OFFICE OF THE HEALTH OMBUDSMAN

Snapshot Outcome Report – Implementation of OHO recommendations relating to sexual safety risks and alleged assaults in mental health services

Update on the implementation of OHO recommendations: An outcome report on improvement actions taken by a health service - August 2025.

Wider learnings and recommendations for service improvements

The investigation identified opportunities for improvement and proposed recommendations relating to:

- Auditing to monitor compliance with policies and procedures for incidents involving alleged sexual assault.
- Training to ensure that staff are equipped with the appropriate knowledge and skills to ensure consumers' sexual safety.
- Compliance with record keeping standards.
- Communication with consumers regarding expectations within the unit, reinforcing the importance of maintaining sexual safety.
- Safety planning
- Performance of visual observations

The OHO's monitoring of the implementation of recommendations highlights the work undertaken by the health service to address the identified issues.

It is also noted that compliance with the performance of visual observations of patients has been identified by the OHO as an issue in complaints and notifications across a number of health services and has been the subject of another 'snap shot' report. All health services and practitioners are reminded of the critical role of visual observations for ensuring patient safety.

Background

The investigation focused on whether the health service complied with their obligations to report and escalate an alleged sexual assault. The investigation also considered the wider issues related to the importance of sexual safety for consumers within mental health units.

Issues investigated

The Office of the Health Ombudsman (OHO) commenced a systemic investigation considering the following key areas:

- Compliance with policies and procedures relating to the reporting of an alleged sexual assault.
- Record keeping - whether records accurately recorded events.
- Compliance with legislative requirements under the *Mental Health Act 2016*.
- Communications from the health service following the alleged incident.

Key findings

Recommendations were made by the OHO to address identified gaps in service provision and the management of sexual safety incidents.

Recommendations included:

- Development of auditing to monitor compliance with policies and procedures for incidents involving alleged sexual assault.
- Undertaking a training needs analysis to ensure that staff are appropriately trained to ensure consumers' sexual safety. This included the development of a mandatory training program.
- Development of an audit to monitor compliance with record keeping standards.
- Reinforcement of strategies to improve sexual safety for consumers including

communicating expectations to consumers upon arrival within the unit.

- Improved auditing to address compliance with:
  - Communication with consumers regarding sexual safety
  - Safety planning
  - Performance of visual observations

Update on the implementation of recommendations

After making recommendations the Health Ombudsman monitors the implementation through ongoing engagement and the provision of reports and supporting evidence demonstrating progress made by the health service in addressing the recommendations.

Following receipt of a report and supporting evidence, the OHO conducts an assessment and reports the status of the recommendations back to the health service. Where the implementation of recommendations has not yet been satisfied, further reporting and evidence is required from the health service.

In this matter, the health service has undertaken considerable work to improve the sexual safety of consumers within the mental health unit.

Evidence has been provided to the OHO which demonstrates the performance of a training needs analysis for staff and the implementation of annual mandatory training relating to sexual safety and responses to sexual assault. The system allows for live tracking of staff compliance with the training.

The health service has introduced a comprehensive audit which encompasses risk assessments, sexual safety planning, performance of visual observations and completion of documentation. Quality indicators and audit results are discussed at monthly performance meetings, shared through memos and monthly staff meetings to ensure a consistent sexual safety systems approach in the identification of areas for improvement.

Performance of visual observations is a critical aspect of mental health care. The purpose of performing visual observations is to provide an enhanced level of care to ensure the safe monitoring of a consumer's well-being, mitigate risk and enable swift response to any changes in a consumer's health or behaviour.

The OHO has identified issues with non-compliance with performance of visual observations in other health services and recently published a snapshot report highlighting wider learnings for service improvement - https://www.oho.qld.gov.au/reports/review-into-hospital-and-health-service-compliance-with-therapeutic-visual-observations-tvo-in-a-mental-health-facility.

Substantial work is being undertaken at the health service to address the completion of visual observations with increased auditing, weekly updates escalated to senior management and frequent reminders to staff.

Outcomes

The health service engaged positively with the OHO during the monitoring of the implementation of recommendations.

Five of the recommendations made to the health service have been fully implemented.

In relation to the performance of visual observations, the OHO recognises that this is an issue occurring in a number of health services which requires ongoing attention and dedicated strategies. The OHO commends the health service for their ongoing work and accordingly will not continue to monitor this recommendation.

Further information

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