

[HOSPITAL / HEALTH AUTHORITY NAME]

SECURITY, VIOLENCE, MISSING PATIENTS, AND STAFF SAFETY

Protocol 58: Prevention; Dynamic Risk Assessment; De-escalation; Security Response; Restrictive Intervention Safeguards; Weapons and Lockdown; Missing-Patient Response; Staff Support; and Organisational Learning

DRAFT FOR EMERGENCY MEDICINE, NURSING, HOSPITAL EXECUTIVE / INCIDENT COMMAND, SECURITY, MENTAL HEALTH, PAEDIATRICS, SAFEGUARDING, OCCUPATIONAL HEALTH, HUMAN RESOURCES, FACILITIES, AMBULANCE, POLICE LIAISON, LEGAL / RISK, QUALITY, AND ALL SUPPORT SERVICES

STATUS: This is a draft clinical-governance, security and occupational-safety document. It does not replace local law, police powers, mental-health legislation, child-protection duties, occupational-safety requirements, fire / lockdown procedures or approved restraint and rapid-tranquillisation policies. All legal thresholds, emergency codes, contact details and security procedures must be locally validated before approval.

CORE RULE: Prevent violence through safe systems, early recognition, respectful communication and timely clinical care. When risk escalates, protect patients, visitors and staff using the least restrictive effective response, while continuing essential assessment and treatment whenever this can be done safely.

IMMEDIATE DANGER OVERRIDE: An active assault, credible weapon, hostage event, fire-setting, serious threat, attempted abduction or uncontrolled high-risk violence requires an immediate security / police alert, removal of bystanders from danger, clinical command, and activation of the approved lockdown, evacuation or armed-threat plan. Staff must not enter or remain in an unsecured danger zone.

RESTRAINT AND DEPARTURE OVERRIDE: Physical force, restraint, sedation, detention, searching, restriction of movement and disclosure to police require a lawful, necessary and proportionate basis. A capacitous adult is not physically prevented from leaving merely because care is incomplete. Any intervention must be the least restrictive option, time limited, monitored and documented.

Document control	Details
Document owner	Emergency Department / Hospital Security and Safety Committee / Medical Services Directorate / Nursing Directorate
Clinical and operational leads	Emergency Medicine; Nursing; Security; Mental Health; Paediatrics; Safeguarding; Occupational Health; Human Resources; Facilities; Ambulance; Police Liaison; Legal / Risk; Quality
Applies to	All ED staff, contractors, students, volunteers, security personnel, patients, accompanying persons and hospital services supporting emergency care
Related protocols	Protocols 1, 2, 4, 8, 19, 29, 31-37, 40-43, 48, 50-52, 54-57 and 59; hospital fire, evacuation, lockdown, restraint, missing-child, occupational-injury and major-incident procedures
Version / status	Draft 1.0 for multidisciplinary review and local configuration
Approval authority	_____
Effective date	_____
Review date	_____ or after any serious incident, use of weapon, death / major injury, abduction, failed alarm, lockdown, legal change or major environmental alteration
24-hour escalation contact	ED senior clinician: _____ Nurse in charge: _____ Security: _____ Police / emergency services: _____

1. Purpose

To provide a practical, auditable framework for preventing and managing violence, aggression, threats, weapons, unauthorised access, missing or absconded patients, and other security incidents in the emergency department while preserving clinically necessary care, dignity, lawful decision-making, staff safety and organisational learning.

2. Core principles

- Violence and abuse are occupational and patient-safety hazards. They are not an inevitable or acceptable part of emergency work, and staff must be supported to report them without blame.
- Prevention begins with system design: timely clinical care, clear information, safe staffing, visible leadership, controlled access, reliable alarms, appropriate security presence, environmental safety and respectful communication.
- Clinical causes of distress or aggression must be sought and treated urgently. Hypoxia, hypoglycaemia, pain, delirium, sepsis, head injury, intoxication, withdrawal, medication effects, neurodevelopmental needs and mental illness can coexist with security risk.

- De-escalation is the preferred first response when it can be attempted safely. Use calm communication, one lead speaker, personal space, practical choices, explanation, symptom relief and removal of unnecessary stimulation.
- Use the least restrictive effective intervention for the shortest possible time. Restriction is never used for punishment, convenience, coercion, staff retaliation or solely because a patient is verbally challenging.
- Security and police support clinical care but do not replace clinical assessment. Clinicians determine medical priorities, capacity and treatment; security personnel control immediate safety within their training and lawful authority.
- Risk assessment is dynamic and behaviour specific. Do not equate diagnosis, disability, ethnicity, age, poverty, substance use or previous attendance with dangerousness.
- No person is denied emergency assessment solely because of abusive behaviour when a serious or time-critical condition may be present. Where care cannot be delivered safely, stabilize as possible, use additional resources, modify the environment or arrange protected transfer.
- A person who leaves unexpectedly is managed according to actual risk, capacity, legal status, safeguarding needs and danger to others - not by a single label or automatic police referral.
- Every incident is followed by immediate care, factual reporting, staff support and system learning. Confidentiality applies, but it does not prevent proportionate information sharing to avert serious harm or meet legal duties.

