Abstract

Hospitals, even five years past the events of September 11, with their unguarded front doors and unlocked patient rooms have conspicuously failed to implement even basic security procedures to protect the society’s most vulnerable against violence. The degree of complacency is so great that even hospitals that have experienced shootings refuse to institute basic security measures such as metal detectors and identification checks. Over the six-month period, from June through December 2006, there were at least eight hospital shootings in the United States and Canada. This article outlines these shootings and presents a model “Code Silver” policy that hospitals can adopt to mitigate some of the risk of internal hospital shootings. Key concepts of the policy include training hospital staff to “shelter in place” during a violent event, marking locked doors, and having hospital security respond in an appropriate manner.

Key words: hospital, physical security, policy, security, violence

Introduction

The Hudson Valley Regional Resource Center is a New York State Department of Health–funded resource center providing incident command, emergency management, decontamination, counterterrorism education, evaluation, and exercises to the 39 hospitals in the seven counties of the Hudson Valley, fanning out in “V” to the immediate north of New York City. As part of our services, we began offering formal counterterrorism assessment in 2006 using a standardized instrument developed by federal agencies and distributed by the Federal Emergency Management Agency. As part of this assessment, based in part on the researcher’s experience with training graduate students on counterterrorism issues in Israel, we specifically queried regional hospitals, as well as over two dozen other hospitals throughout North America, regarding their ability to manage an “active shooter” gunman in the hospital. Hospital emergency managers were specifically asked the following questions:

• “Do you have a lockdown policy that secured the inside of the hospital?”
• “Do you have an overhead code for a violent event in the hospital?”
• “Have you identified areas of safe refuge with locking doors?” and
• “Does law enforcement have a current copy of your hospital floor plan?”

The answer was an overwhelmingly “no” to all four questions, with the exception of one hospital that had a plan, explicitly the result of an internal hospital shooting a decade ago. These results have led to this work.

Hospital “open door” policies

Hospitals in North America have traditionally viewed their role in society as a safe refuge from terrorism and violence, and as a result, many hospital administrators are more concerned with an “open door” policy toward the community than in the safety and security of their staff and patients. This has
resulted in hospital policies that do not really provide any real filtering of people entering the facility, either by confirming their purpose and identity, or ensuring that they do not have weapons. In fact, many hospitals, both in the Hudson Valley and throughout North America, continue to use the services of poorly trained volunteers to staff entrances, lacking in both authority and ability to stop trespassers.

This “open door” ethic is so pervasive and persistent that even hospitals that have experienced recent shootings do not dramatically change the way they control access and screen visitors. One hospital spokesperson who experienced a recent shooting in his hospital commented, “We ask that visitors check in at the desk and get a badge. We try to keep track of who is coming and going, but there’s a lot of people coming in and out of a hospital.” According to a hospital association CEO, “It’s not feasible to have security

