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INVESTIGATION OF THE INCIDENCE AND ANALYSIS OF CASES OF ALLEGED VIOLENCE REPORTING TO THE ACCIDENT AND EMERGENCY CENTRE, ST. VINCENT'S HOSPITAL

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PREFACE

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Marjorie Cuthbert

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ABSTRACT

This report primarily studies the victims of violence who have presented to the Accident and Emergency Centre (AEC) of St. Vincent's as 'Alleged Assaults' in the six month period from the 25th December, 1988 through to the 30th June, 1989. A comprehensive profile of these cases is revealed from the structured Victim Survey that was the research tool. This study demonstrates that the victims of violence are a significant proportion of cases seen in this busy Emergency Department and it gives strong indications that violence is a prevalent problem for the whole community. This is a problem which cannot be conveniently brushed aside as media sensationalism. Evidence of this is revealed through a comparison of the Alleged Assault presentations with the Worker's Compensation, Motor Vehicle Accidents, Alcohol and Drug related presentations in the AEC. Additionally, these figures are correlated with metropolitan and statewide police figures on violence and related to the reporting of incidents to the police. Results provide a profile of the victims of assault and their attackers and these profiles are similar to those reported from a number of studies in different locations. Recommendations include the ongoing collection of data on the cases presenting to all AECs, education of staff in handling victims of violence and dealing with violent patients, and liaison with community support groups for victims of violence.

INTRODUCTION

Accidents and Emergency Centres (AEC) are generally only found in large metropolitan, base or district hospitals. As the name indicates they are for the treatment of patients suffering from accidents and associated trauma, and medical or surgical emergencies. One of the functions of an AEC is triage which is sorting patients according to the degree of urgency required for treatment. These centres were previously known as casualty centres.

For some years the staff of the Accident and Emergency Centre at St Vincent's General Hospital (SVGH), which is about one kilometre from Kings Cross in Sydney, have been routinely collecting data on the types of patients presenting for treatment (Appendix 1). Included in this data is the number of patients presenting with 'alleged assaults'. In the past three years there has been an increase in the number of patients presenting with 'alleged assaults'. There has also been an increase in the numbers referred by police and charitable organisations, and in the numbers of patients affected by alcohol. Additionally police statistics for the metropolitan area 1986-1988 (NSW Crime Statistics For The 1987/88 Financial Year p.29) show an increase in 'Offences against the person' of 15.08 per cent. These statistics indicate that violence is increasing in the population from which SVGH draws its clientele. However much more information is required to pinpoint how and where the violence occurs and

what can be done to prevent its occurrence.

Examination of the scanty literature available relating to presentations of alleged violence in AECs reveals that police statistics may not represent the full picture of numbers of victims and of assaults. Shepherd et al (1987) in a study at the Bristol Royal Infirmary, found a marked increase in violence over the ten years 1976-1986. Police records showed lower rates of violence than did hospital records.

Staff members in hospitals also encounter violence against self. Walsh (1986) in a survey of AEC staff perceptions and recollections of violence found significant differences existed between city, urban and rural AECs in the frequency and type of abuse encountered by staff members. The problem was worse in city centres than in rural centres. Walsh also found that groups of people were more likely to be violent than individuals. Walsh recommended that all violent incidents in AECs should be accurately recorded and that staff should be given training in the handling of the violent and aggressive patients.

Child abuse has also been identified as a major problem presenting to AECs. Caniano et al (1986) examined 'family unit characteristics' of 256 cases of suspected child abuse in Ohio and found that the greatest incidence of reports occurred in single parent families and the parent was the suspected abuser.

Domestic abuse has also been identified as a problem. McLeer and

Anwar (1987) found that 16-30 per cent of women presenting at AECs in Pennsylvania have injuries resulting from domestic violence. AEC staff did little towards preventing future injuries.

Most of the current information on the extent of violence in our community is based on police records. However the underreporting of violent incidents to the police is well documented (Biles and Braithwaite,1979; Robb,1988). It would seem an obvious assumption that if someone is the victim of a violent act, which causes actual bodily harm, then a likely outcome of that incident is the seeking of medical attention. Accordingly St. Vincent's Accident and Emergency Centre (AEC) discussed the presentation of the victims of violence to their department, and examined their statistics of alleged assault and related presentations (Appendix 1), to confirm their evaluation that this is a significant population within those seen in the department. It was felt that an examination of factors involved in these presentations would both contribute to the limited knowledge about the extent of violence within our community and also provide information to more effectively plan the organisation, treatment and follow-up of these patients with a view to also identifying any preventable or recurring risk factors.

As discussed in the monograph on the *Victims of Violence* (Grabosky,1989), there has been an increasing focus on 'the forgotten participants in the criminal justice system', that is, the victims. An obvious

starting point for an examination of the multifaceted factors involved in violence in our community is the location that many of those injured by acts of violence will first approach for help - the nearest Emergency Department. Whilst it has been noted that Emergency Departments can contribute to an understanding of the problems related to violence through bridging the gap between information that has almost entirely relied upon police/crime reports and infrequent National census (Shepherd, et al 1987), the little Emergency Department based research that has been undertaken has concentrated on injury surveillance (Hocking, 1988) and, in American studies, has focused on the specific issues of the Emergency Department role in 'evidence collection' (Adkinson, 1986) and development of protocols for the management of domestic violence (McLeer & Anwar, 1987, 1989).

There was little difficulty in defining the population to be studied for this research. The Concise Oxford Dictionary defines violence as 'the exercise of physical force so as to inflict injury on, or cause damage to, persons or property'. All patients who presented to AEC as a result of such an act of violence by another person were entered as Alleged Assaults in the AEC Register System on the computer and were considered appropriate for the purpose of this study. To the extent then that they all have 'actual bodily harm' there should be a correlation between those seen in AEC and the police statistics on Assaults. An important part of the analysis was

therefore to include whether the victim had reported to the police and the reasons involved in their decision to report or not report.

Other factors repeatedly mentioned in the wide-ranging literature on violence that were thought to be useful included such socio-economic and cultural issues as employment, age and sex, residence including postcode of the victim, ethnicity, group/gangs, relationship with assailant, the influence of alcohol and other drugs, and the use of weapons (Lewis, 1983; Newman, 1979; Stannard, 1987). As the information derived from this study was to be used in developing and planning hospital and support services there was a need to also identify the type and extent of the injuries received from the assault, as well as the support available to the victim on leaving the hospital.

Since the data entry for the survey was to be recorded on an Apple Macintosh SE, using the statistical software Statview 512+ (Feldman & Gagnon, 1986), and in consideration of the wide range of relevant factors that were involved in analysing the incidence of violence, it was decided that the most appropriate research tool would be a structured questionnaire (Appendix 2).

METHODOLOGY

The present study seeks to provide Australian data on the circumstances of 'alleged assaults' and characteristics of victims presenting to AEC. The

aims included:

1. through the provision of information about the incidence and type of violence that presents to the A.E.C at St. Vincent's, to contribute to the evaluation and understanding of violence in the Australian community;

2. to use the information obtained from the survey of victims of violence to review and develop protocols for the organisation and management of the 'Alleged Assaults' presenting to AEC;

3. through liaison with relevant support and community services to provide information from the victims of violence survey which could contribute to the planning and organisation of their services.