3. Scope and definitions

Term	Working definition
Workplace violence	Any incident in which a person is abused, threatened, harassed, sexually harassed, intimidated or assaulted in circumstances related to work. It includes verbal, written, online and physical conduct.
Aggression	Behaviour that signals hostility or potential harm, including shouting, threatening posture, property damage, intimidation, stalking, spitting, biting or attempted assault.
Acute behavioural disturbance	A clinical emergency involving severe agitation or disordered behaviour with potential physiological compromise. Manage under Protocol 42 with simultaneous medical and safety assessment.
Security incident	Any event affecting safe access, movement, property, information, staff or patient safety, including trespass, theft, vandalism, weapon, suspicious package, abduction, crowd disorder or targeted threat.
Restrictive intervention	Any act that limits a person's movement or freedom, including physical restraint, mechanical restraint, seclusion, forced medication, locked-door restriction or detention.
Unplanned departure	A patient leaves before assessment, treatment or discharge is complete, with or without informing staff.
Missing / absconded patient	A patient whose location is unknown after leaving unexpectedly and for whom there is a credible concern because of clinical risk, impaired capacity, legal status, safeguarding vulnerability or risk to others.
Elopement / abduction	Removal or attempted removal of a child, dependent adult, newborn or other person by an unauthorized individual, or flight from lawful custody or restriction.
Active armed threat	A person actively using or credibly preparing to use a firearm, blade, explosive, vehicle, fire or other weapon to cause serious harm.
Staff-on-staff violence	Bullying, threats, harassment, sexual misconduct, assault or coercive behaviour involving employees, contractors, students or volunteers. This protocol complements human-resources and safeguarding procedures.

4. Governance and baseline prevention

- Maintain a board- or executive-approved workplace-violence prevention programme with named clinical, security, workforce and safety accountability. Align it with the organisation's incident command, occupational health, safeguarding, mental-health and emergency-preparedness systems.
- Complete and review an ED-specific violence and security risk assessment covering entrance, triage, waiting areas, resuscitation, mental-health rooms, medication and oxygen storage, staff-only areas, ambulance bay, car park, night access, cash / valuables, lone working and routes used for transfer or evacuation.
- Use incident data, staff surveys, near misses, complaints, police calls, restraint episodes, missing-patient events and environmental walk-throughs to identify patterns by time, place, trigger, injury, staffing and response.
- Design safe access with visible reception, controlled clinical-zone entry, appropriate visitor management, clear staff escape routes, unobstructed doors, safe furniture, adequate lighting, alarm coverage, CCTV where lawful, protected staff bases and secure storage for medicines, sharps, keys and personal information.
- Maintain reliable fixed and personal duress alarms with defined responders, response-time targets, testing, battery management, fault escalation and backup communication. Staff must know what each emergency code means and who takes command.
- Provide an appropriately trained security presence based on risk, not solely on historic budget or bed count. Security staff require role boundaries, communication equipment, de-escalation and restraint competence, first aid, safeguarding awareness, evidence preservation and escalation access.

- Establish written policies for visitors, prohibited items, searches, weapons, police requests, patients in custody, use of force, restraint equipment, body-worn video if used, CCTV access, staff confidentiality and preservation of evidence.
- Flag known risks only through an approved, factual and reviewable process. Alerts should describe specific recent behaviour, triggers, effective calming strategies and necessary precautions; they require an owner, date, review and removal process.
- Train staff at induction and recurrently in personal safety, dynamic risk assessment, de-escalation, alarm use, escape, team response, physical intervention appropriate to role, post-restraint monitoring, missing-patient procedures, weapon / lockdown response and incident reporting.
- Plan for discriminatory abuse, sexual harassment, domestic-abuse spillover and staff-on-staff violence. Provide confidential reporting and protection that does not depend on the person confronting the alleged perpetrator alone.

5. Recognition, dynamic risk assessment and activation

Risk classification is based on current behaviour, capability, access to weapons, clinical state, proximity, environmental factors and available support. Escalate whenever the situation exceeds local control, regardless of the label assigned.