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<tr>
<th>Date</th>
<th>November 19, 2006</th>
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<tbody>
<tr>
<td>Location</td>
<td>Provena Mercy Medical Center, Aurora, IL8-10</td>
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<tr>
<td>Event</td>
<td>Security staff notified a police officer at the hospital that a patient was combative. The officer went to the hospital room, saw that the 58-year-old patient was armed with a loaded, two-shot Derringer handgun and a 71-year-old patient hostage in room. She then cleared the hallway of hospital staff and patients. Authorities had relocated 26 patients from the floor and locked down the hospital.</td>
</tr>
<tr>
<td>Outcome</td>
<td>Perpetrator killed when raised gun at police officer.</td>
</tr>
<tr>
<td>Comments</td>
<td>Bill Brown, president and CEO, said that he did not know how the patient brought a gun into the hospital, but that staff members do not check patients’ belongings. Hospital officials will “take any appropriate measures” to ensure patient safety, but metal detectors and searches “would really not be appropriate,” he said. “We’re not an airport,” Brown said. “We’re a quasi-public institute and building… It’s not the same level of security as an airport.”</td>
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<tr>
<th>Date</th>
<th>September 26, 2006</th>
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<tbody>
<tr>
<td>Location</td>
<td>Pulaski Community Hospital, Pulaski, VA</td>
</tr>
<tr>
<td>Event</td>
<td>A patient shot and killed himself inside his room in the skilled nursing unit.</td>
</tr>
<tr>
<td>Outcome</td>
<td>Victim dead.</td>
</tr>
<tr>
<td>Comments</td>
<td>The police chief said that he didn’t think the hospital was locked down.</td>
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<tr>
<th>Date</th>
<th>September 8, 2006</th>
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<tr>
<td>Location</td>
<td>Methodist University Hospital, Memphis, TN</td>
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<tr>
<td>Event</td>
<td>A woman who was previously assaulted and was seeking care in the emergency department reported to police that the man who assaulted her was outside, circling the hospital with his car. Police investigated and the perpetrator accelerated toward the officer in his car. The officer fired a single shot, hitting the perpetrator in the head through the windshield. The car crashed into a bus stop, with a total of four injured.</td>
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<tr>
<td>Outcome</td>
<td>Perpetrator dead, three bystanders injured.</td>
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<tr>
<th>Date</th>
<th>August 29, 2006</th>
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<tbody>
<tr>
<td>Location</td>
<td>Penticton Regional Hospital, British Columbia, Canada</td>
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<tr>
<td>Event</td>
<td>A 77-year-old man walked into the hospital and shot his 80-year-old wife with a handgun before turning the weapon onto himself.</td>
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<tr>
<td>Outcome</td>
<td>Perpetrator and wife dead.</td>
</tr>
<tr>
<td>Comments</td>
<td>This was the third instance of violent death at a B.C. hospital in less than 4 years. In April, a 78-year-old hospital volunteer was beaten to death at the Campbell River Hospital.</td>
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<tr>
<th>Date</th>
<th>August 20, 2006</th>
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<tr>
<td>Location</td>
<td>Montgomery Regional Hospital, Blacksburg, VA</td>
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<tr>
<td>Event</td>
<td>An inmate of the Montgomery County Deputy Sheriff overpowered Deputy, gained control of his service pistol and attempted to escape custody. A Montgomery Regional Hospital Security Officer attempted to assist the Deputy and stop the prisoner’s escape. Shots were fired inside the hospital Emergency Room area.</td>
</tr>
<tr>
<td>Outcome</td>
<td>Hospital security officer dead, Deputy Sheriff wounded.</td>
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Figure 1. Hospital shooting in North America, June to December 2006 (continued on next page).
devices in hospitals that you would see in airports and courthouses . . . Hospitals are large places with numerous entrances and exits."³

This attitude is at odds with the reality of what hospitals do—house elderly and incapacitated people at the weakest and sickest, in unlocked and usually unsupervised rooms. Almost by definition, you could not find a population more vulnerable. If a responsible government agency was placing elderly residents in apartments where none of the doors (including the front door) are locked, the community would find this unacceptable, yet this is the standard for hospitals across the country.

The reality of hospital violence

The common hospital refrain that “It’s not feasible to have security devices in hospitals that you would see in airports and courthouses” reveals a widespread lack of understanding of the risk faced by hospitals.³ Although various government agencies track workplace violence, there is not a single source to track hospital violence by category. A search of Google news and the Internet for “hospital shooting” reveals incontrovertible evidence that hospital violence involving guns is not particularly unusual in North America, with at least eight hospital shootings in the United States and Canada over a six-month period from June to December 2006 (Figure 1). Of these eight, three were apparent suicide, two were homicide, and three were police-involved shootings (one of which killed a hospital security officer). These events are just the most dramatic—we have no data on the incidence of