From such data it may be possible to formulate more appropriate policies and procedures for victim support and for reduction of any stress in AEC staff assisting these persons.

The St. Vincent's A.E.C is located within one kilometre of Kings Cross, Sydney. The AEC is a unit of St. Vincent's General Hospital, which has 503 beds. The hospital is a major public teaching hospital of the University of New South Wales and is operated by the Sisters of Charity. The local catchment area for the hospital includes Kings Cross, the Eastern Suburbs, parts of Bondi, Woolloomooloo, and Surry Hills (that is, the Eastern Area Health Service, Appendix 3).

All patients who presented to the AEC as a result of injury being deliberately inflicted upon them by another person or persons, have

historically been identified on the AEC computerised register as 'Alleged Assaults'. Therefore all presentations of 'Alleged Assaults' in the research period were asked to participate in the survey.

It should be noted here that severely injured victims of alleged assaults were admitted straight to the operating theatres or intensive care unit and thus these persons were not included in the survey. Victims who were dead on arrival were taken straight to the morgue. These victims also were not included in the survey.

The data were collected using a structured questionnaire which underwent a number of changes prior to conducting the main study. The questionnaire was constructed by the principal researchers and the research assistant. Each change was submitted to the full panel of researchers and AEC staff and then trialled to ensure face and content validity.

Much of the information included on the interview form is already collected by the AEC staff when completing the A & E Trauma Admission form (MR-13:12/85, Appendix 4). This A & E Trauma Admission form consists of four pages of data which records cardiorespiratory status, neurological status, coma score, trauma score. Details relating to place of injury, type of injury sustained, treatment at scene or at referring hospital, alcohol or drugs used, family and social status, physical regions injured and progress and treatment are also included on the form. A pilot

study was conducted for one month. The main study commenced at midnight on December 24th, 1988 and finished six months later at midnight on June 30th, 1989.

The proposal and the instrument for data collection were submitted to the SVGH Research and Ethics Committee for permission to undertake the study. Members of the AEC staff collected the data in addition to their normal course of duty. Reliability of responses relating to alleged assault was corroborated by accompanying persons whenever possible. Injuries received by victims also supported or refuted replies to questions asked by interviewers and this enhanced the general reliability of the data. Questions relating to actions following discharge were projective and no independent checks were made of the answers obtained.

During the six month period of the main survey 60 per cent of the 'Alleged Assaults' patients presenting to AEC consented to participate in the research, and were subsequently interviewed and a form completed. This figure includes all questionnaires where more than 12 questions were completed. It was felt that this was useful information for the data base, however it led to an increase in the number of unanswered questions in the second half of the survey form. The questions were answered in a consistent manner by the respondents and recorded consistently by the staff of AEC.

All forms on completion of interview were placed in a box in the

Assistant Director of Nursing's office in the AEC. This was to ensure that confidentiality of the information contained in the replies was maintained. Each form was numbered when data entry commenced. The first analysis consisted of calculating the number of respondents answering each question and the frequency and percentages of answers which fell into each category (Appendix 5). The second analysis consisted of a series of cross-tabulations based on a number of key factors which will be discussed in more detail later.

RESULTS AND DISCUSSION

Before proceeding to an analysis of the 512 survey forms it should be noted that the severity of the assault or other circumstances such as influence of drugs may have affected the respondent's ability to answer questions. Consequently not all questions have been answered by all respondents. The reporting of the results indicates the number of replies to each question as it is presented. Table 1 below shows the time period during which data were collected with numbers of presentations for each month. The admission figures given in brackets may be used as an indicator of severe assaults. However where the assault was so severe that the victim was unconscious or dead no questionnaire was completed. The numbers of patients in these categories can be obtained by examination of Table 4.

It will be noted in Table 1 that 'alleged assaults' occur on a regular basis throughout the year but the figures bear out the commonly held belief that the Christmas / New year holiday period and other holiday periods such as Easter are particularly busy times for this type of presentation to AEC. Sporting fixtures at the nearby Sydney Cricket Ground and Football Stadium were also demonstrated to bring about an increase in the 'alleged assault' presentations.

TABLE 1. AEC VICTIM SURVEY

Presentations of alleged assaults (Admissions in brackets)				
	December	: 184	(34)	- Pilot study
25 Dec. -	January	: 176	(55)	- Main study commenced
	February	: 113	(33)	
	March	: 169	(35)	
	April	: 147	(36)	
	May	: 118	(30)	
	June	: 131	(44)	- Main study completed
	Total	= 1038	(199)	
	Surveyed	= 512	(60%)	Completed forms, main study
		= 65	(35%)	Completed forms, pilot study

When the annual figures for aggravated and non-aggravated assault [combined] statistics for metropolitan Sydney (NSW Crime Statistics 1987/88, p.30) are examined in Table 2, there is an increase shown of 8.08% in aggravated assaults and 22.33% in non-aggravated assaults in the metropolitan area between the 1986-87 and 1987-88 figures. When the figures for these categories of offences are examined for the whole of NSW a

similar increase is identifed. For aggravated assaults the increase in NSW between 1986-87 and 1987-88 figures is 8.69% and for non-aggravated assaults 17.66%. In order to keep 'alleged assaults' as a proportion of cases seen in the AEC in context, Table 3 shows the figures for a number of major categories of patients presenting to the AEC in the twelve months from 1st July 1988 to 30th June 1989.

Table 2. COMPARISON OF POLICE AGGRAVATED AND NON ASSAULT STATISTICS FOR WHOLE OF NSW WITH ST VINCENT'S HOSPITAL AND METROPOLITAN SYDNEY

	AEC	*SYDNEY*	*N.S.W.*
July, 1986 - June, 1987	1076	9792	17501
July, 1987 - June, 1988	1416	11663	20254
July, 1988 - June, 1989	1604	Not released.	
CONTEXT : Victim survey			
Report to police ?	Yes =	38.5%	n.197
Report to police?	No =	57.4%	n.294
	No Answer =	4.1%	n. 21

Table 3. COMPARATIVE SUMMARY OF AEC PRESENTATIONS AND ADMISSIONS FROM 1ST JULY, 1988 TO 30TH JUNE, 1989

	PRESENTATIONS	*ADMISSIONS*
Chest pain	1973	1075
Alleged Assault	1604	407
Workers Compensation	1390	147
Drug / Alcohol	1192	589
Motor Vehicle Accident	875	300
Overdose	760	403
Known Aids	523	377

Table 4 displays the figures for the period covered by the survey, the first six months of 1989 only. For a full summary of the results obtained from respondents see Appendix 5 which contains numbers and percentages of respondents answering each category of each question in the survey. An overview of the results obtained is provided in Table 5.

Table 4. SUMMARY OF AEC PRESENTATIONS FROM 1ST JANUARY, 1989 to 30TH JUNE, 1989.