Level	Typical indicators	Minimum response
Level 0 - Routine	Calm or distressed but cooperative; no credible threat; environment and staffing adequate.	Normal care; explain waits and plan; maintain situational awareness; address pain, hunger, communication and practical needs.
Level 1 - Concern / Amber	Rising voice, pacing, fixation, verbal hostility, boundary testing, intoxication, escalating family conflict, concerning history or early environmental risk.	Notify nurse in charge; one lead communicator; reduce stimulation; position staff safely; call security to stand by if indicated; review medical causes and care delay.
Level 2 - Imminent violence / Red	Explicit threat, clenched fists, weapon-like object, attempted assault, serious property damage, blocking exits, stalking staff, escalating crowd or inability to maintain safe distance.	Activate security response; summon senior clinician; move uninvolved persons; maintain exit route; prepare clinical and restraint / sedation plan; call police when threshold met.
Level 3 - Active / Critical	Assault in progress, credible weapon, hostage, abduction, fire-setting, active shooter / armed assailant, coordinated attack or multiple casualties.	Immediate emergency-services alert; activate lockdown / evacuation / armed-threat plan; do not enter unsecured zone; incident command; Protocol 56 if mass casualties.

- Reassess after any change in behaviour, clinical condition, staffing, arrival of supporters or police, administration of medication, restraint, relocation or new information.
- Ask directly and calmly about immediate needs, fear, pain, substance use, access to weapons, intent to harm, target, plan and protective factors when it is safe to do so.
- Never conduct a high-risk interview in a room where staff are blocked from the exit or where unsecured sharps, oxygen cylinders, cords, heavy furniture or other weapons are readily available.
- Avoid crowding the person. Uncoordinated arrival of multiple staff or security officers can increase threat perception; one person should communicate while the team remains ready.

6. Immediate response: first five minutes

1. Identify the immediate threat. Is there a weapon, active assault, fire, hostage, abduction, dangerous crowd, clinical emergency or blocked escape route?
2. Call the approved security / emergency code. State exact location, nature of threat, number of people involved, weapons if seen, injuries, direction of movement and whether police / fire / ambulance are required.
3. Protect life. Move uninvolved patients, children, visitors and staff out of the danger area when safe; close or secure access points according to the local plan; preserve a route for emergency responders.
4. Appoint one clinical lead and one security lead. Use one communicator with the distressed person and one command channel for the response team.
5. Address immediately reversible medical causes when this can be done without exposing staff or others to unacceptable danger. Bring emergency equipment to a safe boundary rather than sending unprotected staff into an unsafe space.
6. Remove accessible hazards only when safe: sharps, loose equipment, oxygen cylinders, cords, hot liquids, medications, bags and unnecessary furniture. Do not attempt to seize a weapon from a person unless unavoidable to prevent immediate loss of life.
7. Decide the next safest action: de-escalation, environmental modification, additional trained staff, clinical treatment, supported departure, lawful restrictive intervention, protected transfer, police action, lockdown or evacuation.
8. Record key times and decisions as soon as possible: first concern, alarm, security arrival, police call, restraint / medication, injuries, weapon recovery, all clear and recovery.

7. Environmental, access and visitor controls

- Keep clinical exits usable and staff-only routes secure. Staff must not be trapped behind a desk, bed or patient. Doors used for security must also meet fire and evacuation requirements.
- Control access to resuscitation, paediatric, maternity / neonatal, medication, staff-rest and records areas. Tailgating and propped secure doors should be corrected immediately.
- Visitor limits are based on safety, privacy, infection control and clinical need, applied consistently and with reasonable adjustment for disability, communication, culture, children and end-of-life care.

- Explain behavioural expectations and reasons for restrictions. A visitor who threatens, assaults, obstructs care, films unlawfully, breaches privacy or refuses safety instructions may be required to leave under approved policy and lawful authority.
- Searches of a person or property require consent or a specific lawful / policy basis, trained staff, privacy, witness and documentation. Emergency care must not be delayed for routine searching when immediate treatment is required.
- Potential weapons or prohibited items should not be casually handled. Isolate the area, alert security / police, protect chain of custody and use approved storage or handover procedures.
- CCTV, access logs and body-worn video are used only under approved governance defining purpose, activation, notice, privacy, retention, access, disclosure and audit. Recording never replaces contemporaneous clinical and incident documentation.
- Parking, external walkways and staff transport require lighting, emergency contact methods, security patrol / escort arrangements and procedures for stalking, threats, domestic abuse or targeted risk.

