from Liberty police. Officers called the Kansas City Bomb and Arson unit to help investigate. The device was moved and detonated. According to police, metal BB type projectiles, which apparently functioned as shrapnel, were recovered, along with the remnants of the explosive device. The man was reportedly treated and released. He was not arrested.

NURSES ACCUSED IN DRUG THEFTS AT MINNESOTA HOSPITALS
COON RAPIDS, MN. Drug thefts at two Minnesota hospitals have been linked to nurses—one former and one currently licensed, according to newspaper reports. At Mercy Hospital, a former nurse was charged with entering patients’ rooms and using a syringe to siphon off the painkiller Dilaudid from IV bags. The woman entered the hospital wearing scrubs and an ID badge. The federal charges stem from an investigation that originated with the Anoka County Sheriff’s Office, which began looking into the incident after hospital security stopped the woman because they thought she was...
behaving suspiciously. Officials at St. Mary’s Medical Center in Duluth, MN, suspected the same woman of similar activity and banned her from the premises after she lost her job there in 2010. In a similar incident, a nurse anesthetist on staff at Abbott Northwestern Hospital in Minneapolis was alleged to have used a portion of a dose of the painkiller Fentanyl on herself, rather than giving the full dose to a kidney stone patient.

SECURITY VIDEO USED TO ID ALLEGED DRUG THIEF
LOUISVILLE, KY. A former employee at Saints Mary and Elizabeth Hospital was captured on hospital security video entering and exiting the hospital around the times of several drug thefts and eventually was charged with trafficking in controlled substances for logging into the drug dispensing machine system with a fingerprint scan and obtaining the drugs. According to an arrest citation cited in a news report, the 30-year-old man did this on four dates either when he was not scheduled to work or after working hours.

LAWSUITS

PAVEMENT CRACK COSTS NURSING HOME $500,000 IN PATIENT ACCIDENT DEATH
GRINNELL, IA. A nursing home that had been previously fined for regulatory violations was hit with a $500,000 jury award following the death of an 89-year-old man, who died following an accident at the Friendship Manor Care Center. The man, who was a short-term rehabilitation stay patient, was fatally injured when the gurney on which he was being transported got a wheel caught in a crack in the pavement and flipped over. The elderly man hit his head, lapsed into a coma and never regained consciousness, according to newspaper accounts. The family sued the nursing home and the ambulance company. In the months prior to the trial, officials with Friendship Manor gave depositions in which they said the cracks in the walkway had existed for years but hadn’t been considered a threat to anyone’s safety. In his deposition, the nursing home owner said he was aware of the cracks and knew that rebar was exposed and protruding through them, but didn’t consider it to be sticking up enough to be hazardous.

HOSPITAL SECURITY AND POLICE SUED BY ‘DENIED ACCESS’ VISITOR
PARK RIDGE, IL. Three security officers at Advocate Lutheran General Hospital, along with the hospital, the city and two police officers were named in a lawsuit filed by a man claiming police attacked him after hospital security denied him access to his mother, who was in the emergency room. The suit alleges that security staff refused to let the man see his mother, were rude and condescending and pushed him in the abdomen. The incident was captured on security cameras, but the tape was destroyed, according to the suit. The lawsuit also says police officers jumped the man from behind as he was exiting the building, twisted his right arm and handcuffed him. The suit seeks more than $3.1 million from the hospital and security and an additional $1.2 million from the city and police.

OFFICER DENIED WORKER’S COMP FOR STRESS-RELATED DISABILITY
NEWARK, NJ. A former security officer for the University of Medicine and Dentistry of New Jersey was denied worker’s compensation benefits because of on-the-job stress that resulted in an alleged psychiatric disability. According to new reports, the female officer claimed the stressful environment and harassment by a supervisor left her unable to work. Among the stressful situations identified by the woman were being asked to remove a blanket that she had wrapped around herself while watching the emergency room; being told she had used too many sick days; her belief that other officers were allowed to take longer breaks; and being questioned about leaving her guard post a half hour early. The court found that the woman, now living in Florida and working as a hospital security officer, failed to demonstrate any of her allegations resulted in a compensable, psychiatric disability.
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With the addition of a standard-size, corrections-style shield, security officers at Blount Memorial Hospital, Maryville, TN, have an added option when confronting an unruly patient or visitor to the facility.

Mike Steele, Assistant Security Director at Blount, says while officers may rarely need to use the shield in their day-to-day dealings with disruptive people, it does provide a level of protection and security that other equipment does not.

“It’s an added control feature,” says Steele, but it also can protect against contamination from blood or bodily fluids. Within the emergency department at Blount, Steele says there are small safe rooms used for forensic patients as well as persons who present behavioral problems or may be a flight risk. In such close quarters, the shield can provide a protective barrier between the officer and a person who may be combative or even armed.

In 2010, about 90 percent of the security staff and all supervisory security personnel took part in a training program on shield usage in conjunction with the Blount County Sheriff’s Office’s Corrections Emergency Response Team (CERT), a special unit within the sheriff’s department that addresses higher risk scenarios at the local detention facility.

Steele says Blount’s security department wanted its officers “to learn the safe approach” to dealing with conflict, especially within the ER and the safe rooms. Blount’s officers are equipped with chemical foam, a baton and handcuffs, says Steele, but they aren’t armed. There are no metal detectors on site, but safe room patients are wanded before and after they are seen by a physician, he explains.

Steele, who is a certified instructor in Crisis Prevention Intervention (CPI), says officers are already taught de-escalation techniques based on the use-of-force continuum. The shield isn’t part of the use of force training, but is more of an option for officer safety, he says. Steele recalls an incident within the ER when a patient broke off a piece of a bed rail and tried to use it as a weapon. The shield would be a likely option in such a scenario, he says.

The training program involved various scenarios within a simulated hospital, he says, such as entering and exiting a space the size of the safe room and getting control of the combative person. As with working with any security tool, the shield requires training and skill for it to be used properly.

Adding the shield to its protective gear is all part of the security department’s goal to stay as innovative as possible, says Steele. “We looked at the shield as part of adopting a safe approach,” he says.

The shield training is just part of the ongoing training that Blount’s 17 security employees, including 12 certified security officers, receive.

During monthly in service programs, Steele says they address topics such as how to protect the equipment on their belts, vehicle approach methodology and CPI training. As a certified CPI instructor, Steele has instructed not only officers but also medical staff on how to use certain physical techniques to prepare themselves to safely respond to particular situations.

FOR FURTHER INFORMATION, CONTACT:
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An Interview With:

Rosemarie Harris on Addressing Violence Against Children

Rosemarie Harris is the Public Safety Manager at St. Louis Children’s Hospital, St. Louis, MO, a 250-bed pediatric teaching hospital that serves approximately 275,000 patients each year. The hospital has a security department with 32 officers, who are both armed and unarmed. Harris is driving force behind a treatment program being instituted at Children’s that would address gun violence involving young people. Hospital officials say more than 10 percent of patients at Children’s are treated for gunshots or stab wounds.