TOTAL NO. OF PRESENTATIONS	16604
Number of Males	10450
Number of Females	6150
Average Age	40,
NO. OF PATIENTS COVERED BY:	
'Alleged Assault' Patients	854
Workers Compensation	691
Victims of Motor Vehicle Accidents	447
Victims of Overdose	377
Drug / Alcohol Patients	641
Known Aids Victims	284
Patients Dead on Arrival	127
Patients Dead in AEC	61

From the tables presented and from the results shown in Appendix 5 it is clearly demonstrated that most of the 'alleged assault' victims surveyed were young, single males (85% n=436). Of those who were victims of streeet violence which is the most common type of violence, 90% were

males (n=359) and they were likely to be under the influence of alcohol (54% n=276).

Table 5. OVERVIEW OF RESULTS OF AEC 'ALLEGED ASSAULT' VICTIM SURVEY BY MODAL CATEGORY

VICTIMS	*MODAL CATEGORY*	*n*	*%*
Age	20-29 years	268	52
Gender	Male	436	85
Marital status	Single	355	69
Postcode of victim	Local	238	46
Residence	With family/ friends	320	63
Race	Caucasian	458	89
Occupation	Unemployed	68	13
Drug influence	Yes	303	59
Which drugs?	Alcohol	276	54
Time of alleged assault	12mn-3am	191	37
Day of alleged assault	Sunday	121	24
Category of assault	Street attack	398	78
Treatment required	Outpatients	387	75
Location of injury	Head & neck	277	54
Type of injury	Open wound	129	25
Type of assault	Hit/punched /attacked	177	35
Location of assault	Kings Cross/ Darlinghurst	219	43
Knew attacker?	No	372	73
Weapon involved	No	265	52
Reported to police	No	294	57
Destination after hospital	Own home/flat	319	62
Accompanied by another	No	194	38
Relative or friend stay	Yes	317	62
This happen before	No	320	63

These males were also likely to have come from the eastern metropolitan and city areas (46% n=238) and to have been in or near a hotel or club in Kings Cross at the time of the incident. Most incidents occurred between the hours of 9 pm and 6 am (75%, n=383) on Thursday, Friday, Saturday and Sunday nights (78%, n=397). It was unlikely that the violent incident was reported to the police (57%, n=294). Most of those injured had lacerations, abrasions or bruising around the head and neck area (54%, n=277) and were allowed to go home after treatment in the AEC.

These findings support those of Yates and Chambers (1987) who found that 'between 2% and 5% of their patients who have been injured in accidents claim to have been assaulted' These researchers also found that the numbers increased markedly on New Year's Eve with all of the patients being intoxicated. They state that these cases were always handled by junior residents and hence the 'link with alcohol was rarely emphasised'.

Shepherd et al (1987) who investigated changing incidences of violence at Bristol Royal Infirmary found that 34% of assaults took place 'in or near discos or public houses and 16% at home'. In the SVH study 78% of alleged assaults were street violence, often close to, or after leaving a hotel, disco or licensed restaurant, and 12% were domestic violence.

Table 6. OVERVIEW OF RESULTS ON 'ALLEGED ATTACKERS' FROM AEC 'ALLEGED ASSAULT' VICTIM SURVEY BY MODAL CATEGORY

ALLEGED ATTACKERS	*MODAL CATEGORY*	*n*	*%*
No. of attackers	One	247	48
Age of alleged attackers	20-29 years	304	59
Racial origin	Caucasian	334	65
Drug influence of all attackers	Yes	219	43
Drug of influence	Not known	224	44

The latter result was surprising as it was unexpectedly higher than anticipated although McLeer and Anwar (1987) generally found that the incidence of battered women ranged from 21% to 29% in the four studies they reviewed. They suspected that 'many battered women pass through emergency departments undetected' and that may well have been the case in SVH. Shepherd et al (1987) also found that many assault cases were unreported as did Biles and Braithwaite (1979). The same was true of victims in this study as there was a general reluctance to report the assault to police.

Results have demonstrated that child abuse is not a problem at SVGH as the hospital does not have a paediatric department. Sick or injured children usually attend one of the two hospitals for children in the metropolitan area and these hospitals should be able to provide figures for this type of violence against children.

Whilst the analysis confirmed both the anecdotal impressions of the AEC staff and the profiles that have been developed in the literature (Grabosky, 1989; Lewis, 1983) a more detailed analysis was developed through cross-tabulations using the SPSS programme (SPSS Inc., 1989) in the computer services department of the University of New South Wales. The cross-tabulations examined five key factors - sex differences, the drug influence of the victim, the drug influence of the alleged assailant, whether the victim had been assaulted before and the reporting of the

alleged assault to the police.

1. SEX DIFFERENCES

Single males (males 86%, n=510, p < .03) were more likely to be victims of violence than females and 90% of the 302 victims under the influence of drugs at the time were also males (n=510, p < .001). The drug influence for victims of alleged assaults of both sexes was usually alcohol (males 58%, n=252, females 31%, n=23, p<.000).

Table 7. SEX DIFFERENCES BETWEEN VICTIMS OF ALLEGED ASSAULTS

QUESTION	NUMBER OF RESPONDTS	MALES	FEMALES	X2	DF	P	NO. CELLS WITH Fe<5
1 - Age	510	436	74	4.56	1	<.03	8 of 18
8 - Drugs	510	436	74	9.79	1	<.001	1 of 6
8 - Which drug	510	436	74	14.60	1	<.000	12 of 18
9 - Time	510	436	74	7.93	1	<.004	5 of 18
11-Type assault	510	436	74	20.33	1	<.000	12 of 18
12-No.attackers	510	436	74	10.70	1	<.001	2 of 12
18-What happen	510	436	74	7.44	1	<.006	32 of 52
21-Know attacker	510	436	74	15.47	1	<.000	1 of 6

The time of alleged assaults varied between sexes. Attacks on females were more likely to occur earlier in the night from 6pm onwards with the peak time between midnight and 3am. This was also a busy time for attacks on males but males were more likely than females to be attacked between 3am and 6am (Table 8).

Table 8. SEX DIFFERENCES IN TIME OF ALLEGED ASSAULT

TIME	*MALES*		*FEMALES*	
HOURS	*n*	*%*	*n*	*%*
12mn- 3am	168	39	22	30
3am - 6am	82	19	5	7
6am - 9am	14	3	2	3
9am -12md	12	3	4	5
12md - 3pm	23	5	6	8
3pm - 6pm	14	3	4	5
6pm - 9pm	27	6	13	18
9pm -12mn	90	21	15	20
No ans/Dont know	6	1	3	4
Total	436	100	74	100

Male victims were more likely to be engaged in an assault that involved two or more people (55%, n=241 males, and 30%, n= 22 females were attacked by 2 or more persons) and usually did not know the assailants whereas a higher proportion of females did know the aggressors (Table 9). The assault for males was most likely to have occurred in the street or in or near a hotel or club and was not likely to be reported to the police by the victim (58%, N=254 of males and 54%, n=40 did not report alleged assault). Females were more likely to be victims of domestic violence than males (51%, n=38 of females and 82%, n=359 of males were victims of street violence while 7%, n=32 males and 38%, n=28 females were assaulted in the home).