8. Clinical assessment, communication and de-escalation

8.1 Rapid clinical assessment

- Use ABCDE with attention to oxygenation, glucose, temperature, head injury, sepsis, pain, intoxication / withdrawal, medication toxicity, pregnancy, neurological disease and delirium.
- Obtain collateral information and previous care plans when lawful and useful, but do not let a historic behavioural label replace current assessment.
- Provide analgesia, antiemetic treatment, hydration, nicotine replacement when appropriate, toileting, warmth, food if permitted, interpreter support, sensory aids and clear information about delays.
- For severe agitation or acute behavioural disturbance, follow Protocol 42. Prepare airway, monitoring and resuscitation capability before rapid tranquillisation whenever circumstances allow.

8.2 De-escalation method

- Introduce yourself, use the person's preferred name and ask what would help most right now. Acknowledge emotion without agreeing to threats or unsafe demands.
- Use one calm speaker, short sentences and a low, even tone. Allow time to respond. Avoid arguing about delusions, humiliating correction, sarcasm, threats, shouting across the room or simultaneous instructions from several staff.
- Maintain personal space and a safe stance near an exit. Do not touch unexpectedly. Ask permission before examination or moving belongings whenever possible.
- Offer limited realistic choices: quieter area, support person, drink, symptom treatment, timing, position, gender of clinician where feasible or a short pause with continued observation.
- Set respectful boundaries: describe the unsafe behaviour, its effect, what must stop and what support or consequence will follow. Focus on behaviour, not character.
- End de-escalation and withdraw to safety if a weapon appears, distance closes rapidly, the person moves to attack, staff lose an escape route or the team cannot maintain situational control.

9. Security response, physical intervention and police involvement

- Security personnel should receive a concise clinical safety briefing: known medical risks, communication needs, legal status, infection risks, injury, pregnancy, age, equipment attached and planned intervention.
- Physical intervention is a last resort for immediate prevention of harm, serious disruption of life-saving care or lawful detention. It must be necessary, proportionate, led by trained personnel and stopped as soon as the danger resolves.
- Use sufficient trained staff, a named team leader and role allocation. Protect head, neck, airway, chest, abdomen, limbs, lines and drains. Avoid prone restraint, neck holds, chest / abdominal compression, airway obstruction and positions that impair breathing.
- Never restrain by tying a person to fixed furniture, using improvised devices or applying handcuffs solely for clinical convenience. Police restraints remain police responsibility; clinicians must still monitor circulation, position, breathing and medical risk.
- Following any physical intervention, perform immediate ABCDE assessment, injury check, observations, glucose when indicated, mental-state review and documentation. Continue direct observation and monitoring at an intensity proportionate to risk and any medication used.
- Sedation / rapid tranquillisation follows Protocol 42 and local medication policy. It is not used as punishment or to make an unsafe staffing situation easier.
- Police are requested when there is immediate danger, credible weapon, serious assault, abduction, criminal damage with ongoing risk, threat to the public, need for lawful police powers, or when hospital security cannot safely control the incident.
- Police presence does not transfer clinical responsibility. Share only information that is lawful, necessary and proportionate. Document the request, reason, information disclosed, officer details and outcome.
- A patient with capacity who chooses to leave is not detained by security or police merely because clinicians advise continued care, unless another lawful basis applies. Follow Protocol 51.

10. Weapons, armed threat, lockdown and evacuation

- Any credible report or sighting of a firearm, explosive, blade or other serious weapon is treated as real until assessed by security / police. Do not gather staff to inspect or confront the person.
- Call police / emergency services immediately and activate the local armed-threat / lockdown plan without waiting for routine managerial approval. Give verified facts only and update changes.
- When safe, evacuate away from the threat. When evacuation is unsafe, secure in place, silence devices, remain out of view, maintain cover where possible and await authoritative instructions. Resistance is a last resort only when life is in immediate danger and escape is impossible.

- Do not open a secured area until identity and authority of responders are verified under the local plan. Keep hands visible and follow police instructions during their response.
- Clinical staff must not enter an unsecured hot zone. Once police declare an area sufficiently safe, provide lifesaving haemorrhage control and triage under the coordinated incident plan.
- Protect oxygen, anaesthetic gases, medicines, sharps, blood products, newborns, children, persons with disability and patients who cannot self-evacuate. Assign responsibilities in advance for these groups.
- After an all clear, account for patients, visitors and staff; inspect for secondary hazards; preserve the scene and evidence; activate Protocol 56 if casualty numbers or system impact meet major-incident criteria.

11. Missing, absconded and unplanned-departure patients

Use the least stigmatizing accurate term. The response is based on risk and legal status, not on whether the person informed staff before leaving.