Q. What is your background?

A. My background is in law enforcement administration, having worked in Indiana and then in Ohio as an instructor. I switched to public safety and was with Nationwide Children’s Hospital in Columbus, Ohio. After I received my master’s degree, I moved back to my hometown of St. Louis, where I’ve been the manager of public safety at Children’s for a little more than three years.

Q. Your training has also included a program at the FBI: What was that about?

A. It’s designed for law enforcement administrators. It’s a three-month program that covers areas such as criminal law, child abduction, psychology of the law and other areas.

Q. The hospital is currently working on a Juvenile Anti-Violence Initiative: Can you explain your role and how this came about?

A. Maybe a year and half, two years ago, I was attending a luncheon in the area and was seated near the chief of police. We began talking, and I told him about my concerns regarding the impact of violence that we see at Children’s, especially regarding firearms. He said he was interested, and I was, in doing something about this and agreed to meet with us. The Chief came to Children’s and met with the hospital president, some vice presidents and other administrators and from there we put together a committee. I’m leading it from the hospital side and the police have a representative as well. There are also community leaders, members of the trauma staff and others participating.

Q. What is the status now?

A. We’re at the stage now where we want to get a designated social worker that can follow young victims of gun violence through the system. The trauma team is doing studies as well. The program hasn’t officially started yet, as we are working on getting funding, but it keeps moving forward.

Q. Why was this issue important to you as public safety manager?

A. I look at the numbers and the fact that these are children who are being shot, many because they are just in the wrong place at the wrong time. These are children. Many of them aren’t even teenagers yet and they aren’t always involved with gangs. In 2009, there wasn’t a week when we didn’t have a child who was a victim of violence. While most lived, some have injuries they can’t fully recover from. And the sad reality is, we see kids come in a second or third time. St. Louis was listed as the No. 1 most violent city.

Q. Is this program restricted to victims of gun violence?

A. My original thought was gun violence, but when we look at the injuries, it isn’t restricted to that.

Q. How will the program work?

A. What we’re talking about is having a social worker that would follow a child through the system, getting them the care and services they need to stay out of trouble. This would include after school programs, working with the families on making sure kids go to school and stay away from the violence. We would also develop a safety plan, and maybe even help them find employment.

continued on next page
Interview cont.

Q. In addition to participating in the planning, will security have a particular role?

A. From where I sit, it's difficult to do more. Our primary purpose is to make everyone safe. Our officers do a wonderful job of working with families and kids. We try not to get involved on a personal level, but we are still touched by what occurs. Some of our officers have been in the system for 40 years, so they have a good rapport with staff and social workers.

Q. Are there other programs like this in the country?

A. The University of Maryland Medical Center in Baltimore has had a program like this for a while. There has been some visiting back and forth, and we are trying to get our trauma people and social workers to find out about it. But we are a pediatric facility, so we'll see some differences here.

Q. What do you hope to achieve by starting this program at Children's?

A. I just hope that people will not only take notice, but will also take action. For me, these are children who may not otherwise get a second chance, so if we can do something, let's make sure to do so.

FOR FURTHER INFORMATION, CONTACT:
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ARMED VS. UNARMED OFFICERS IN ACTIVE SHOOTER INCIDENTS

Because time is of the essence in an active shooter situation, having armed hospital security officers could make a life-or-death difference. Tzviel “BK” Blankchtein, President, CEO and Chief Instructor for Masada Tactical Inc., Pikesville, Md., says unarmed officers have limited options—“try to barricade the shooter and call in local law enforcement.

The problem, he says, is by the time local police arrive, even if they are nearby, it is often too late. “Time equals life in an active shooter situation. If you wait even one minute, you can have loss of life, especially in a target-dense area like a hospital,” explains Blankchtein. He recalls the shooting on the Virginia Tech campus in which 30 people were killed within a couple of minutes.

BARRIERS TO ARMING SECURITY

Although hospitals may indeed want to have armed security, there are barriers to approval. Among these is the perception issue, he says. “Hospitals may want an active shooter program (with armed security officers), but they are concerned about what that says to the community. It shows a high level of security, but it can also send the message that the hospital requires it,” he says. This can be interpreted to mean that the facility is unsafe, he adds.

Another factor that comes into play is the cost. An armed security staff requires guns, initial training, ongoing training and insurance. A gun, ammunition and gear can cost about $1,500 per officer, says Blankchtein, along with addition costs for quarterly shooting practice. And the insurance, he notes, “is in the tens of thousands.”

Having an active shooter response force also requires a higher skill level than just teaching someone to shoot, he says. “Tactically, they have to plan to shoot on the run,” he says.

BENEFITS AND DRAWBACKS OF ALTERNATE WEAPONS

Even with all the added costs, training and public relations issues, Blankchtein says the deterrent factor of having an armed force “is of great value, and it means you’re prepared for when something will happen.” Still, he notes, just 20 percent of hospitals have armed officers at this point.

continued on next page

CHPA Renewal:
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Blankchtein acknowledges that many hospital security departments already provide their officers with tools that can be used in most situations. But in his definition, this still makes them unarmed. “For most cases, a collapsible baton or pepper spray is sufficient,” he says. He also finds a taser useful in a hospital setting “because it is very targeted.” The problems with pepper spray, he says, is it can affect many more people than just the one at whom it is directed. And the baton requires the officer to be close to the target, he adds. Batons also can play into the excessive force perception, even when used appropriately, he says. Tasers provide the ability to respond from a greater distance (up to 15 feet) and can give the officer time to react by rendering the person unresponsive for up to 15 seconds.

“These are all good tools against violence,” he says, “but not an active threat.” Blankchtein defines an active threat as not just someone with a gun, but with a knife, blade or stick as well.

**ARMING SOME OFFICERS**

Not everyone on the staff needs to be armed, says Blankchtein. “Typically, we recommend they (hospitals) have someone on staff each shift who is armed.” That person, he says, “is someone who can come faster than the police and who knows the layout of the hospital.”

While most hospitals have several officers on duty and may have more than one respond to the scene of an active threat, Blankchtein says his company focuses on the one-person response. It may be just one person on staff who is armed, “and he has to make the judgment call.”

The armed officer or officers, says Blankchtein, should be qualified with weapons and should meet set standards for carrying and using a weapon. They should also have combat-oriented training so they can respond appropriately. Typically, he says, law enforcement recommends rifles for active shooter situations, but within a hospital, with its curtained enclosures and glass walls, a high-caliber weapon may be a problem. Blankchtein advises hospital security to use medium-caliber guns, such as the Smith & Wesson M&P or a Beretta rifle that uses handgun caliber rounds. “That way you don’t get over penetration,” he says, when the weapon is fired.

**ELEMENTS OF ASSAULT TRAINING**

Blankchtein says with the training he does for security officers, “We do assault training in the hospital” teaching about shooting, but also about proper communications. “We teach them to react to a group or an individual, an active shooter vs. a barricade situation and a hostage situation.”

Training should take place in a setting as close to the actual setup as possible, he says, noting he does drills using people and props. What drills shouldn’t do, he says, is set up the trainee for failure. “A lot of drills are designed to fail the person because they make it so hard. We make it as simple as possible, so it gives them the opportunity to think about it and learn from it.”