Table 9. SEX DIFFERENCES IN VICTIMS KNOWLEDGE OF IDENTITY OF ALLEGED ATTACKERS

KNEW IDENTITY OF ATTACKERS	*MALES*		*FEMALES*	
	n	%	n	%
Yes	82	19	35	47
No	337	77	33	45
No Reply	17	4	6	8
Total	436	100	74	100

In contrast, the female victim was less likely to have been under the influence of drugs than her male counterpart (62%, n=272 males and 41%, n=30 females p<.001 were under influence of drugs). Females were more likely to have been victims of assault in their own homes and this assault usually occurred earlier in the evening than the male assaults (38% females n=28 and 7% n=32 males p<.001 were victims of domestic violence). Women had an equal likelihood of informing the police of the assault and were often the victims when the police were called to the scene (only 38% n=166 males and 40% n=30 p<.4 women reported the alleged attack). Therefore the main sex difference in cases of alleged assault presentations was that females were more likely to have been involved in domestic violence while males were involved in street violence

2. VICTIM'S DRUG INFLUENCE

Significantly more male victims were under the influence of drugs than female victims. Of the 62% n=302 victims under drug influence 90% n=272 p<.001 were males. The victims under the influence of drugs were more likely to be the victims of street violence (84% n=254, p<.001) even though this was the most common type of violence experienced. The drug most commonly affecting both sexes was alcohol (92% n=272 p<.001). Alcohol was also the drug most commonly affecting both victim and attackers (70% n=120 X^2 7.8 DF 1 p<.005 attacks where both victim and attackers were affected). This supports the findings of Yates and Chambers (1987) that alcohol often affected both the attacker and the victim. Older victims of both sexes were less likely to be under the influence of drugs (Table 10). It is worth noting that the modal age of the victims under the influence of drugs is the same modal age as that for the alleged attackers (Table 6).

There was a significant difference in marital status between the victims under the influence of drugs and those who were not (X^2 4.3 DF 1 p<.04). The majority of victims were single (69% non-drug and 70% for those under the influence) but the group under the influence had higher percentages in the widowed, divorced, and separated categories and fewer in the married group.

There was no significant difference between the occupations of those in the group influenced by drugs and those not so influenced, but there were significant occupational differences within the groups. The group who were under the influence of drugs (62% n=302, p<.01) contained similar numbers of managers, professional and para-professional persons but higher numbers of tradespersons, salespersons, tourists, labourers, unemployed and those on pensions and social security benefits. The victims influenced by drugs were also less likely to report the alleged attack to the police (68% n=184 p<.01) than those not under the influence (53% n=94).

Table 10 - AGES OF VICTIMS UNDER INFLUENCE OF DRUGS

AGE RANGES	*n*	*%*
0 - 9 Years	2	1
10 - 19 Years	36	11
20 - 29 Years	174	58
30 - 39 Years	58	19
40 - 49 Years	20	7
50 - 59 Years	7	2
60 - 69 Years	5	2
Total	302	100

3. ASSAILANT'S DRUG INFLUENCE.

Attackers were less likely than victims to have been under the

influence of drugs but again in those alleged attackers affected by drugs, alcohol was the drug found to be a significant influence (64% n=134, p<.001). This was difficult to evaluate with any reliability however, as it was dependent on the victim's perception of the attacker's age and drug influence. In only 23% (n=117) of cases overall was the attacker known to the victim.

Table 9 provides further clarification of sex differences in knowledge of attacker. When victims were attacked in the street those responsible for perpetrating the violence were much more likely to be under the influence of drugs, (X^2 8.11, DF 1, p<.004) particularly alcohol. Drugs were also implicated in domestic violence (Table 11).

The Australian Institute of Criminology (1989: 27-31) report a number of studies carried out in Australia in recent years which link alcohol with violent assaults. They suggest that 'many assaults co-incide with hotel and pub closing times' (p.29). Our findings certainly support this statement (Table 8). Tomsen et al (1989:16-20) in their study of situational variables which contribute to violence in and around suburban hotels and other drinking places found that violence was more likely to occur in 'the busy periods late at night, and towards or during the weekend' and was influenced by the 'patron type, the social atmosphere, drinking and staff behaviour'. Again their conclusion supports the results of this study.

Table 11. DRUG INFLUENCE OF ALLEGED ATTACKERS BY TYPE OF ALLEGED ASSAULT

TYPE OF ASSAULT	*NO DRUGS*		*DRUG INFLUENCE*	
	n	*%*	*n*	*%*
Street violence	43	58	166	76
Elder abuse	-	-	1	.4
Police violence	4	5	1	.4
Domestic violence	16	21	33	15
Workplace violence	5	7	7	3
Verbal abuse	-	-	1	.4
Criminal intent	7	9	8	4
Gay/racist violence	-	-	2	1
Total	75	100	219	100

NB. Percentages have been rounded off to the nearest whole number.

4. PREVIOUS EXPERIENCE OF ASSAULT

Proportionately more females than males were likely to have been assaulted before although the difference was not statistically significant. The first attack was more likely to have been within the last 12 months for both sexes although almost as many males reported the first attack occurring five or more years ago, as those reporting in the last 12 months. Of the 34% n=164 who had been vicitims of violence on a previous occasion 19% n=31 had required hospital admission, 35% n=57 had needed outpatients treatment while 46% n=75 had not been injured sufficiently enough to require treatment.

5. REPORT TO POLICE

A majority of victims did not intend to report the alleged assault to the police (57.4%, n= 294). Sex of victim was not a significant factor in determining whether to report or not report the alleged assault and neither was age of victim. However drug inflence was a factor in whether assault was likely to be reported to police. Those victims affected by drugs were less likely to report than those not affected by drugs (64% n=188, p<.001).

In an Australian wide study by Biles and Braithwaite (1979) it was found that the majority of crimes were not reported to police. Only 46% of assaults were reported with by far the greater number of these being reported by males. The type of crime against females influenced the liklihood of it being reported. Biles and Braithwaite found that 'females were almost twice as likely as males to report fraud, forgery, false pretences to the police'. As reported above sex did not influence the reporting of alleged assaults to the police in this study.

The three months study by Hocking (1987) carried out in a teaching hospital in Lewisham, a borough close to London, found also that assault victims formed a significant part of the patient population. Most were male victims aged 15-30 years who 'was punched while on the street or in a public house and was likely to have been drinking'. Again only 46% of the cases were reported to police.

CONCLUSION

Although this study only examined the alleged assault population of one AEC in an area close to the entertainment heart of the city, the findings show that this is a considerable and growing proportion of the patient population. The fact that many of these assaults are not reported to the police, begs the recommendation that all AECs should collect similar data on an ongoing basis. Further research is required to determine whether cases of alleged assault are a significant proportion of other AECs in Australia. Research is also required to determine whether the patient characteristics are similar to those of the SVH AEC population and whether the needs of these types of patients and the staff who care for them are being met.

Such ongoing data from AECs would provide information on the types of violent actions committed in suburban and rural areas as well as metropolitan precints. This data could be compared to that obtained by the police of similar occurrences of violent episodes because it appears that hospitals may well be dealing with a different population to that which comes to the notice of the police.

