

Murder in the Hospital: A Lesson from an Actual Security Event

A tragic event in Virginia is a reminder of the importance of proper hospital security procedures



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The prisoner's transport from the local jail to the hospital emergency department seemed no different from the countless number of trips the sheriff's deputies had experienced in the past. Charged with armed robbery, departmental policy mandated that leg irons and handcuffs be securely fastened around the convict's extremities.

Unfortunately, the experienced deputy had no way of knowing that his prisoner had earlier made a statement to a fellow inmate revealing his intent to escape. Typical of most inmates, the prisoner's complaint of arm and leg pain was not discernible by the jail's medical staff. As a result, policy required that the inmate be taken to the local hospital's emergency department for further evaluation.

Upon arrival at the hospital the prisoner, now termed a forensic patient, was placed in an ED treatment cubical where he was immediately examined by a physician. After a quick examination the doctor ordered the inmate's shackles removed from the prisoner's right side so X-rays could be taken of the alleged injury. While waiting unshackled for his test results, the prisoner requested permission to go to the bathroom. After using the bathroom the inmate called for the deputy's assistance. As the officer peered into the bathroom the inmate feigned having difficulty pulling up his orange jump suit. In an attempt to help the inmate, the deputy bent over exposing his gun side to the inmate. The deputy was struck in the head with an object later identified as the metal tube from the center of a toilet paper dispenser. The desperate prisoner grabbed the dazed deputy's gun from his holster as the injured officer fell to the floor.

The Emergency department immediately initiated a lockdown of the unit, not knowing the prisoner had taken possession of the deputy's handgun. Having heard the commotion, one of the hospital's security officers immediately responded to the ED in an attempt to gain access through the locked glass door. As the guard pushed on the locked door, a shot, fired from the deputy's gun, penetrated the glass striking the guard, mortally wounding him.

During his escape, the fleeing felon shot and killed an approaching deputy, as well as forcing a state college to shutdown on their first day of school. An entire community would be thrown into a massive panic before the escaping felon could finally be captured.

The above isn't a tale of fiction; it's the reality from late August 2006, when an inmate, sent for treatment to a hospital in Blacksburg, Va., managed to overpower his accompanying deputy. In his escape, the suspect, William Morva, left a hospital security officer dead, as well as a pursuing deputy. You can see the full story [here](#).

This incident, in security terms, is the result of an unbroken chain of events that led to a tragic sentinel event -- an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof.

Examining the Root Cause

A shooting death on hospital grounds invariably draws close scrutiny from Federal and state regulatory agencies. Litigation exposure moves to the forefront and the hospital's order of the day typically becomes 'damage control', notwithstanding the pending wrath of the Joint Commission, which is a virtual certainty. Still, many hospitals and healthcare facilities across the country continue to accept this type of incident as a "necessary evil" in the treatment of forensic patients in their emergency department setting.

It is clear that several critical factors lead to this tragic event. A Root Cause Analysis (RCA), required by the Joint Commission following any sentinel event, will undoubtedly identify the causative factors.

But can this type of tragic sentinel event be avoided?

For the moment let's set aside the issue of whether or not hospital security officers should be armed or unarmed, and the pros and cons of contract guard services vs. a proprietary security force. The Blacksburg, Va., incident involves the issue of gun retention by a Sheriff's deputy guarding a forensic patient and the ensuing death of an unarmed hospital security guard.

Gun retention is a much debated issue among law enforcement professionals. Training courses across the U.S. teach body positioning and gun retention. Officers are trained to protect and maintain control of their weapons at all costs, but they still occasionally lose control of them. Statistics are not kept on how often law enforcement officers lose control of their firearms, but FBI data indicates that about 10 percent of felonious police deaths nationwide from 2000 to 2004 involved officers being killed by their own weapons.

The threat of gun violence on health care providers does not always come from unauthorized weapons brought into the facility. Several instances, including this most recent event in Blacksburg, record an officer, medical practitioner or innocent bystander being shot with the officer's weapon lost during a struggle in the emergency room or on hospital grounds. Training in gun retention in all situations is an essential element for all armed officers. When charged with guarding forensic patients, it is equally incumbent upon the officer to maintain control of their weapon. Loss of a weapon renders an officer incapable of guarding their prisoner or protecting health care workers or others who may then be placed in imminent danger.