Masada Tactical currently works with Northeast Georgia Health System, he says, conducting a training program about every nine months. The weeklong program may be spent on restraint and control techniques for unruly patients, active shooter response and clinical staff training.

The latter is important, says Blankchtein “because the first person on site is usually a doctor or a nurse. We have to give them the tools to be safe and they need to know how to assist security. We want them to be proactive, not reactive,” he says.

**FOR FURTHER INFORMATION, CONTACT:**

Tzviel “BK” Blankchtein, President, CEO and Chief Instructor, Masada Tactical, 1414 Reisterstown Road, Pikesville, MD 21208.
Senior Crimestoppers, a program offered across the country to long term care facilities by a Memphis, TN, agency, claims it has reduced incidents of theft, abuse, and other crimes by 90% among participants. According to Terry Rooker, President, some 1500 nursing homes, veteran homes, assisted living, and senior retirement facilities in 45 states are currently enrolled in the program which features three basic components:

- Education and marketing.
- Lockboxes for residents or family members to lock up and secure personal belongings.
- Cash rewards to employees of up to $1,000 per incident for anonymous reporting of crimes to a 24-hour 800 number.

Established in 1995, Senior Crimestoppers, Rooker says, is owned and operated by a non-profit organization, the Senior Housing Crime Prevention Foundation which works with financial institutions across the country to help them meet their Community Reinvestment Act (CRA) credit mandates.

“Banks make investments and loans with the foundation to qualify for CRA credits. The Foundation takes a portion of the proceeds, goes out into the bank’s assessment areas, identifies long term care facilities, and provides the Senior Crimestoppers program along with the Time of Your Life and Wish Comes True programs to those facilities at no cost,” he adds. In areas where no bank sponsor is available, facilities pay a discounted rate which Rooker estimates would average $250 a month for a 100 bed nursing home.

MAINTAINING THE KNOWLEDGE AND EDUCATIONAL LEVEL OF EMPLOYEES

The education component of the program, Rooker says, includes

- an in-service video
- management and staff briefing
- employee in-service training
- employee oath sheets
- membership charter

- continual reinforcement of “zero tolerance” policy

“Depending on the situation,” Rooker says, “we have consultants around the country who visit each of our facilities twice a year as well as reach out to them with phone calls two to three times a year to make sure things are running smoothly or if they are having any issues. We’re available 24/7 to help them as well here at the office in Memphis. Our recommendation to the facility is that they use the in-servicing and educational materials each time someone is hired during the orientation process to maintain the knowledge and educational level of all staff members.” This is essential, Rooker says, because the employee turnover rate in nursing homes is estimated at 140%.

GETTING RESULTS

Rooker describes Senior Crimestoppers as similar to community crime stoppers and crime watch programs.

“Essentially it is the identical program except that it has been tweaked and molded to fit inside the micro environment of a nursing home type of setting. Studies have shown that nursing home administrators often have a difficult time in getting information about things that have occurred within their facility because employees are fearful of being identified as being involved in negative situations, but also fearful perhaps of their fellow employees—the perpetrators of what has taken place. The program brings to the facility the opportunity to get information that they otherwise might not get that will help them prevent and/or resolve a given situation. By offering a completely anonymous 800 number, people can call in and provide information they may have about something that is occurring or has occurred without being retaliated against.

“Before the program, an employee, a family member or a resident would say, ‘I’m not going to bother because there is nothing they can do about it.’ But now, something will happen. Somebody will call it in. Somebody will get paid a cash reward. Somebody will be terminated. Somebody will be arrested. The word spreads that the program works and people stop doing what they were doing.”

REACTION OF MEMBERS OF THE LTC COMMUNITY ADMINISTRATORS.

A former assistant administrator of a 287-bed nursing home in Memphis which was the first to put the program in place, Rooker understands the reluctance of administrators to market the program because they do not want to call attention to the fact that they have security problems.
Report all incidents of crime in this facility to the Senior Crimestoppers Hotline. All calls to the hotline are totally anonymous – you will receive a code number for identification. Cash rewards are paid for any tips that lead to the solving of reported incidents. Operators are available 24 hours a day, 365 days a year. Call this number today if you have information that could lead to solving a crime.
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Included for the first time in the 2009 IAHSS Crime Survey, the number of inpatient and outpatient forensic and psychiatric patients treated by 90% of the acute care hospitals who participated in the survey ranged from a few hundred a year per hospital to as many as a few thousand (forensic patients) and from over 500 to as many as 10,000 a year (psychiatric patients). These patients, according to Thomas Smith, CHPA, CPP, co-author of the survey with Victoria A. Mikow-Porto, PhD, tend to carry the highest risks of violence and aggression when compared to the general patient population. In following up member response to the survey, Smith adds, coping with problems posed by prisoner and mental health patients ranked first and second in IAHSS member concerns. In this special report, we’ll present updates on recent developments in each area of concern and report on steps being taken and not being taken to defuse them.

**NEW IHSSF STUDY:**
**74 PRISONER ESCAPES FROM HOSPITALS IN 2010. MOST INVOLVED SOME TYPE OF ASSAULT**

A new study, sponsored by the International Healthcare Security and Safety Foundation (IHSSF), is being conducted by Mikow-Porto, principal of the consulting firm of Research and Analytics, Carrboro, NC, to assess the number and type of incidents associated with prisoner/inmate escapes from hospitals while in the custody of corrections, police or sheriff’s departments. In a progress report on data from January 1, 2010 through December 31, 2010, she finds that there were 72 incidents of reported prisoner attempted or completed escapes from hospitals in 2010 while in custody of law enforcement or hospital security professionals, and two escapes from hospital while not in custody, but wanted for crimes. In breaking down the types of escapes, she notes that the majority of cases involved some type of assault on local, correction, hospital security, or hospital staff. Escape incidents included:

- Prisoner unaccompanied by local, correctional, or hospital security staff
- Slipping out of restraints, then assaulting security or other hospital staff
- Having restraints removed for bathroom visits
- Feigning illneses, when in transit or at the hospital facility
- Kidnapping hospital staff or ED visitors to escape
- Escape facilitated by armed or unarmed accomplices
- Prisoner(s) left alone in treatment rooms
- Escaping while in restraints (handcuffs and/or shackles)
- Removing IVs, bandages, etc and simply walking out of the hospital, often while wearing prison or hospital garb

**DETAILS OF SOME RECENT INCIDENTS**

Smith, who is Director of Hospitals Police and Transportation at the University of North Carolina Hospitals, Chapel Hill, and a past president of IAHSS, urges security directors to lean heavily on the IAHSS guideline on Patient Prisoner Security (0203), but concedes, “even if you follow every one of these steps to the letter, it doesn’t mean things can’t happen. At least you have an understanding of the facilities who are bringing prisoners to you.” That an escape can take place even where strict rules are in effect was brought home to him last November when an inmate serving a 25-year prison term for kidnapping, robbery with a dangerous weapon and possession of stolen goods, escaped his guards while receiving medical treatment at UNC Hospital, stole a patrol car and led authorities on a high-speed chase spanning two central North Carolina counties before he was captured after he ran into a box truck on Interstate 40.