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<tr>
<th>Date</th>
<th>August 10, 2006</th>
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<tr>
<td>Location</td>
<td>Scripps Green, La Jolla, CA¹⁵</td>
</tr>
<tr>
<td>Event</td>
<td>The perpetrator, 86-year-old, shot and killed himself after shooting his 95-year-old wife, who was bedridden and being treated in the hospital’s cardiac unit. There were no other patients or hospital staff in the room at the time. Hospital workers heard gunshots. A nurse went to the room and found the perpetrator seated in a chair with what appeared to be a self-inflicted gunshot wound. Next to him, on the bed, was his wife. A gun was seen nearby.</td>
</tr>
<tr>
<td>Outcome</td>
<td>Perpetrator and wife dead.</td>
</tr>
<tr>
<td>Comments</td>
<td>“After the gunshots were heard, security and medical personnel were mobilized through a Code Blue signal indicating a medical emergency,” said Johnny Hagerman, the hospital’s marketing and communications director. Security officers blocked off the room, and police sent a homicide unit. At Scripps Green there are no metal detectors and security guards are not armed. “We ask that visitors check in at the desk and get a badge. We try to keep track of who is coming and going, but there’s a lot of people coming in and out of a hospital,” said Stanziano, the hospital’s spokesman. Steve Escoboz, CEO of the Hospital Association of San Diego and Imperial Counties, said he is not aware of a hospital in either county with metal detectors. “It’s not feasible to have security devices in hospitals that you would see in airports and courthouses,” Escoboz said. “Hospitals are large places with numerous entrances and exits.”</td>
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<tr>
<th>Date</th>
<th>July 19, 2006</th>
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<tr>
<td>Location</td>
<td>Advocate Lutheran General Hospital, Park Ridge, IL¹⁶</td>
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<tr>
<td>Event</td>
<td>In July, a 68-year-old patient at Advocate Lutheran General Hospital in Park Ridge shot himself to death in a hospital room.</td>
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<tr>
<td>Outcome</td>
<td>One victim, apparent suicide.</td>
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<tr>
<th>Date</th>
<th>June 26, 2006</th>
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<tr>
<td>Location</td>
<td>Northwestern Memorial Hospital, Chicago, IL¹⁷</td>
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<tr>
<td>Event</td>
<td>A 70-year-old patient at Northwestern Memorial Hospital in Chicago died in June, two days after he shot himself in the head. The shooting happened as the man and a caretaker, not employed by the hospital, were in the 10th-floor hospital room. After the shooting, security personnel went to the room and then called the police.</td>
</tr>
<tr>
<td>Outcome</td>
<td>One dead.</td>
</tr>
<tr>
<td>Comments</td>
<td>“It’s not a case of gunman running through the hospital,” hospital spokesman Andrew Buchanan said.</td>
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</tbody>
</table>
gun events not involving a shooting or not reported, events involving other weapons, or other homicides in hospitals. What we do know is that hospitals are violent places: Occupational Safety and Health Administration (OSHA) statistics for hospital workers (not patients) reveals a 400 percent higher incidence of assaults than among the average private-sector worker.4

Across many public institutions, September 11th and the aftermath have changed the paradigm of open buildings—from significantly more intrusive airport security, to metal detectors at schools, to the now ubiquitous wearing of work identification badges, nearly every aspect of physical security of both workers and of those interfacing with public institutions has grown dramatically. Hospitals, five years after September 11th and eight years after the Columbine, are not only behind the curve, they deny that they are even on the curve. Even with the astronomical number of assaults, after experiencing a shooting at their facility, the comments of senior hospital administration somehow continue to negate the fact that hospitals lack even a rudimentary level of protection that you would find at a bargain-rate motel.

What is currently in place: Lockdown actually means lockout

While most hospitals have a “lockdown” policy as part of their security or emergency management plan, what they actually have is a “lockout” policy that prevents outsiders from entering the hospital in the event of a community hazardous materials event. Many hospitals, as part of their abducted infant/child policy (commonly referred to as Code Pink or Code Adam), also have a policy where staff (not security) monitor and limit patients, visitors, and staff from exiting the hospital. But few hospitals have considered what to do when there is a violent act occurring within the hospital itself—How do staff and patients get notified to avoid the area? When do they evacuate? Are there areas of safe refuge with locking doors?