Many psychiatric hospitals for example require law enforcement officers to remove their weapons prior to entering the facility, and to secure them in special weapon lock boxes. These special circumstances are generally known to local law enforcement officials. Although an armed officer may be reluctant to surrender his or her weapon, they will honor the hospital's policies and procedures when properly informed and educated by their superiors who need to work in close cooperation with the hospital's security director.

In acute care facilities, if the hospital's Emergency Department has lock down capabilities and metal detectors, which is becoming the standard across the country, careful consideration should be given to using this same type of lock box process. Alternatively, all law enforcement officers as well as armed hospital security staff should be thoroughly trained in proper gun retention. Armed personnel should wear level-3 or level-4 firearm security holsters, and receive appropriate training in their use. Every effort must be made to reduce the possibility of losing control of firearms in the healthcare setting.

Sympathy Can Lead to Tragedy

One of the cardinal rules for law enforcement officers guarding prisoners is that they are never to become personally involved in the care of a prisoner. The law enforcement officer must remain free to observe the prisoner at all times, and to act immediately to protect the public if needed. Hospital administrators and staff must be educated on this fact, and it should be clearly stated in the hospital's forensic patient policy. When an officer escorts a prisoner to the hospital for treatment, it is their responsibility to guard that prisoner at all times. This responsibility should not be transferred to the hospital.

While cooperation and collaboration on firearm policies and procedures between local law enforcement and hospital security is essential, ultimately it is the hospital that knows best what their needs, issues, regulations and patient populations are. Regrettably, hospital security departments often abdicate their onsite authority to law enforcement agencies which are much less attuned to security in the health care environment.

Developing Appropriate Security Policies and Procedures

Hospital emergency department staff members are often not consulted when planning the security policies and procedures for their area. The physicians, nurses, technicians, clerical and other staff who literally put their lives on the line each day are rarely asked about their perception of their security needs. These dedicated individuals love their jobs, but are often terrified because they are aware of the dangers they face. Consider the types of threats that will enter a hospital on a daily basis:

- patients who have active psychiatric diagnoses
- patients who are acting out
- patients high on drugs or having adverse reactions to illegal drugs and/or alcohol
- gang members with a history of violent behavior
- family members in the midst of abusive situations
- patients and families reacting to stress, pain and grief
- and, of course, prisoners desperate for an opportunity to escape.

All these situations combine to create a highly volatile environment for health care workers.

To respond to such threats, all hospital emergency departments -- regardless of size or location -- should undergo a complete security assessment a minimum of every two years by an experienced healthcare security expert. These consultants know the regulatory requirements, the culture and the issues. They can

assist hospitals and law enforcement agencies to develop policies and procedures to protect patients, visitors, staff and officers. While electronic and physical security devices are essential to a good security program, the key is the development and adherence to policies and procedures with consideration of the end users - nursing staff and healthcare practitioners.

Hospital violence is a significant, growing and widespread concern nationwide. Our emergency departments and clinical areas are by no means immune to acts of violence. Emergency medicine professionals know the direct negative impact violence has on the quality of patient care, their employees and staff retention. Emergency medicine providers across the country continue to voice concern for their safety in this volatile work environment.

We will never be able to eliminate the stressors that patients bring with them to emergency departments. However, we can and should ensure the staff and patients working in these stressful environments, as well as the care they provide to patients and families, occur in a safe environment.

In a previous article, [Securing Forensic Patients in the Public Hospital Setting: Part 2](#), the author describes a *Forensic Patient Action Plan* listing nine of the most commonly identified problems and concerns that arise when dealing with forensic patients. It suggests a plan of action for each problem and shows the individual(s) and/or department(s) that typically have responsible charge for addressing these problems. This plan has been posted on SecurityInfoWatch.com as well as the SAI website. To view or print an action plan for dealing with forensic patients, you can access either the [Forensic Patient Action Plan \(web/HTML version\)](#) or the [Forensic Patient Action Plan \(downloadable Microsoft Excel version\)](#).

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