Risk band	Indicators	Minimum action
Lower concern	Adult with apparent capacity; no immediate life-threatening risk; no safeguarding or legal restriction; reliable contact.	Attempt contact and provide safety advice / result follow-up. Document. Do not automatically call police.
Moderate concern	Incomplete assessment with meaningful but not immediate risk; intoxication resolving; uncertain capacity; significant pending result; vulnerable circumstances.	Immediate senior review; local search; phone / contact plan; consider family / caregiver and security involvement; define escalation time.
High concern	Lacks or may lack capacity; suicidal intent; severe mental or physical illness; child or vulnerable adult; serious treatment dependency; involuntary legal status; credible risk of harm.	Activate missing-patient response immediately; security search; senior clinical and safeguarding review; notify responsible services and police when lawful / necessary.
Critical concern	Newborn / child abduction, patient at imminent risk of death, violent person posing serious public danger, forensic / custody escape, or person missing during fire / disaster.	Immediate emergency-services alert, lockdown / controlled access as appropriate, incident command and executive notification.

1. Confirm the person is absent and not in a toilet, imaging area, ward, ambulance bay, quiet room or other expected location. Ask who last saw them, at what exact time, wearing what, with whom and in which direction they moved.
2. Conduct an immediate senior clinical review of diagnosis, observations, treatment received / missed, capacity, mental state, self-harm or violence risk, safeguarding, legal status, mobility, communication needs, transport access and risk to the public.
3. Alert security and initiate the locally approved search. Preserve CCTV and access-control information. Searchers must not abandon other critical patients or enter unsafe areas alone.
4. Try the patient's phone and approved contacts when proportionate. Use neutral messages that protect privacy. Do not reveal sensitive information to an unverified person.
5. Notify police promptly for a missing child / newborn, abduction, imminent serious harm, high-risk incapacity, lawful detention, dangerous person or other threshold defined in local policy. Police are not used simply to compel a capacitous adult to return for treatment.
6. Notify safeguarding, mental-health, ward / specialty, ambulance, public-health or other services according to risk. The senior clinician retains responsibility for clinical information and follow-up until formally handed over.
7. Document decisions, contacts, search areas, police reference, information shared, review times and stand-down. Complete outstanding-result follow-up under Protocol 51.
8. When the person returns or is found, receive them without punishment, repeat ABCDE and capacity / risk assessment, examine for injury, address the reason for leaving and revise the care and safety plan.

12. Children, vulnerable adults, patients in custody and other safeguards

- Any missing child, newborn, dependent adult or suspected abduction is an immediate safeguarding and security emergency. Activate the child / infant abduction procedure, control exits as locally approved and notify police without delay.
- Children should not be used as interpreters, messengers or physical intermediaries. A parent or guardian who is aggressive may need separate management while the child continues to receive safe care.
- For cognitive disability, autism, dementia, sensory impairment or communication difficulty, use reasonable adjustments, familiar supporters, communication aids, reduced stimulation and individualized plans. Distress behaviour may signal unmet need or pain.
- Older adults with delirium or wandering risk require clinical treatment, observation and environmental safety, not automatic security detention. Follow Protocol 44.
- Patients in police or correctional custody remain entitled to confidential, dignified clinical care. Custody staff manage legal restraints and security; clinicians can request repositioning or removal when medically necessary and safe, but cannot promise it.
- Safeguarding concerns, domestic violence, trafficking, sexual assault, discriminatory abuse or coercive control follow Protocol 43. Separate the patient from a controlling companion when safe and use confidential inquiry.
- Pregnant, postpartum and medically fragile patients require restraint avoidance wherever possible and immediate senior review if any intervention could impair breathing, circulation, uteroplacental perfusion or access to emergency care.

13. Staff safety, lone working and targeted threats

- No staff member should assess a known or escalating high-risk person alone. Arrange a colleague, security presence, open door, visible location, personal alarm or alternative setting according to risk.

- Use check-in / check-out procedures for isolated rooms, external areas, transport, home visits and after-hours movement. A failed check-in triggers a defined response, not informal assumption.
- Staff may withdraw from an immediate danger while summoning help and maintaining essential care at a safe boundary. Concerns about safety must be heard without accusations of abandonment or cowardice.
- Personal addresses, phone numbers, duty rosters and identifying information are protected. Threats involving stalking, doxxing, domestic abuse, targeted harassment or social media require security, HR, police and confidentiality review.
- Staff-on-staff aggression, bullying, sexual harassment or discriminatory abuse is reported through confidential pathways independent of the immediate line manager when necessary. Retaliation is prohibited.
- Provide safe staff parking / escort options, secure rest areas, reliable communication, adequate breaks and fatigue management. Crowding, prolonged waits and understaffing are violence risk factors and require operational escalation under Protocol 55.
- Pregnant staff, young workers, students, agency staff, workers with disability and those previously targeted may require individualized risk controls and must not be assigned high-risk duties without appropriate support.