What is currently in place: Code grey security response

Hospitals almost always have an overhead code (“Code Grey” in HEICS Version Three5) to alert security officers and nursing management of a violent event occurring in the hospital. Unfortunately, an unarmed security officer running toward an actively shooting gunman (“active shooter”) is both dangerous to the security officer and fails to protect other hospital employees. This concept is compounded by three factors: weapons, training, and use of force guidelines. The most common modality in the Hudson Valley is that hospital security officers are unarmed, without a firearm, or probably more generally appropriate for the hospital setting, a baton or pepper spray. Second, most hospital security officers have a minimum eight-hour New York State-mandated security guard training and a hospital orientation, in contrast to the peace officer status held by the NYC Health & Hospitals Corporation Police and limited police officer status held by the Veterans Administration Hospital Police.6,7 Finally, many hospitals have defined the appropriate use of force guidelines for security officers as “observe and notify” only, which outlines what force they can use to detain and restrain, fundamentally tying the hands of the security officer when confronted with an active, violent event.

A model code silver program

Given the incidence of hospital-based shootings, hospitals need to adopt a clear program to minimize risk to staff, patients, and visitors (Appendix 1). Part of this program, in addition to the model policy, involves providing current hospital floor plans to police, exercising Code Silver response on at least an annual basis so that local law enforcement and regional special law enforcement teams get to understand the hospital environment and coordinate better with the hospital security team, identifying locking doors and marking them with a grey doorplate in contrast to the normal marking colors, and educating hospital employees about what is expected of them during an active shooter event.

Conclusion

Hospital administration in North America, even in hospitals that have experienced shootings, have...
consistently failed to provide any reasonable degree of physical security to the society’s most vulnerable. Unfortunately, it may take either a large-scale hospital terrorist event or Columbine-type shooting to shock hospital administrators out of their current behavior. Part of adopting a broader security program is implementation of a Code Silver program, which will limit vulnerability of patients, visitors, and hospital staff to active shooters in the hospital. Given the incidence of 2006 hospital-based shootings in North America, adoption of Code Silver programs is acutely needed.

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Garrett Doering, MS, Paramedic; Deputy Director, Hudson Valley Regional Resource Center, Westchester Medical Center; Lecturer, New York Medical College, Valhalla, New York.

References
Appendix 1. A model “code silver” policy

I. Purpose

To provide assistance to staff members and/or visitors, who are confronted by an individual brandishing or claiming to possess a weapon, or one who has taken hostages within the healthcare facility or within its property. To ensure a safe and secure environment for patients, visitors, and staff. This type of situation must be approached calmly, carefully, and thoughtfully to reduce danger to patients, staff, and visitors.

II. Supporting information

Patients, visitors, or staff are at risk of being confronted by a person with a weapon or of being involved in a violent crime/hostage situation. If such a situation arises, staff members should not attempt to intervene or negotiate.

A. For purposes of this protocol, the definition of a weapon is any firearm, knife, or instrument that can cause bodily harm or injury.

B. The facility reserves the right to inspect the contents of all packages or articles entering or being removed from the facility. Firearms and illegal weapons are prohibited from being on the premises. Weapons, dangerous devices, and illegal or unsafe items will be retained by security personnel and/or local law enforcement authorities.

C. Weapons are not permitted on the facility’s property, except for persons who are professionally exempted or authorized by law to carry a weapon in the performance of their duties, such as City, County, State, or Federal law enforcement officers.

D. All rooms with locking doors are indicated by a grey nameplate on the door, in contrast to the general white nameplate found on other doors in the hospital.

Procedure:

A. Any staff person who encounters or suspects a person brandishing a weapon or a hostage situation should

• Call the police department immediately.

• Secure immediate area if possible by removing all patients and personnel to the unit’s safe havens (grey nameplates).

• Secure unit doors to isolate incident.

• Dial the operator emergency number to report Code Silver and provide following information:

  • Location of the event and if the perpetrator is still on the scene.

  • The number of perpetrators, victims, and hostages.

  • Type of weapon(s) involved.

B. Switchboard operator will

• Initiate Code Silver announcement three times and announce location.

C. Security officer arriving at the scene will

• Report the incident to the local police department including the location and number of assailants, description of perpetrators, and approximate number of victims/hostages.

• Assess the situation.

• Take control until administration or police arrives.