Commenting on the incident, Smith pointed to the root cause. “The prisoner was in the room with two guards...
from the Department of Corrections who removed his leg restraints and handcuffs, which was a violation of policy, and he escaped.” He adds that there should be interaction particularly for organizations that have contracts with correctional facilities. “There should be a review and discussion of incident activity when the contracts are being developed and/or renewed, usually on an annual basis.”

**TWO ‘CLASSIC’ ESCAPES USING THE BATHROOM PLOY**

“The key risk area is the bathroom when they take the handcuffs or other restraint devices off,” Smith maintains. “Forensic guys don’t want to go in there while the prisoner is using the bathroom. The bottom line is they go out the window or, while they have their handcuffs off, assault the officer and try to take his gun.” (That was the scenario in 2006 at Montgomery Regional Hospital, Blacksburg, VA, when forensic patient William Charles Morva, freed from his restraints to go to the bathroom, wrested a pistol away from the deputy guarding him and shot and killed unarmed security officer Derrick McFarland.)

In early February, Wade Leon Willis, 31, a man with a lengthy criminal history, faked a seizure when he was arrested for violating parole. Taken by police to the emergency room at Utah Valley Regional Medical Center, Springville, he was allowed to go to the restroom unaccompanied. There, he removed ceiling tiles and accessed a catwalk system to escape from the hospital, police said. Surveillance footage showed him walking away. Springville Police Lt. David Caron was quoted as saying the officers should not have left Willis alone. “They thought they were close enough,” he said. “They thought they could see or hear what he was doing.” Listed by federal authorities as “armed and dangerous,” he was arrested the next day in Salt Lake City.

Susan Smith, 46, who was arrested in early January on allegations of shoplifting, assaulting a security mall guard, and violating a probation order, was taken to Burnaby General Hospital, Burnaby, British Columbia, in shackles and handcuffs with an RCMP escort. At around 4:30 p.m., according to the police report, medical staff asked that one of Smith’s handcuffs be removed so she could use the washroom, which the guarding officer left to give her privacy. When the officer checked back, she was gone. Hospital surveillance video showed her leaving the hospital at 4:41 p.m. She was last seen wearing a pair of hospital scrub pants with a white sheet or blanket wrapped around her. She was in shackles with her left wrist handcuffed and no shoes on.

**REMOVING RERAINTS FOR MEDICAL PROCEDURES: RISKY AND POSSIBLY UNNECESSARY**

After a 30-hour search, in which he eluded police, rapist Willie B. Wright was arrested by security officers and sheriff’s deputies at Harper Hospital, Detroit, MI, from which he had escaped the day earlier. Wright, 45, was still wearing the white shirt and green jail uniform pants he wore when he overpowered two deputies who had brought him to the hospital for treatment. Wright had been sentenced in December, 2010 to 35 - 60 years in state prison after he was convicted of assault with intent to commit murder, kidnapping, first-degree criminal sexual conduct and felony firearms charges. According to the Wayne County Sheriff’s Department, he had been taken to the hospital for treatment of a wrist injury, and was wearing leg chains but wasn’t handcuffed because of treatment. Wright worked his way out of one of the leg irons before escaping, she said. It was not clear why authorities did not secure Wright’s uninjured wrist to a stomach chain that authorities could use with the leg chains when transporting a prisoner.

After an all-day manhunt, Maurice Ainsworth, 24, a 6’ 7”, 275 lb. inmate with a history of police confrontations who continued on next page
beat, tased, and stole a 5'3" female sheriff’s deputy's gun in escaping from Dominican Hospital, Santa Cruz, CA, surrendered peacefully to a SWAT team in a house a few blocks from the hospital. Ainsworth had his handcuffs and leg shackles removed to take an MRI. While the deputy was putting the shackles back on, according to police reports, he punched her; bit her; and then ran out into the parking lot. The deputy, a 12-year veteran, chased him out into the perimeter of the hospital where they fought again. According to Santa Cruz County Sheriff’s spokesperson, “The inmate took the deputy’s taser; tased the deputy, and then took the deputy’s handgun. He fired a round at a female bystander; and then fled into a neighborhood nearby.” In the next few hours, Ainsworth reportedly ran towards a preschool where he put a gun on a teacher’s head demanding her car keys which he discarded when he heard police in the area. He broke into a home less than a mile from the hospital. In the process of clearing the house next door; the SWAT team came across the suspect in the other home. He surrendered after a four-hour standoff.

“There are very few procedures that cannot be done with alternative-type restraints,” Smith claims. “There are restraints that can be applied as an alternative to the metal restraints, non-metallic flex cuffs that should be used;” Conceding that there may be times that the positioning of the prisoner could be a problem. In most situations, he says, hand shackles, handcuffs, and leg irons should be on at all times for guarded prisoners.

THE DANGERS OF ACCEPTING INMATE ‘DROP-OFFS’

In an inmate escape incident about which hospital and law enforcement officials disagreed over who was responsible, Anthony Koehlhoeffer, a 20-year old charged with bank robbery and other felonies, with a history of escape attempts, was “dropped off” by deputies at 11:15 p.m. on December 15 at the University of Iowa Hospital and Clinics, Iowa City, walked out the door dressed in the hospital-issued gown, flip-flops and a hooded sweat shirt without being stopped, and embarked on a 19-hour crime spree before being recaptured. The additional crimes he was charged with include assaulting a University of Iowa female student in a residence hall parking lot and stealing her car; and kidnapping a woman and forcing her to drive him to Davenport, IA, where he carjacked another vehicle.

According to press reports, the Jefferson County Sheriff said his deputies delivered Koehlhoeffer to the hospital for court-ordered treatment and that the hospital signed paperwork taking custody. A police spokesperson said county jail inmates are routinely transported to the hospital for treatment, and turned over to security there. The county attorney added, “When we get a document that’s signed by someone there on their staff that says they’ve accepted custody, we’re under the impression that they accept custody, and they’re in control of that person.”

However, Tom Moore, UIHC spokesperson disagreed in a statement addressing the procedures of the hospital when receiving an inmate for treatment: “University of Iowa Hospitals and Clinics is not a custodial facility. A law enforcement agency cannot transfer custody of a prisoner to UI Hospitals and Clinics. A law enforcement agency may choose to release a person from custody in order to bring the person here to receive medical care, at which point in time they are not in custody, are not a prisoner, but are rather a patient receiving care. If a law enforcement agency chooses to maintain custody of a prisoner while that person receives care, that agency must assign one of its own staff to remain with that person throughout the course of their treatment. The staff of UI Hospitals and Clinics is not empowered to place anyone in custody. They are not armed. They are not trained to place a person in

continued on next page
custody. Therefore, attempting to do so would be unsafe and inappropriate.”