14. Post-incident clinical care, evidence and staff support

- Treat injured patients, visitors and staff promptly. Consider head injury, strangulation, bites, sharps, blood / body-fluid exposure, fractures, soft-tissue injury, pregnancy risk, sexual assault and psychological trauma.
- Do not assume absence of visible injury after choking, neck compression or strangulation. Arrange appropriate clinical assessment and safety-netting.
- Preserve clothing, photographs, video, damaged equipment and other evidence under consent, privacy and chain-of-custody procedures. Do not contaminate or discard potential evidence unnecessarily.
- Offer the affected staff member a private check-in, medical assessment, occupational-health referral, exposure prophylaxis when indicated, practical support, transport home, relief from duty and information about police / legal and compensation processes.
- Provide immediate psychological first aid without forcing detailed emotional debrief. Offer follow-up at 24-72 hours and later as needed; monitor for sleep disturbance, intrusive memories, anxiety, depression, substance use and impaired functioning.
- Complete clinical notes and a separate safety incident report. Record facts, exact words when important, behaviour, injuries, interventions, monitoring, witnesses, alarms, response times and outcome. Avoid pejorative or speculative language.
- Notify executive, safeguarding, occupational health, regulator, insurer, police or other bodies according to severity and local requirements. A serious incident requires preservation of evidence and early legal / risk advice.
- Patients or visitors who caused harm may still require emergency care. Future access plans should balance safety, treatment need and legal duties, with senior multidisciplinary review rather than informal blacklisting.

15. Communication, confidentiality and public information

- Give patients and families timely, realistic information about waits, restrictions, visiting, searches, recording, security presence and behavioural expectations. Uncertainty and contradictory messages increase conflict.
- Use trained interpreters and accessible formats. Avoid communicating complex safety instructions through a child or untrained bystander.
- During an incident, use plain-language updates and one operational command channel. Staff should not post photographs, names, rumours or incident details on personal messaging or social media.
- Information shared with security or police should be the minimum necessary for immediate safety, lawful investigation, safeguarding or prevention of serious harm. Record the legal / professional basis and recipient.
- Media and public statements are coordinated by the authorized hospital / health-authority lead and police where applicable. Protect confidentiality and do not confirm an individual's presence without lawful authority.

16. Recovery, stand-down and organisational learning

1. Confirm that the immediate threat has ended, injured persons are treated, weapons / hazards are controlled, missing persons are accounted for or formally handed over, and clinical areas are safe to reopen.
2. Conduct a structured patient and department safety sweep: observations, medicines, interrupted procedures, results, security restrictions, visitor status, staffing, damaged equipment and outstanding follow-up.
3. Restore normal access in stages. Do not remove lockdown or controlled-entry measures solely because noise has stopped; use verified security / police confirmation.
4. Within the same shift, identify staff needing relief, medical care, occupational-health or psychological support and ensure an accountable contact for follow-up.
5. Hold a brief operational hot debrief focused on immediate facts, equipment / alarm failures, communication and urgent actions. Do not use the hot debrief to assign blame or require trauma narration.
6. Complete a multidisciplinary review proportionate to severity. Include frontline staff, security, clinical teams, facilities, safeguarding, HR / occupational health and police liaison as relevant.
7. Track actions to completion. Recurrent incidents require system changes in staffing, flow, environment, communication, access, care pathways, visitor policy, training or regional support - not repeated reliance on individual vigilance.

17. Responsibilities

Role	Minimum responsibility
Hospital executive / incident command	Approve programme and resources; define legal / police interfaces; maintain lockdown and major-threat plans; oversee serious incidents and corrective actions.

Role	Minimum responsibility
ED senior clinician	Lead clinical risk assessment; ensure medical causes and care needs are addressed; authorize proportionate clinical interventions; decide missing-patient clinical risk and handover.
Nurse in charge	Coordinate staffing, observation, patient movement, alarms, documentation, medicines and post-incident care; maintain department-wide situational awareness.
Security lead / officers	Maintain immediate safety, access control and scene management within training and lawful authority; support de-escalation; coordinate police; document force and evidence.
Mental-health / safeguarding teams	Provide specialist risk, capacity, child / adult protection and care-planning support; ensure continuity and safe disposition.
Occupational health / HR	Provide injury and exposure follow-up, psychological support, return-to-work planning, confidential reporting and action on staff-on-staff or targeted threats.
Facilities / biomedical / IT	Maintain alarms, doors, CCTV, lighting, communications, safe furniture and environmental controls; respond urgently to defects.
Quality / risk / legal	Maintain reporting, review, disclosure and legal guidance; analyse trends; ensure actions, training and policy revisions are completed.
All staff	Use de-escalation and safety procedures; summon help early; do not take avoidable risks; report incidents and hazards; support colleagues and preserve confidentiality.