• Security will supplement and reinforce personnel on the scene as the situation dictates to prevent injury to hostages.

• Advise both administration and police of all known information.
D. The security department will
   • Control access to the area until the arrival of the police department personnel.
   • Notify nursing administration.
   • Notify public relations and inform them of the situation.
   • Refer all phone calls to the Hospital Command Center (HCC) when it is established.
   • Alert the emergency room and surgery.
   • Movement within other areas of the facility away from the incident must be minimized and should be
     coordinated with the police department. Building entrances shall be evaluated and secured with the
     advice of the police. All unnecessary movement within the building shall cease.
   • Interview witnesses to determine the exact location, number, and identities of the hostages, the number
     of perpetrators/abductors and how they are armed, their apparent motivation, and any demands made.
   • Provide police with a copy of the facility layout indicating rooms, exits, windows, and utility access.
   • Assist the police department by establishing a command post for negotiators and communications.
   • Assist the police department by providing logistical and manpower support.

E. Police and administration:
   • When the police and administration arrive, the following information should be available:
     • Number of perpetrators.
     • Number of victims/hostages.
     • Previous medical conditions of victims.
     • Injuries to any victims.
     • Threats and demands made by perpetrators.
     • Type and number of weapons thought to be in the perpetrator’s possession.
     • All necessary individuals still in the area.
     • Precise area controlled by perpetrators.
     • Floor plan of the area.
     • Location and number of telephones in the area.
   • The Hospital Command Center will be established per protocol unless otherwise instructed by the
     Emergency Manager in conjunction with the police.

F. Facilities
   • Stand by and be ready to shut off utilities, phones, and medical gasses to the effected area.

G. All healthcare facility personnel
   • Upon hearing Code Silver, do not go to the area specified in Code Silver. This is an extremely danger-
     ous and sensitive situation that should only be handled by trained authorities.
   • Secure unit doors to isolate incident.
   • Staff should control entrances and exits to their units.
   • Staff should move all patients away from adjacent windows, walls, and doors, as well as all exposed
     windows in the line of sight of the area.

H. Healthcare facility personnel in the floor
   • All healthcare facility personnel in the floor of the Code Silver shall
     • Not panic and stay alert.
     • Evacuate ambulatory patients off of the Code Silver floor IF SAFE, otherwise;
• Seek shelter in safe havens (grey nameplates) and lock the door.
• All telephone extensions to the area should be identified and secured.
• Call the hospital operator and inform them
  • Where they are
  • How many people are in the room
  • How many people were on the unit (if known)
  • Any other pertinent information

I. Hospital managers
• Should report to their respective units (not on the Code Silver floor) and assume control of their area with regard to the above procedures.
• They should endeavor to make sure all patients and staff are present or accounted for, and advise the Hospital Command Center of any discrepancies.
• They should be briefed about the situation and receive instruction and assignment from the administrator in charge of the incident.
• “Floor Wardens” should be assigned to assure that each area of the facility is secured and people are protected.
• Any staff member in an area distant from the area stated in the Code Silver should
  • Take cover in safe havens (grey nameplates).
  • Avoid the Code Silver area.
  • Secure unit doors and stand by for further instructions.
  • Provide assistance as requested.
• Human resources must be notified immediately of any employee involved in a weapons incident.

J. Public relations
• The Public Relations Department will serve as a liaison with the media.
• All media coverage is to be directed by the Public Relations Office.
• Staff must NOT give out any information to the media. Media representatives may be quite assertive and some may not display official identification.
• The police will request that any and all official statements of the facility be discussed with the designated police representative before being released.

K. All clear
• At the conclusion of the incident, the police will report to the hospital Incident Commander and release the site.
• At this time, the facility may return to normal operation.
• When the incident has been resolved, an “ALL CLEAR” will be called.
• When “Code Silver, ALL CLEAR” is announced three times, anyone in need should get medical help as required and complete an incident report.
• Return to normal work duties, unless otherwise directed.

L. Critical incident stress management
• The hospital-based critical incident debriefing team should be notified of potential need by staff for intervention related to the psychological trauma of event.