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Health service investigation—snapshot report

Investigation: Review into the management of alleged sexual safety incidents and device restrictions within an inpatient mental health unit

As the health service initiated and progressed significant improvements in the management of sexual safety incidents throughout the duration of the investigation, no formal recommendations were made. Additional actions were suggested to enhance service improvement.

Background

A systemic investigation was conducted by the Office of the Health Ombudsman (OHO) following a complaint regarding the management of sexual safety incidents and communication device restrictions in an inpatient mental health unit.

The investigation aimed to assess the adequacy of the health service's response to these allegations and its management of personal communication device restrictions, with the goal of identifying systemic issues and recommending health service improvements.

Investigation scope

The investigation sought to determine whether the health service's response to the allegations adhered to local policies and state-wide guidelines, and to identify opportunities for systemic improvement.

Key Issues

The investigation examined:

- the adequacy of the processes for reporting, responding to, and escalating allegations of sexual safety incidents, and

Wider learnings and suggested actions for service improvement

Strengthen policy adherence:

- Ensure consistent documentation and reporting of all sexual safety allegations, regardless of perceived plausibility of the incident.
- Maintain clear records of risk assessments, actions taken, and clinical support provided.

Enhance Staff Training:

- Provide comprehensive training to all staff on sexual safety policies, risk assessment, and incident management.

Improve Communication:

- Clearly communicate the rationale for any restrictions on personal communication devices to consumers at the time of admission and establish transparent review processes.

Policy Review:

- Review local sexual safety policies to ensure alignment with the revised state-wide guidelines and incorporate best practice standards.

Implement Risk Mitigation Strategies:

- Develop clear and consistent risk mitigation strategies to address sexual safety risks in mental health settings with regular review.

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- the management, review and rationale for restricting consumer access to personal communication devices.

Key findings

Reporting and Documentation:

- Sexual safety allegations were not reported, escalated, or documented in line with local policy and statewide guidelines.
- Staff relied on assumptions about the consumer's mental state without recording assessments or rationales.
- Incomplete documentation limited understanding of actions taken and increased risk of consumer harm.

Risk Assessment

- Initial assessments indicated further comprehensive risk assessments were required, but these were either not completed or not documented.
- No formal risk assessments addressing potential harm or protective measures were documented.

Staff Training:

- Staff did not consistently follow requirements for documenting, assessing, responding to, and reporting sexual safety incidents, highlighting the need for improved training.

Device Restrictions:

- Restrictions on personal communication devices lacked clear documentation and transparent review processes.
- Local device restriction guideline lacked defined criteria, roles and responsibilities of staff, and expected review timeframes.

Improvements

The Queensland Health guideline, *Sexual health and safety guidelines - Mental health, alcohol and other drug services (2016),* is being reviewed to address identified gaps and ensure a consistent approach to managing sexual safety incidents across all health services. The revised guideline, developed in consultation with key stakeholders and consumers with lived experience, aligns with current legislation, frameworks, and best practice standards. The revised guideline aims to provide clearer, practice-focused direction for staff, emphasising trauma-informed care, risk assessment and effective incident management.

The review and publication of the updated guideline is currently in progress.

Once published, it is intended that the updated guideline will guide local policy reviews to ensure alignment and enhance sexual safety management in health services statewide.

The health service has also initiated significant improvements in the management of sexual safety incidents including:

- staff receive comprehensive education and training to promote sexual health and safety, enabling them to respond appropriately to reports of sexual safety incidents
- the introduction of a dedicated *Sexual Assault Response Service* team to provide clinical and support services to consumers
- the Safety, Quality & Improvement Support Unit triage all alleged incidents of sexual assault to ensure responses promoting systematically and promptly review and management
- a Triage Committee now monitors all sexual safety incidents, with organisational oversight of these incidents provided through a clinical governance dashboard.

Conclusion

The investigation highlighted gaps in the reporting and management of sexual safety incidents and the application of device restrictions.

Taking action to reinforce adherence to policies, enhance staff training, improve communication, and align local procedures with state-wide guidelines fosters a safer and more supportive environment for all consumers in mental health settings.