18. Quality indicators and review

Domain	Suggested measure
Violence reporting	Number and rate of verbal threats, physical assaults, discriminatory / sexual abuse, weapon events and staff-on-staff incidents; proportion reported within 24 hours.
Harm	Staff / patient injuries, lost work days, blood exposures, restraint injuries, police injuries, deaths and serious psychological harm.
Response reliability	Alarm test pass rate; median security response time; police activation appropriateness; percentage of staff current in role-appropriate training.
Restrictive interventions	Rate, duration, indication, prone-position occurrence, post-intervention monitoring completion, injury and demographic equity review.
Missing patients	Number by risk band; time to senior review, security alert and police notification; outcome; outstanding-result follow-up; repeat events.
Environment	Completion of annual ED violence risk assessment; open high-risk defects; CCTV / access / lighting / alarm availability; visitor-control incidents.
Support	Percentage of injured or significantly affected staff offered clinical assessment, occupational health and follow-up; staff perception of reporting safety.
Learning	Completion of serious-incident reviews and corrective actions by deadline; recurrence of known contributory factors.

Review this protocol at least every two years and earlier after a serious assault, weapon event, death or major injury, child / newborn abduction, failed alarm or lockdown, unsafe restraint, significant police-interface concern, major environmental change, new legal requirement or repeated incident pattern.

19. Evidence base and source framework

Source	Application in this protocol
NHS England. Violence Prevention and Reduction Standard, updated 2024.	Leadership, governance, data, workforce, interventions and evaluation for a whole-organisation violence-prevention programme.
World Health Organization / International Labour Office / International Council of Nurses / Public Services International. Framework Guidelines for Addressing Workplace Violence in the Health Sector.	Policy, prevention, organisational responsibility, reporting, support and evaluation principles.
US Occupational Safety and Health Administration. Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers; hospital and ED resources.	Management commitment, worker participation, worksite analysis, hazard prevention, training, recordkeeping and programme evaluation.

Source	Application in this protocol
Health and Safety Executive. Managing the Risk of Violence and Aggression in Health and Social Care; work-related violence and lone-working guidance, current webpages reviewed 2026.	Risk assessment, layered controls, lone working, reporting and employer responsibilities.
Royal College of Emergency Medicine. Best Practice Guideline: The Patient Who Absconds, 2024.	Risk-based response, police interface, documentation and service learning for patients who leave unexpectedly.
Joint Commission. De-escalation in Health Care and Workplace Violence Prevention resources.	Structured de-escalation, programme design, training, incident reporting and post-event response.
US HHS Administration for Strategic Preparedness and Response. Active Shooter Planning and Response in a Healthcare Setting.	Healthcare-specific armed-threat preparedness, communications, lockdown / evacuation and continuity considerations.
Related local clinical guidance	Protocol 42 for behavioural emergency and rapid tranquillisation; Protocol 43 safeguarding; Protocol 51 capacity and departure; Protocol 55 crowding; Protocol 56 mass casualty response.

Evidence and legal disclaimer: Guidance from other jurisdictions provides a safety framework but does not determine local legal authority. Before approval, the hospital must validate Saint Kitts and Nevis law and policy concerning occupational safety, assault, weapons, searches, detention, restraint, mental-health powers, child protection, missing persons, police information sharing, CCTV / recording, evidence handling and employer duties.

Annex A. Dynamic violence-risk and de-escalation checklist

Domain	Prompt
Immediate danger	Weapon seen / reported; assault in progress; blocked exit; hostage / abduction; fire; multiple aggressors; crowd disorder; credible targeted threat.
Behaviour	Threats, target / plan, escalating voice, pacing, staring, clenched fists, invasion of space, property damage, stalking, sudden quiet after escalation.
Capability	Size / strength, weapon access, intoxication, companions, previous serious violence, proximity to vulnerable people, staff numbers and escape route.
Clinical contributors	Hypoxia, glucose, pain, delirium, sepsis, head injury, intoxication / withdrawal, medication effect, pregnancy, neurodevelopmental or communication need.
Environment	Noise, delay, crowding, heat, hunger, bad news, privacy breach, unsecured hazards, room layout, lighting, alarm / security availability.
Protective factors	Rapport, trusted supporter, willingness to accept care, specific request, calmer area, symptom relief, food / drink, interpreter, agreed choices.
De-escalation actions	One lead speaker; introduce self; acknowledge distress; simple language; personal space; do not touch unexpectedly; realistic choices; clear behavioural boundary.
Stop / withdraw triggers	Weapon, lunge, rapid closure of distance, loss of exit, assault, uncontrolled crowd, responder unable to communicate or team unable to maintain safety.