**BELLINO: STANDARDIZED AGREEMENTS NECESSARY**

Commenting on the problem, Joseph V. Bellino, CHPA, HEM, System Executive, Security, Memorial Hermann Health System, Houston, TX, and past president of IAHSS, stresses communication with law enforcement, but he says patients are ultimately a county’s responsibility. "Leaving inmates may be an acceptable risk for them, but it is not for us," says Bellino. "Under law, we can’t refuse treatment. But if they leave a patient, we are not responsible for their custody." Bellino cites the IAHSS Guidelines for forensic patients which include processes for keeping inmates restrained unless it would interfere with treatment, monitoring them at all times, evaluating physical security in the facility and ensuring all medical care providers understand the policy. Neither the federal government nor any state legislature, however, has passed any legislation to create standardized policies for both hospitals and public safety departments. “County budgets are 100 percent funded by taxes. They have to determine the acceptable level of risk.”

The closest any state has come to creating a standardized policy is Maryland’s “Model Guidelines for the Security of Prisoners for EMS and Hospital Settings,” developed in collaboration with Maryland Law Enforcement, Department of Corrections and the Maryland Hospital Association. Eighteen months in the making, the guidelines include providing hospitals with a risk assessment for each patient an agency brings in, leaving multiple deputies with inmates deemed to carry a certain risk level, keeping restraints on patients at all times, and regulating meal times, telephone access and use of restrooms. It is hoped that the Maryland law will be adopted by other states, Bellino says. However, the guidelines have yet to be introduced in or passed by the Maryland General Assembly.

**DEALING WITH MULTIPLE JURISDICTIONS; NOT ALL CRIMINALS ARE PRISON INMATES**

In striving to protect patients, staff, and security officers from potentially dangerous forensic patients, hospitals must go beyond county sheriff departments, state police, and corrections departments to obtain agreements and institute policies for handling such patients, Smith says. Local police, for example, will bring persons arrested for alcoholism to the ER to be tested before taking them in for booking. Parolees, some with violent backgrounds, living at halfway houses, may be brought in for treatment by unarmed officials or come in unattended. Unarmed aides may accompany a patient sentenced to a mental institution in lieu of prison for criminal acts. And finally, psychiatric patients living in the community will be brought to the hospital by police when they act out, or may come in on their own in disturbed states.

‘CODE LEGAL’: ALLAYING STAFF FEARS ABOUT ‘SATURDAY NIGHT DRUNKS’ AND THEIR POLICE ESCORTS

When an incident in which a forensic prisoner attempted to escape from a Western Colorado hospital’s ER restroom exposed fears on the part of emergency department staff, lab leadership, and phlebotomists, Jason T. Bittle, Security Consultant, JTB Security, Grand Junction, CO, who was then the hospital’s security supervisor, set into motion a course of action which resulted in a “Code Legal” system. The fears, Bittle reports in an article in the Journal of Healthcare Protection Management, not only were for the behavior of the patient-prisoners. Staff indicated that they did not feel “safe” with law enforcement officers securing these patients. They indicated the officers typically removed the handcuffs, often turning their backs on belligerent, possibly unruly subjects. Other officers apparently would ignore the situation while accomplishing their paperwork; still others would sometimes briefly leave the area to seek food or social interactions with staff members in other departments.
As a result of these and other similar concerns for employee and patient safety, the security department leadership, Bittle says, decided to involve security officers in all of these visits, to ensure that an effective template of security was consistently applied. The process and procedure that resulted was termed a “Code Legal” (to mirror the term of “legal blood draw” used by local law enforcement and hospital staff). A new hospital-wide policy was created and subsequently approved by the Chief Operating Officer.

The “patient flow” was simple enough, he says. First, all law enforcement personnel were asked to enter through the ambulance bay of the emergency department with their detainees for this purpose. “Federal, state, county and local agencies were all provided with a simple one-page talking paper regarding the new procedure and the very simple expectations we had for their officers.” This was very well received, he reports. This new route immediately mitigated the risks posed by this prisoner population in the hospital’s public areas as well as reducing the visible presence of a drunken subject in handcuffs being manhandled through the public spaces in the hospital.

Once inside the ED, the law enforcement officer simply had to ask a staff member for a “Code Legal”. All ED staff was then trained to direct the officer to one of several specific rooms, all of which were equipped with duress alarms. The ED staff then contacted the Communications Center to initiate a Code Legal. A pager message was then sent to the on-duty phlebotomist and also the security supervisor. Radio traffic to the security supervisor also notified the security supervisor of their new “visitor.” Upon arrival in the ED, the security supervisor or officer reviewed a brief checklist with the law enforcement officer, to ensure that the security and custody of the prisoner-patient was properly maintained.

The new program was an unqualified success, Bittle reports. The phlebotomy staff indicated they felt much safer due to the presence of the security team members. Additionally, this program provided metrics which were reported to hospital leadership regarding short-term prisoner patient populations. “We found that in the first several months of the program, we had 15-20 visits per month, with each visit typically only tying up a security team member for 12-15 minutes. Most of the visits were between 10 pm and 2 am, and Fridays, Saturdays and Sundays seemed to be the most popular days of the week for these visits.

**PAROLEE LEAVES HOSPITAL; MURDERS EX-GIRLFRIEND**

In August, David Goodell, an ex-inmate staying in a privately-run halfway house as a condition of his parole, was brought to University Hospital, Newark, NJ, at 11:50 p.m. on a Sunday evening, accompanied by an unarmed civilian employee of the halfway house. According to the Bergen County prosecutor, he fled upon arrival, and was picked up by a former girlfriend who was later found dead by suffocation in the passenger seat of a car driven by Goodell who was captured when he rammed a police car on a dead-end residential street. Goodell was charged with murder, assault by auto and two counts of aggravated assault on a police officer. He had served five months in Northern State Prison in Newark from September until February for assaulting and threatening a previous girlfriend.

“We should have agreements with state parole boards,” Smith adds. “I think we’re relying upon the judgment of the facilities that we’re dealing with and that can be very difficult. Many of these prisoners are places that they can walk out anywhere, like a halfway house, so their priority level has to be determined by the facilities where they are coming from. There are prisoners who have a low custody level. Some are on work release and some are in transition from a higher level custody to a lower level custody. When they are in low level custody there are prisoners who are unescorted. What happened in Newark could happen today.”

continued on next page
SONOMA VALLEY HOSPITAL: TREATING THE CRIMINALLY INSANE

Residents of state mental hospitals brought to acute care hospitals for emergency or specialized medical treatment can pose serious threats of violence if parties involved are not aware of the dangers some of those residents pose. At Napa State Hospital, Napa, CA, it is estimated that 80% of the population is made up of “forensic” individuals, who have been deemed by the courts as either “not guilty by reason of insanity” or “incompetent to stand trial.” Only 20 percent of the population is made up of “people who have been civilly committed, are unable to care for themselves or, because of their mental afflictions, present a hazard to themselves or others.”

“The days when Grandpa’s a little crazy and ended up at Napa State Hospital for a while, those days are gone,” said Brad Leggs, the facility president for the California Association of Psychiatric Technicians. “Now we have a barbed wire fence up and we have police officers guarding the perimeter. There’s a prison mentality.”

Within the grounds, however; residents, some of whom gave committed rape, murder, assault and other crimes, are cared for by unarmed staff. Legge was quoted last October after a 54-year-old psychiatric technician, Donna Gross, was murdered as she returned from dinner break allegedly by Jess Willard Massy, a patient who had been at the facility 17 years after being found incompetent to stand trial for an attempted murder.