This study has certainly fulfilled the original aim of providing an understanding of the characteristics of the patients presenting to AECs suffering from an alleged assault. It has also enabled the staff to arrange inservice education on issues related to dealing with agressive patients and

the needs of particular groups of patients such as those suffering from domestic violence. Until this study was undertaken this group of patients was not recognised as a significant part of the patient population of this hospital and it is possible that staff may have been missing cases.

Since this study commenced the awareness of this problem in the eastern suburbs has grown. The Randwick Domestic Violence Group, set up under the auspices of the Department of Family and Community Services, have commenced a number of mutual help groups which will commence in April, 1990 to coincide with Domestic Violence Month (Arnold, 1990). These groups will be a vital resource for AEC staff. However for both domestic violence and child abuse cases it is necessary to have a protocol which staff can follow when patients who are suspected of suffering from this type of violent act are admitted. Ricci (1986) provides a protocol and suggested work-up for chilren who are suspected victims of abuse.

The instrument used by Mcleer and Anwar (1987) in domestic violence cases could well be a model to guide protocol development in AECs. The researchers (Mcleer & Anwar, 1989) found that use of the instrument in female trauma cases increased detection of battering by 25 per cent.

It is hoped that this report will be widely disseminated to other hospitals, health services and police organisations so that appropriate policies can be formulated to reduce the problem of assaults against

persons. Within AECs there is a need to monitor the patient population and ensure that the policies and protocols meet the needs of both patients and staff for the best possible care. The costs of monitoring and attempted prevention of these assaults are likely to be less than the costs of treatment and ongoing care are to the community.

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APPENDIX 1

1.1 - PRESENTATIONS OF ALLEGED ASSAULTS AT AEC

YEAR	1986	1987	1988
JANUARY	69	80	144
FEBRUARY	40	126	113
MARCH	50	90	123
APRIL	45	123	126
MAY	71	107	125
JUNE	61	127	98
JULY	40	94	93
AUGUST	57	96	87
SEPTEMBER	60	105	91
OCTOBER	67	108	
NOVEMBER	109	120	
DECEMBER	90	164	
TOTAL	759	1340	1000

1.2 - PATIENTS REFERRED BY POLICE

YEAR	1986	1987
JANUARY	8	23
FEBRUARY	7	32
MARCH	9	22
APRIL	15	22
MAY	25	23
JUNE	13	23
JULY	18	29
AUGUST	11	22
SEPTEMBER	12	12
OCTOBER	10	
NOVEMBER	30	
DECEMBER	22	
TOTAL	180	208

1.3 - NUMBER OF PATIENTS REFERRED BY MATTHEW TALBOT

GORMAN HOUSE AND MISSION BEAT

YEAR	1986	1987
JANUARY	19	21
FEBRUARY	21	21
MARCH	31	20
APRIL	27	24
MAY	19	19
JUNE	19	25
JULY	20	29
AUGUST	18	19
SEPTEMBER	21	15
OCTOBER	28	
NOVEMBER	21	
DECEMBER	14	
TOTAL	258	193

1.4 - NUMBER OF ALCOHOL RELATED PATIENTS PRESENTING TO

ACCIDENT AND EMERGENCY CENTRE

YEAR	1986	1987	1988
JANUARY	11	20	24
FEBRUARY	23	41	25
MARCH	26	25	32
APRIL	19	23	30
MAY	11	19	32
JUNE	15	23	33
JULY	16	25	22
AUGUST	17	21	26
SEPTEMBER	29	25	21
OCTOBER	22	29	
NOVEMBER	38	25	
DECEMBER	25	32	
TOTAL	252	308	245

1.5 - NUMBER OF DRUG RELATED PRESENTATIONS TO AEC

YEAR	1986	1987	1988
JANUARY	35	44	84
FEBRUARY	43	70	92
MARCH	50	62	73
APRIL	56	65	55
MAY	54	80	64
JUNE	30	59	61
JULY	45	67	79
AUGUST	43	53	55
SEPTEMBER	42	66	58
OCTOBER	61	97	
NOVEMBER	53	81	
DECEMBER	57	70	
TOTAL	569	814	621

Appendix 2-

ST VINCENT'S ACCIDENT AND EMERGENCY CENTRE
VIOLENCE SURVEY

1. Age of victim
   0- 9 yrs ☐ 10-19 yrs ☐ 20-29 yrs ☐ 30-39 yrs ☐ 40-49 yrs ☐ 50-59 yrs ☐ 60-69 yrs ☐ 70-79 yrs ☐ 80+ yrs ☐
   .....yrs

2. Sex of victim
   Male ☐ Female ☐ Other ☐

3. Married ☐ Single ☐ Widowed ☐ Divorced ☐ Other ☐

4. Residential postcode of victim .....Overseas country.....

5. Residence? With family ☐ With friends ☐ Lives Alone ☐ Refuge ☐
   Hotel ☐ Hostel ☐ Streets ☐ Nursing Home ☐

6. What is the racial origin of victim?
   Caucausian ☐ Aboriginal ☐
   Negro ☐ Asian ☐
   Other.....

7. What is the occupation of victim?
   Manager or Administrator ☐
   Professional eg. Lawyer ☐
   Para-profess eg. Teacher ☐
   Tradesperso. ☐
   Clerk ☐
   Salesperson or Personal Service Worker ☐
   Armed Services ☐
   Overseas Tourist ☐
   Tourist living in Australia ☐
   Plant and Machine Operator ☐
   Driver ☐
   Labourer or related worker ☐
   Unemployed ☐
   Student ☐
   Home duties ☐
   Social Security Benefit ☐
   Pensioner ☐
   St Vincent's Employee ☐
   Other (specify).....

8. Is victim under influence of drug/s? Not known ☐ No ☐ Yes ☐
   Which Drug/s? Alcohol ☐ Other.....

ALLEGED ASSAILANTS

9. Time of alleged assault
   2400-0259 ☐ 0300-0559 ☐ 0600-0859 ☐ 0900-1159 ☐ 1200-1459 ☐ 1500-1759 ☐ 1800-2059 ☐ 2100-2359 ☐

10. Day of alleged assault..... Date of alleged assault / /198

11. Type of alleged assault

Child abuse	☐	Street violence	☐
Sexual Assault	☐	Elder abuse	☐
Police violence	☐	Other	☐
Domestic violence	☐		

Comment (to clarify and justify type of assault).....

.....

.....

12. Number of alleged attackers 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5≥ ☐

13. Age/s of alleged attacker/s

0- 9 yrs	☐	30-39 yrs	☐	60-69 yr	☐
10-19 yrs	☐	40-49 yrs	☐	70-79 yrs	☐
20-29 yrs	☐	50-59 yrs	☐	80+ yrs	☐

14. What was racial origin of alleged assailants?

Caucausian	☐	Aboriginal	☐
Asian	☐	Negro	☐

Other.....

15. Was alleged assailant/s under influence of drugs? No ☐ Yes ☐

Not known ☐

Which Drug/s? Alcohol ☐

Not known ☐

Other.....