Annex B. Graded response action card

Status	Actions
Amber	Notify nurse in charge; one communicator; clinical review; address pain / needs; reduce stimulation; safe positioning; security standby; reassess.
Red	Activate security; senior clinician; move bystanders; remove hazards; police threshold review; prepare trained team, monitoring and treatment plan; document times.
Critical / armed threat	Call police / emergency services; activate lockdown / evacuation; do not enter unsecured zone; incident command; protect vulnerable patients; major-incident protocol if needed.
Stand-down	Verified all clear; account for people; treat injuries; clinical sweep; preserve evidence; staff relief and support; report; debrief; corrective actions.

Annex C. Missing-patient action card

1. Confirm absence and exact last-known location / time; check expected internal locations.
2. Immediate senior clinical risk review: illness, capacity, self-harm / violence, safeguarding, legal status, treatment dependency and risk to public.
3. Notify security and initiate approved search; preserve CCTV / access data; obtain description and photograph lawfully.
4. Attempt proportionate patient / contact communication while protecting confidentiality.
5. Notify police immediately when child / newborn, abduction, imminent serious harm, dangerous person, lawful detention or other local threshold applies.
6. Assign review time and responsible clinician; continue outstanding-result and treatment follow-up.
7. Document all times, decisions, disclosures, reference numbers, search and stand-down.
8. On return: welcome, ABCDE, injury check, capacity / risk reassessment, reason for leaving and revised plan.

Annex D. Restrictive-intervention safety and monitoring record

Stage	Minimum record
Before / decision	Immediate harm being prevented; alternatives tried or unsafe; legal / clinical basis; senior decision-maker; team leader; planned position and exit strategy.

Stage	Minimum record
During	Airway and breathing visible; no neck / chest / abdominal compression; avoid prone position; head / limbs protected; lines / drains protected; continuous communication; time started.
Physiological monitoring	Respiratory rate, oxygen saturation, pulse, blood pressure, consciousness, temperature and glucose as clinically indicated; continuous monitoring after sedative medication per Protocol 42.
Review	Behaviour, need for continued restriction, position, circulation, pain, distress and readiness to release at frequent defined intervals.
After	Time ended; ABCDE; injury examination; patient explanation and opportunity to discuss; staff injury check; documentation; incident report; senior review and support.

Annex E. Staff post-incident checklist

Time	Actions
Immediate	Move to safety; clinical assessment; first aid; blood / body-fluid exposure pathway; preserve evidence; relief from duty; safe transport / contact person.
Same shift	Incident report; manager / security review; police option / mandatory report; occupational-health referral; practical support; duty / roster adjustment.
24-72 hours	Confidential follow-up; symptom check; occupational health / psychological support; injury documentation; compensation / legal information; return-to-work plan.
Later	Review persistent symptoms or absence; peer / professional support; update personal safety plan; communicate learning and completed system changes.

Annex F. Local configuration and approval checklist

Configuration domain	Required local entry / confirmation
Emergency codes	Security / violence: _____ Weapon / armed threat: _____ Child / infant abduction: _____ Fire: _____ Major incident: _____
Contacts	Security: _____ Police: _____ Mental health: _____ Safeguarding: _____ Occupational health: _____ Executive / legal: _____
Legal validation	Capacity / detention; restraint; searching; weapons; police powers; missing children / adults; information sharing; evidence; CCTV / body-worn video; occupational injury reporting.
Environment	Entrances and access; duress alarms; CCTV; lighting; safe rooms; staff escape routes; furniture; secure stores; car park; lockdown zones; evacuation routes.
Training	Induction and update frequency; de-escalation; alarm / code response; physical intervention by role; post-restraint monitoring; armed threat; missing patient; lone working.
Equipment	Personal alarms; radios; PPE; approved restraint equipment; monitoring; first aid / trauma kits; evidence bags; forms; backup communications.
Police / security interface	Memorandum or agreed procedure for urgent attendance, weapons, restraint, custody, missing patients, information sharing, evidence and post-incident review.
Approval record	Clinical lead: _____ Nursing lead: _____ Security lead: _____ Mental health: _____ Safeguarding: _____ Occupational health / HR: _____ Legal / risk: _____ Executive: _____

FINAL APPROVAL REQUIREMENT: This protocol must not be implemented until the hospital has tested alarms and communications, confirmed 24-hour security / police escalation, validated legal authority and local reporting duties, approved restraint and rapid-tranquillisation procedures, completed an environmental risk assessment, and exercised at least one missing-child / patient scenario and one violent / armed-threat scenario.