The murder, and other recent violent attacks on staff at Napa State that attracted considerable media coverage, also impacted on 83-bed Sonoma Valley Hospital, Sonoma, which in September began providing acute care for patients from the state-run psychiatric care facility, under a contract estimated to be worth $3.9 million. The money will pay for the transfer of about 200 to 300 patients, according to press reports.

Concerns had been raised regarding security at Sonoma Valley, but hospital officials stressed that precautions have been taken and “extensive study and negotiations” occurred to ensure “optimum security.” Napa State also contracts with Queen of the Valley Medical Center, a level III trauma center in Napa. A relationship there will continue for patients in suffering life-threatening or more severe traumas.

“This is a tragic incident we’re taking very seriously,” said Kelly Mather, Sonoma Valley Hospital’s (SVH) chief executive officer, who added the manner in which patients and staff interact at Napa State Hospital, is not indicative of how they interact with staff in Sonoma. “I feel very comfortable with the safety measures we’ve taken here at Sonoma Valley Hospital.”

Sonoma Valley Hospital administrators reconfirmed the safety measures Napa State Hospital staff must take with every patient admitted. Each patient must be accompanied by at least one NSH staff member; or possibly more, as each patient’s level of security is evaluated based on their past behaviors. The NSH staff stays with the patient throughout the entire visit. “No patient encounter will occur without a Napa State person present,” said the chief medical officer of SVH and director of the emergency room where all NSH patients enter the hospital.

Napa State patients are kept in a separate ward on the second floor; where rooms are equipped with panic buttons, it was reported. The ward is not locked because 20 percent of Napa State patients are not on forensic holds and legally cannot be treated behind locked doors. However, patients on forensic holds are handcuffed to their beds for additional security. The staff at Sonoma Valley Hospital received specialty training on how to deal with psychiatric patients. At the advice of local law enforcement, Sonoma Valley Hospital also hired a security guard to work nights at the facility.

“(The murder) was a sobering reminder of how violent and unpredictable this type of population is;” a vocal critic of the contract was quoted as saying. “I’m still not convinced Sonoma Valley Hospital can handle the criminally insane population.”

continued on next page
SMITH: SEPARATING FORENSIC PATIENTS FROM OTHER PATIENTS

Converting one floor in a hospital as a secure area to take care of forensic patients is not always feasible for a hospital if it is not doing sufficient volume in such services, Tom Smith points out. “Even if you have such a restricted area,” he says, “depending on the illness, there are special areas elsewhere in the hospital that you have to go to. You will have a hard time doing every procedure in that one location.” At his hospital, he adds, and others without special floors or sections for forensic patients, “we created centralized waiting areas where they wait with other prisoners and are then dispersed throughout the facility. They are not waiting in other clinic areas with other patients.”

WHEN MENTAL HEALTH PATIENTS IN THE COMMUNITY ‘ACT OUT’: LIMITED OPTIONS FOR HOSPITAL SECURITY

The high percentage of forensic residents of Napa State and other state psychiatric facilities compared to the number who are civilly committed reflects the movement of persons with mental health problems from mental institutions to the community where with the help of medication and community services, millions are expected to be able to deal with their problems. When they can’t for one reason or another; hundreds of thousands a year wind up in emergency rooms of hospitals, brought in by police or by relatives or coming in on their own. Unlike prisoner patients or the criminally insane, police and security officers cannot use higher level restraints when such patients threaten or commit violence, unless a “high felony crime” is in progress, according to CMS regulations, Smith says.

“There are two things working here. We all have to keep our eye on what the standard of care is in this area and you cannot use a law enforcement restraint or devices on a patient. Essentially you cannot use handcuffs, pepper spray any of the higher level restraint techniques on a patient unless they committed a high felony crime. So I think what you are seeing is that security people are in between a rock and the hard place.

“It’s a tenuous process in mental health care right now. The money is no longer available to treat people like the Tucson shooter early enough. Many of our patients are out in the community not taking their medicine, not getting care on an outpatient basis. When they do come in they are much sicker and they stay for a longer period of time. Today, when a patient commits a crime, even a forensic patient, many hospitals are resistant to allowing the police or their staff to use tools that are in their arsenal, such as taser, or even pepper spray. Punching a staff member in the nose is not a felony crime.”

CMS: THE ELEPHANT IN THE LEHIGH VALLEY HOSPITAL EMERGENCY ROOM

“A mentally ill person who hasn’t taken his medicine is brought to a hospital emergency department and begins cursing and throwing wild punches at nurses and doctors. Is that person a patient needing firm, appropriate health care or a potential criminal…?” So began an article by Tim Darragh of the Allentown, PA, Morning Call last December following the citing of Lehigh Valley Hospital by the Pennsylvania Department of Health for violating CMS regulations by allowing its security officers to use electric stun guns on out-of-control patients.

The Department of Health claimed in the report that the hospital’s security staff deployed electric shock devices four times since December 2008 -- including three times in the summer of 2010 -- to subdue unruly and violent patients. The state alleged in the report that the hospital and its management failed in its mission to protect patients and to use the least restrictive means of restraint possible in all four situations. It concluded that the hospital violated state and federal rules for the use of stun guns. The taser use incidents, according to the department of health were: continued on next page
--Dec. 16, 2008: A patient tried to leave the hospital, pushed a guard onto a road and began hitting him. The guard warned the patient three times before deploying the electro-shock weapon.

--Aug. 19, 2010: A patient refused a transfusion, began yelling in a language other than English and brandished an IV pole as a weapon. The man was shocked after he barricaded himself in a room and refused to comply with staff.

--Aug. 26, 2010: A patient, on a host of sedatives, remained agitated, pulled out an IV and allegedly was aggressive with security staff and was shocked.

--Aug. 31, 2010: A patient ran out of a room, swung at security staff, fought with two security officers and was shocked after barricading himself in a room.

In a statement the hospital refuted the state’s findings, saying that the events were not related to patient care, but instead viewed as law enforcement incidents. The hospital did suspend use of tasers, and removed the device from service due to the state’s report.

“It’s a gulf that pits the classic view of hospitals as places of caring and healing versus the reality of a sometimes violent society, where health care workers on the front lines may be spit at, punched, kicked or worse,” the article continues.

It concludes by quoting Joe Bellino of IAHSS. “None of us in this profession wants to ever harm a patient. But we run into patients who want to harm nurses and doctors.”

‘BABY-SITTING’ DISTRESSED PATIENTS: A ROLE FOR SECURITY OFFICERS?

A unique agreement between Augusta Health, a 255 bed acute care hospital in Fisherville, VA, in the Shenandoah Valley, local law enforcement jurisdictions and the community service agency, transfers custody of a person with mental illness brought by police to the hospital in distress, from police officers to hospital security officers.

If a person is in a mental health crisis — likely to harm him/herself or others — and refuses to be evaluated by a mental health clinician, an officer can initiate an emergency order to hold the person for up to four hours. That person is then transported to the emergency room to be screened by a clinician with Valley Community Services Board. Before the agreement, signed in October, officers had to wait in the emergency room until the mental health clinician could find a bed and request an involuntary commitment order from the magistrate.