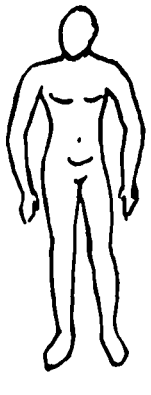
INJURIES RECEIVED

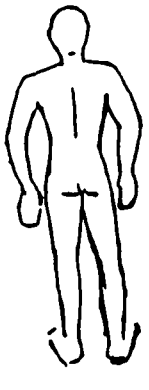
16. How badly is victim hurt?

Required hospital admission ☐

Required medical or other health workers treatment ☐

17. What injuries were received? (Please mark injuries on diagram and tick box for type of injury)





Open wound	☐
Abrasion	☐
Contusion	☐
Fracture	☐
Sprain / strain	☐
Concussion	☐
Visceral Injury	☐

18. What happened to you?.....

.....

19. What were you doing at the time?.....

.....

20. Where did the alleged assault occur?.....

.....

21. Is alleged attacker/s known to you? Yes ☐ No ☐

22. Was a weapon involved in this attack? No ☐ Yes ☐

23. What kind of weapon?

Blunt instrument	☐	Fist	☐
Shotgun/rifle/Pistol	☐	Boot	☐
Knife	☐		

Other(please specify).....

24. Did you report this alleged incident to the police? No ☐ Yes ☐

If no, why did you not report it?.....

.....

If yes, what was the police action?.....

.....

25. Where will you go when you leave hospital?

Own home/flat/unit	☐	Hotel	☐	Rooming House	☐
To a friend's place	☐	Work	☐	Hostel	☐
Refuge	☐	Other	☐	Do not know	☐

26. Will anyone be going with you?

		No	☐	Partner/ Spouse	☐
Relatives	☐	Friends	☐	Other	☐

Other (please specify).....

27. Will a relative or friend be staying with you? No ☐ Yes ☐

PREVIOUS INJURIES RECEIVED

28. Has this happened before? Yes ☐ No ☐

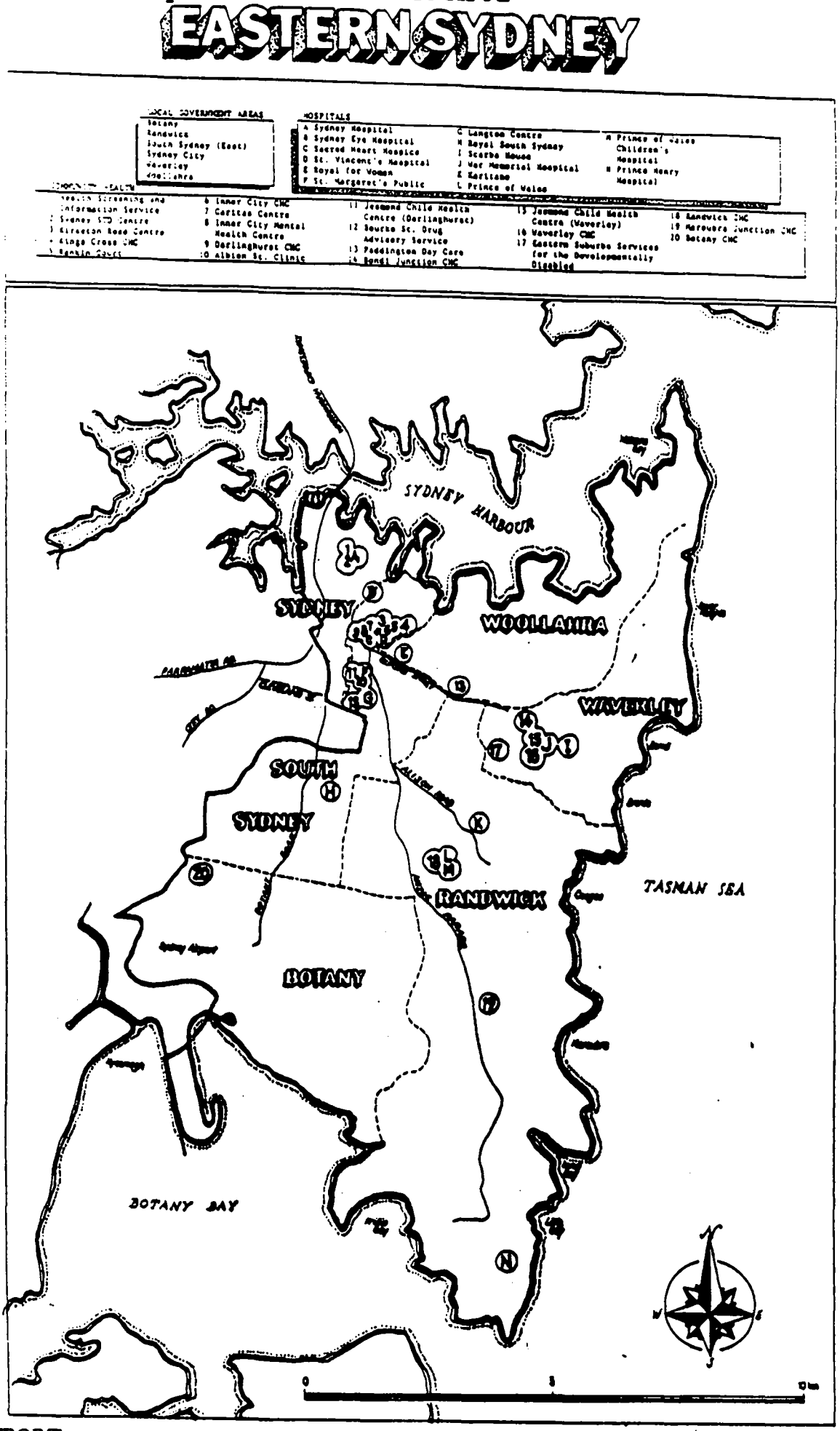
29. When did it first happen?

< 1 year	☐	1-2 yrs	☐
3-4yrs	☐	5 yrs+	☐

30. How badly have you been hurt in the past?

Required hospital admission	
Received outpatients treatment	☐
No treatment required	☐

Appendix 3- Map of the Catchment Area



Appendix 4- St Vincent's Hospital A & E Trauma Admission Form

ST. VINCENT'S HOSPITAL, SYDNEY.

Title	Family Name	MRN	
Given Names		CMO	
Address	Street	Age	Sex HIS
Suburb	Postcode	Adm date	

Date:

Assessment time: ____ hours

RR ☐ Cas ☐ Obs ☐

Prim. Care ☐ Fract. Clinic ☐

CARDIORESPIRATORY STATUS

Pulse rate = _____/min.

Blood Pressure — A

Systolic	> 90	4
	70-90	3
	50-69	2
B.P. _____/_____	< 50	1
	0	0

Capillary Filling — B
(Forehead, lip, mucosa, nailbed)

< 2 secs	2
> 2 secs	1
nil	0

Respiratory Rate — C

10-24	4
25-35	3
> 35	2
< 10	1
0	0

Rate = _____/min.