Under the agreement, before the transfer of a person takes place, the security officer in charge talks to the police officer about the case and decides whether they can safely and securely take custody of the person, it is reported. If a person in the security officer’s custody becomes violent, security personnel can ask the police officer to return. “It works great,” the hospital security director is quoted as saying. He points out that his staff has had much of the same type of training the crisis intervention team offers police, in addition to the classes and state certification that gives them arrest powers.

Before considering such agreements, however, Tom Smith recommends consulting IAHSS Guideline 0204-- Security Role In Patient Management—which includes a review of the long-term use of security as sitters or in patient watch
situations. He also voices concern about the timeliness of asking the police officer to return if the patient becomes violent. "Unfortunately, by that time it may be too late to call police."

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WATCH OUT FOR:

INCREASES IN PARKING LOT/GARAGE CRIMES, SCAMS
Attractive, Expensive New Targets That Trigger Increases In ‘Smash And Grab’ Incidents
Police are investigating a string of recent break-ins, averaging almost two per week, in cars parked at Wishaw General Hospital, in South Central Scotland. In almost all of these incidents a window was smashed in the vehicles, police report, and $180 GPS systems were targeted, along with the usual CD players, cameras, laptops and mobile phones. This type of crime is soaring, local police officials say, since the introduction of GPS systems “which are small, easy to steal, and even easier to sell on the street.” Visitors, staff, and patients using hospital or long term care parking facilities should be advised to remove the GPS box, charger and dashboard bracket. Any suction pad marks should be wiped away as these are a sign that a system is on board. The system should not be put in the glove box, but taken with the driver or locked in the trunk.

LEAVING GARAGE OPENERS IN PARKED CARS
Police in Happy Valley, OR, are looking for a man suspected of breaking into a car while the owners were visiting Providence Portland Medical Center and then using the garage opener to burglarize their home. Credit cards stolen from the couple’s home had been used immediately after the break-in. A spokesman for the Clackamas County Sheriff’s Office said a garage door opener and personal papers giving her home address were stolen from the car of a woman visiting her husband, who had just undergone surgery. When she returned home several hours later, she found their garage door open and lights on in the house. Police were able to identify a suspect vehicle after watching surveillance video provided by hospital security and put out an outstanding felony arrest warrant for a suspect for violating parole from a previous conviction.

PHONY VALET PARKERS
Police in Lowell, MA, are trying to track down the thief who tricked a woman in labor into handing over her car keys. Investigators say a man posing as a hospital valet stole the woman’s car when she drove to the Lowell General Hospital emergency room. “He tells her that she can’t park there, it’s illegally parked, but that he’s the valet and if she wants, he’ll take the keys and move the car for her,” said a police spokesman. “So basically, she’s obviously in labor; she hands the keys over. He goes over; takes the car and steals it.” The car has since been recovered.

FAILURE TO CHECK FOR ASBESTOS WHEN RUNNING CABLES THROUGH WALLS AND CEILINGS
An NHS Trust in Northamptonshire, UK, and a firm it hired to upgrade security at Isebrook Hospital have both been fined a total of over $15,000 for health and safety breaches after asbestos was released into a hospital. As part of the work, engineers ran cables through false ceilings and partition walls in public areas. But it led to asbestos fibers being released into the hospital, which had stayed open to the public and staff. An investigation found the Trust did not make sure the contractor had received information about asbestos in the building or planned the project management of the work correctly. It also found the contractor had assumed areas of the hospital did not contain asbestos and that the firms CEO, who was also fine, had not insured his surveys were sufficient to identify if asbestos was present.

NEW CMS GAY PARTNER VISITATION RULE
Effective January 18, 2011, Medicare- and Medicaid-participating hospitals and critical access hospitals (CAH) will be required to have written policies and procedures in place regarding the visitation rights of patients that conform to the final CMS rule as set forth in the November 19, 2010, Federal Register, Volume 75, Number 23, pages 70831-70844. The new rule for the first time extends
visitation rights to the partners of gay men and lesbians. The federal regulations state that healthcare institutions may not prohibit visitation rights based on sexual orientation. Previously, hospitals often barred visitors not related to an incapacitated patient by blood or marriage. Of security, emergency management and the environmental care committee, she said. Hospital employees had criticized previous drills as not being realistic, she reported, so the three had “the best intentions” to make the drill worthwhile. She said the hospital has revised its training policy and will require announcements, signs and other communication with staff to ensure the mistake does not happen again. The other two employees involved in planning the drill were suspended and then stripped of their positions.

**SUICIDE ATTRACTION OF MULTI-LEVEL GARAGES**

The second suicide in four years at the four-deck garage of Berkshire Medical Center, Pittsfield, MA, has prompted hospital officials to seek further safety improvements, according to press reports. Following the first suicide in 2006, when a 52-year old man, a psychiatric patient at BMC, jumped to his death from the top story of the garage, the hospital added security fencing to the garage’s third and fourth floors. (The hospital had been sued by his family for wrongful death. The case was settled out of court.) In August 2010, a 39-year-old man, who was not a patient or employee of the hospital, reportedly jumped to his death from the unfenced second level.

**GIVING ACCESS TO PHONY DOCTORS**

Delaware State Police are investigating three separate reports of unlawful sexual contact at Christiana Hospital, Newark, DE, over a two-week period, according to press reports. A police official said the hospital waited two weeks to report the incidents. The victims, all female patients admitted to the hospital, claim that a man entered their rooms, in a white lab coat, posing as a doctor. The suspect then allegedly performed a physical exam on the women and improperly touched and fondled them before leaving. According to the hospital’s COO, the three patients were in rooms on open-patient floors where there was no need for a badge or credentials to visit or gain access to the women, who were in different units of the building when the incidents took place. Among area hospitals reacting to the news of the imposter was a statement issued internally by John J. Jordan, Security Manager; Shriners Hospital For Children, Philadelphia, PA, which said: “There was a man, posing as a doctor - entering rooms in the hospital and inappropriately touching three patients. He wore a lab coat in order to fit in with others on the unit. The Joint Commission and PADOH mandate that hospital staff and physicians be clearly identified in order for patients to be aware of who is entering their room and what role that person plays in their care. Identification badges should be worn at all times while on duty and in a prominent place so the patient can easily see it. Please be extremely conscientious about wearing your ID badge when on the hospital campus, as well as asking anyone who is unfamiliar - whether they are in “street” clothes or lab coats/scrubs - where their hospital ID is.

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Hospitals and their community partners using Geographic Information Systems, or GIS, can address natural disasters, disease outbreaks and even logistics planning, according to Ric Skinner, GSP, who was program manager from 2002 to 2007 of the country’s first Health Geographics Program at Baystate Medical Center, Springfield, MA. Skinner, who is now Owner and Principal Consultant of The Stoneybrook Group, Sturbridge, MA, employed GIS on a variety of projects that would assist the hospital and area emergency management partners when facing the various perceived threats or potential disasters.

“One of the important things in emergency management is having situational awareness,” says Skinner. Using GIS, information can be displayed in a mapping format, showing operational status and allowing viewers to make appropriate and even life-saving responses.

WORKING WITH COMMUNITY PARTNERS

Often, says Skinner, the use of GIS by hospitals is done in conjunction with community partners responsible for emergency services, or by hospitals planning healthcare logistics projects, such as the delivery of supplies to home healthcare patients. That was one of the uses developed at Baystate, he says. “We developed a vehicle routing system for home-bound patients needing home healthcare services.” While it was used for day-to-day deliveries to plan efficient routes, in the case of an emergency, Skinner says that same information could be used to develop alternative routes if roads are blocked. In addition, if there is a power outage and managers knew that some patients require a back-up power system, that information could also be provided via GIS data.

Baystate also used GIS for a research project on MRSA, the bacterium associated with hospital-borne infections. In this instance, the researchers were looking at people who acquired the infection outside of the hospital. By tracking where people with community-acquired MRSA were living, the emergency department could be alerted when someone from the affected area came in and better diagnosis and treat the infection.

The medical center began using GIS in the late 1990s, he says, “and I was always puzzled why more hospitals didn’t jump into GIS.” Skinner reports emergency management was a secondary or even tertiary focus for GIS. The champion of the program within the hospital was from the surgery department, which tended to keep the program lower profile within the hospital, he says. “As a group, we were better known outside of the hospital than inside,” says Skinner, noting that the program received special achievement and visioning awards during its existence.

PINPOINTING THREATS AND TRACKING EMERGENCY RESOURCES

Before coming to Baystate from New Jersey’s health department, Skinner says the use of GIS in investigating the anthrax bioterrorism attacks, “got me more involved in wanting to do something with emergency management.” While some of Baystate’s projects touched on this area of interest, Skinner says it wasn’t until he left and started consulting and writing a book on the topic “that I got more involved in hospital preparedness.”

These days, says Skinner, GIS is used for such projects as pandemic planning and Hazard Vulnerability Assessments. In assessing a hospital’s risks, he says, the geographic aspect can pinpoint threats from flooding or earthquake zones to proximity to chemical or nuclear plants. GIS is also at the heart of tracking where supplies and emergency resources are located so they can be accessed quickly if needed.

GIS AND SECURITY

Additionally, he says, some health systems use GIS to site trauma centers or urgent care centers based on where people are coming from who use a hospital’s emergency room. During flu season, mapping the concentration of influenza patients can help hospitals set up clinics. And because security is often involved in manning these facilities, GIS has a crossover impact on security planning.

Working in conjunction with local law enforcement, Skinner says GIS has also been deployed to track crime and violence in an area, “so hospitals can do a better job of improving their security.” Hospitals aren’t just concerned about where they are in location to flood plains and flight paths, he says, but also where crime has occurred or is likely to take place. Most law enforcement agencies, via a memorandum of understanding, are willing to share their crime data with hospitals, he says.

But even with all of this taking place, Skinner notes that continued on next page
not every hospital uses or even understands the potential of GIS. Baystate, which at one time had the only full-time GIS department, disbanded its program by 2009, says Skinner. The University of Indiana has a health geographics center; he notes, and Loma Linda University Medical Center has had an active GIS program for emergency management.

Adding such a program to a hospital certainly comes with a cost, says Skinner, “but in terms of other things hospitals spend money on, it’s relatively inexpensive.” At minimum, he says, a hospital pondering such a program would want to bring in a full-time GIS analyst and the appropriate software, computer system and printer. As Skinner did during his time at Baystate, the person will likely become part of the emergency management committee, he says.

As someone who has been in the position and now consults on the topic, Skinner says he would like to see hospitals get more involved using GIS. “Humans are visual thinkers, and I would like emergency management directors to think more along those lines,” he says. “That’s why I did my book with subject-matter experts, to help them explore how GIS is being used.”

Skinner says he’s also working on developing tabletop exercises with interactive maps. These drills can be done in groups or online involving multiple hospitals and community emergency management partners, he says.

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The daily use by hospitals of radiological materials, which if they found their way into the wrong could used to create a so-called “dirty bomb,” has people like Kenneth Luongo, President of the Partnership for Global Security, wondering when, not if, an incident within a medical facility will happen. While some medical facilities, such as the Hospital of the University of Pennsylvania, Philadelphia, have used National Nuclear Security Administration (NNSA) funding to harden buildings and radiological equipment on its campus, Luongo says taking such action on a nationwide, hospital-by-hospital basis is not a priority within the United States right now.

But theft of radiological materials is a real threat, he says, and one that security directors should take seriously. “My feeling is this should be an absolute priority,” says Luongo. “Hospital security directors should write a joint letter to the President and address this cooperatively. The White House hasn’t gripped the seriousness of this yet.”

Luongo notes that what took place at the Hospital of the University of Pennsylvania—what he calls “a complete soup to nuts” retrofit—is what other medical facilities should be exploring.

By working in conjunction with the Nuclear Regulatory Commission and Homeland Security, machines such as blood irradiators were altered to improve the security within them. The retrofitting makes it more difficult for the average person using common tools to open the machinery and access the materials that could be used to make radiological or nuclear devices, says Luongo.

Having realized the potential security hazard, Luongo says manufacturers of such equipment are now making changes to new machines and retrofitting others when the owners can afford it. But there is no comprehensive system in place, he says, to address this problem.

SOME 600 IRRADIATORS STILL LEGIBLE FOR RETROFITTING

An article from Global Security Newswire notes there are more than 800 irradiators in the United States that are eligible for retrofitting, and the threat reduction program has made changes to 215.

In addition to hardening the equipment, Luongo says the University of Pennsylvania also created a liaison position to work with the university’s police force and local law enforcement. This way, he says, if there is a problem with radiological materials, both police forces will be alerted and will know how to handle the event. He added that both police forces are also taking part in training at the National Security Complex in Oak Ridge, Tenn., where they can learn about protecting themselves and others in the event of a materials theft.

‘THE THREAT IS FROM WITHIN’

Hospitals and medical facilities are most at risk, says Luongo, not from outsiders looking to steal materials, but from people already employed at the hospital. “It’s the insider threat that they are worried about,” he says. The prevailing scenario, he says, is for someone to take the material out of the hospital and use it elsewhere to create a bomb. “The feeling is people who are working in the system would be the likely perpetrators,” says Luongo.

Luongo says people are certainly at risk if a dirty bomb were to be set off in a hospital setting. The impact would be determined by the power of the explosive device and the dispersal of the materials based on wind or airflow.

There is also an economic consequence, he says, because the clean up cost of a contaminated area “would be astronomical.”

Facilities and security directors too often view addressing such issues “as problems, costs and headaches,” he says. “But it’s important to understand the consequences of these attacks are serious, and the backlash will be extreme.” While Congress historically addresses specific threats post-event, he says, Luongo urges those involved to take a proactive approach.

Luongo notes the NNSA has estimated the cost to harden a building is about $100,000, or about $125 million to cover the entire country. “It’s not expensive or even hard to do,” he says, “but the amount of action taken is very important. It’s a public safety issue.”

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