Untestable because of: drugs ☐ : other causes ☐

Respiratory Effort — D

Normal	1
Shallow, retractive	0

Untestable because of: drugs ☐ : other causes ☐

Cardiorespiratory score untestable ☐

CARDIORESPIRATORY SCORE (A+B+C+D) — E
Maximum total score = 11

NEUROLOGICAL STATUS

Pupillary size and response

	R.	L.
Size (mm)		
Reaction		
No reaction		
Untestable		

Eye Opening — F

-spontaneous	4
-to voice	3
-to pain	2
-Nil	1

Untestable due to: drugs ☐ : other causes ☐

Verbal Response — G

-Orientated	5
-Confused	4
-Inappropriate words	3
-Incomprehensible	2
-Nil	1

Untestable due to: drugs ☐ : other causes ☐

Best Motor Response — H

-Obeys command	6
-Localises	5
-Withdrawal	4
-Abnormal flexion	3
-Extension	2
-Nil	1

Untestable due to: drugs = : other causes —

Coma score untestable ☐

COMA SCORE (F+G+H)
Maximum total score = 15

IF COMA SCORE		
	14-15	5
	11-13	4
	8-10	3
	5- 7	2
	3- 4	1

TRAUMA SCORE (E+J) _____
Maximum total score = 16

NOTE: If trauma score is below 13 contact surgical registrar and ICU registrar.

NATURE OF ACCIDENT

M.V.A.	Driver	—
	Passenger-Front	=
	-Back	=
	Seatbelt	YES NO
M.B.A.	Rider	=
	Pillion	=
	Helmet	YES / NO
Pedestrian		—
Pedal cyclist		—
	Helmet	YES / NO
Personal assault		—
Stabbing		—
Gunshot		—
Industrial		—
Fall		—
Other		—

Date of injury: _____

Time of injury: _____ hours

Fasted since: _____ hours

A & E Trauma Admission

PLACE OF INJURY:
Street and highway ☐
Home ☐
Residential institution ☐
Industrial premises ☐
Public building ☐
Recreation and sport ☐
Farm ☐
Other ☐

DETAILS OF ACCIDENT SCENE
Loss of consciousness-immediate ☐
-delayed ☐
How long? _____
Cardiac Arrest ☐
Hypotension ☐
External bleeding ☐
Site _____
Vomiting ☐
Airway Obstruction ☐
Other (specify) _____

TREATMENT AT SCENE, REFERRING HOSPITAL OR DURING TRANSPORT.
Nil specific ☐
IV Fluids
Type _____
Volume _____
Intubation (ETT) ☐ Chest tube ☐
CPR ☐ Cervical Collar ☐
MAST Suit ☐ Limb Splint ☐

Medications:
Type _____
Dose _____
Other _____

ALCOHOL & DRUGS	YES	NO	UNKNOWN
Alcohol in last 12 hrs			
Alcohol on breath			
Illicit drugs in last 12 hrs.			

DESCRIPTION OF INCIDENT: _____

PREVIOUS ILLNESS AND OPERATIONS:
C.N.S.
C.V.S.
Resp.
Per. Vasc.
Renal
Other

MEDICATIONS:

ALLERGIES (specify) _____

Previous Blood Tranfusion: YES ☐ NO ☐
Tetanus Immunisation: YES ☐ NO ☐
Date of Last:

FAMILY AND SOCIAL:
Marital Status: M S W D O
Occupation: _____
Alcohol _____ gm/day. Tobacco _____
Illicit drugs _____
Family History: _____

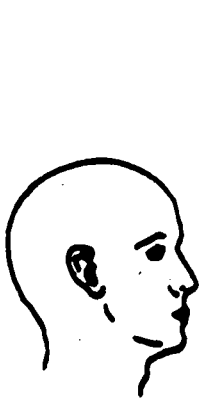
REGIONS INJURED (Also indicate on Diagram)

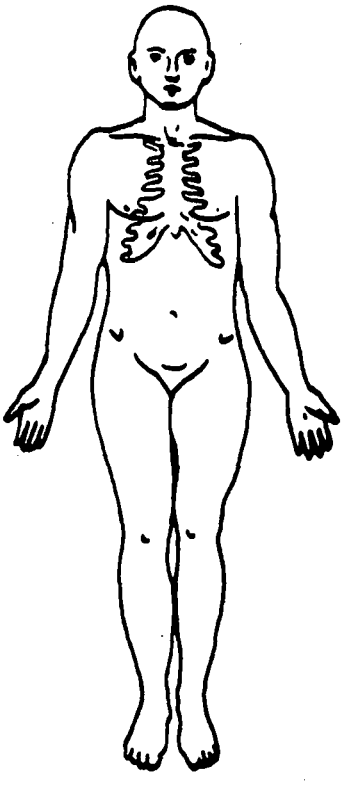
	YES	NO	POSSIBLE	PENETRATING	BLUNT
Head & Face					
Neck/Cerv. Spine					
Chest					
Abdo/Pelvis					
Perineum					
Back/Thoraco-lumbar spine					
G.U. Tract/ Haematuria					
R. Upper Limb					
L. Upper Limb					
R. Lower Limb					
L. Lower Limb					

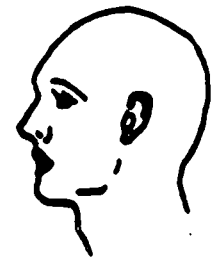
PHYSICAL FINDINGS:

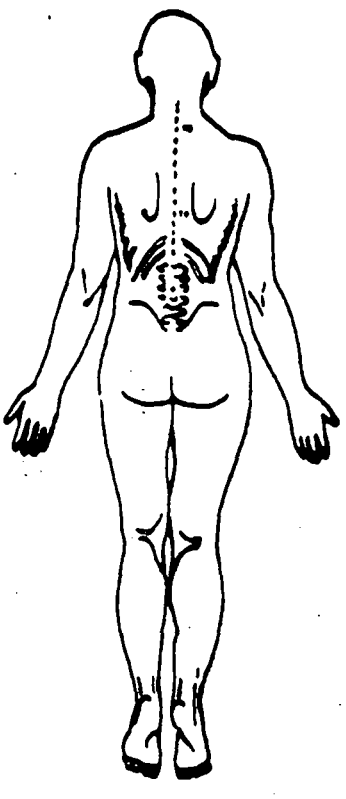
RIGHT

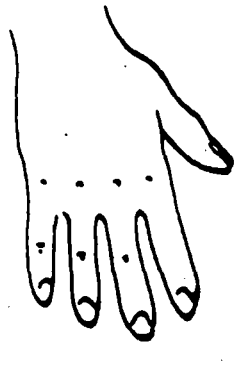
LEFT

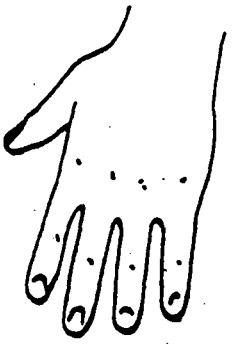












CROSS-MATCH/BLOOD TESTS/RESULTS

O Negative or group compatible units

Partial cross- match units

Full cross-match units

Blood alcohol specimen number:

FBC ☐

MBA12 ☐

Amylase ☐

BSL ☐

ABG ☐

X-RAYS/OTHER TESTS/ RESULTS

Cervical Spine ☐

Erect Chest ☐

Supine Chest ☐

Skull ☐

Head C.T. ☐

Other:

ECG ☐

MEDICAL OFFICER

(Signature) (Block Letters)

PROGRESS AND TREATMENT

Appendix 5- Results of the Violence Survey

ST VINCENT'S ACCIDENT AND EMERGENCY CENTRE
VIOLENCE SURVEY

Age of victim	%			%			%	
0-9 yrs	1	3	30-39 yrs	19	97	60-69 yrs	2	11
10-19 yrs	12	63	40-49 yrs	9	48	70-79 yrs	1	3
20-29 yrs	52	268	50-59 yrs	3	17	80+ yrs		
No Answer	1	2	n = 512					

Sex of victim	%			%			%	
male	85	436	Female	14	74	No Answer	1	2

	%			%			%	
Married	15	78	Single	1	6	Divored	7	35
Other	5	26	No answer	2	12	n=512		

Residential postcode of victim...	%			%	
Overseas country	7	39	Other	38	191
Eastern Metropolitane City	46	238	No Answer	9	44
			n= 512		

Residence?	%			%		
With family	27	139	With friends	35	181	
Lives Alone	19	96	Refuge	1	5	
Hotel	4	21	Hostel	9	46	
Streets	3	13	No Answer	2	11	n=512

What is the racial origin of victim?					
Caucausian	90%	458	Aboriginal	2%	10
Negro	1%	5	Asian	3%	16
Islander	2%	11	n=512		

What is the occupation of victim?

	%			%	
Manager or Administrator	6	32	Plant and Machine Operator	4	19
Professional eg. Lawyer	11	55	Driver		
Para-profess eg. Teacher			Labourer or related worker	8	42
Tradesperson	12	63	Unemployed	14	68
Clerk	5	24	Student	5	26
Salesperson or Personal	7	37	Home duties	1	7
Service Worker			Social Security Benefit	7	32
Armed Services	2	12	Pensioner	5	26
Overseas Tourist	5	26	St Vincent's Employee		
Tourist living in Australia			Other (specify)		
			Journalist/Media	2	11
			Other	5	25
			No Answer	1	7

8. Is victim under influence of drug/s?

Not known	5%	23	No	36%	186	Yes	59	303

Which drug/s?

Alcohol	54%	276	Other	5%	24
Not known/No Answer	5	27	n=512		

AGED ASSAILANTS

9. Time of alleged assualt

	%			%	
2400-0259	37	191	1200-1469	6	29
0300-0559	17	87	1500-1759	3	18
0600-0859	3	16	1800-2059	8	40
0900-1159	3	16	2100-2359	21	105
				n=512	

10. Day of alleged assault

		%		Date of alleged assualt
	Sunday	24	12	/ 19
	Monday	8	39	
	Tuesday	7	38	
	Wednesday	7	38	
	Thursday	16	82	
	Friday	16	83	
	Saturdy	22	111	
	Total	100	512	

11. Type of alleged assualt

	%		%	
Child abuse		Street violence	78	398
Sexual Assualt		Workplace violene	3	16
Police violence	6	Criminal intent	5	27
Domestic violence	60	Other	1	5
			n=512	

Comment (to clarify and justify type ofassualt).....
.....
.....
.....
.....

12. Number of alleged attackers

	%			%	
1.	48	247	2.	15	79
3.	12	62	4.	6	30
5.	14	71			
No Answer	5	23			

13. Age/s of alleged attacker/s

	%			%		
0- 9 yrs			30-39 yrs	13	68	60-69 yr
10-19 yrs	11	55	40-49 yrs	5	27	70-79 yrs
20-29 yrs	60	304	50-59 yrs	2	8	80+ yrs
All other ages	2	12				

4. What was racial origin of alleged assailants?

	%			%		
Caucausian	65	334	Aboriginal	8	43	
Asian	4	19	Negro	4	18	
Islander	8	41	Other	5	25	n=512
			No Answer/Unknown	6	32	

5. Was alleed assailants under influence of drug?

	%			%		
No	15	75	Yes	43	219	
Not known	39	200	No answer	3	18	

Which drug/s?

Alcohol	33	169	Nil Drugs	14	
Not known	44	224			
Other	6	29	No answer	3	16

n=512

NJURIES RECKIVED

6. How badly is victim hurt? n=512

	%	
Required hospital admission	24	125
Required medical or other health workers treatment	76	387

7. What injuries were received?

	%	
Open wound	39	201
Abrasion		
Contusion	10	52
Fracture	7	37
Sprain/strain	2	9
Concussion	6	29
Visceral injury	5	5
Multiple injuries	30	153
No answer	5	26

8. Wat happened to you?.....
.....

9. What were you doin at the time?.....
.....

0. Where did the alleed assualt occur?

	%	n
Hospital	1	4
Eastern suburbs	9	45
Residence	12	60
Kins Cross, Darlinurst, Paddington	41	213
Street/Public place	30	153
Other	2	9
No answer	5	28

n=512

21. Is alleed attacker/s known to you?

	%			%		
Yes	23	117	No	73	372	n=512
No answer	4	23				

22. Was a weapon involved in this attack?

	%			%		
Yes	40	207	No	52	265	n=51
No answer/unknown	8	40				

23. What kind of weapon?

	%	n		%	n
Blunt instrument	14	73	Fist	30	154
Shotgun/rifle/pistol			Boot	2	4
Knife/sharp instrument	9	45	Fist & boot	14	71
Other	3	14	No answer/nil	28	143
			n=512		

24. Did you report this alleged incident to the police?

	%			%		
No	57	294	Yes	39	197	
No answer	4	21				

If no, why did you not report it?	%	n
Did not want trouble	9	42
Not important	20	106
Previous experience negative	5	22
If yes, what was the police action?		
Reported	39	198
Will report later hospital first	15	84

Q24 100% n=512

POLICE ACTION	%	
Not reported	56	289
Report taken & investigate	14	73
Arrest	4	22
Don't know	7	33
Hospital	7	35
Don't want follow up	2	9
No answer	10	52
	n=512	

25. Where will you go when you leave hospital?

	%			%	
Own home/flat/unit	71	361	Hotel + Rooming house	8	41
To a friend's place			Work		
Refuge + hostel	8	42	Other	5	28
Do not know	4	20	No answer	4	20
			n=512		

26. Will anyone be going with you?

	%			%	
No	38	194	Relatives/Partner/Spouse	21	109
No answer	5	25	Friends	34	173
Other	2	11	n=512		

7. Will a relative or friend be staying with you?

	%			%	
No	33	167	Yes	62	317
No answer	5	25	n=512		

REVIOUS INJURIES RECEIVED

. Has this happened before?

	%			%	
Yes	33	167	No	62	320
No answer	6	25	n=512		

. When did it first happen?

	%			%	
Never	62	320			
3-4 yrs	4	20	< 1 yr	12	59
			5+ yrs	9	46

n=512

How badly have you been hurt in the past?

	%	
Required hospital admission	6	31
Received outpatients treatment	11	57
No treatment required	15	75
Never	63	323
No answer	5	26

n=512