Sexual safety incidents

Chief Psychiatrist's reporting directive – September 2023

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Summary of reporting process

1. All bed-based clinical mental health service providers (including those in both hospital, custodial and community settings) must report sexual safety incidents via the Victorian Health Incident Management System (VHIMS).
2. Services are required to extract information from VHIMS into the Excel template provided by the Office of the Chief Psychiatrist (OCP) and submit it to the OCP via SharePoint monthly for the previous month.
3. Incidents with an Incident Severity Rating (ISR) of 1 or 2:
   (a) All ISR 1 incidents must be reported to the OCP by phone within 24 hours. There may be instances where services must report the incident to the Chief Psychiatrist immediately including if a sexual safety incident has resulted in death or major injury.
   (b) All ISR 2 incidents must be reported to the OCP via SharePoint within 72 hours.
4. Health services are responsible for ensuring local clinical governance structures that support reporting and incident management are in place and robust.

Purpose

This directive informs services of how and when to report sexual safety incidents to the Chief Psychiatrist. This document was updated in September 2023 to reflect the new *Mental Health and Wellbeing Act 2022*.

This document does not provide information about how to respond to or prevent sexual safety incidents and must be used alongside the 2023 *Chief Psychiatrist's guideline – Improving sexual safety in mental health services* <https://www.health.vic.gov.au/chief-psychiatrist/improving-sexual-safety>. Services must use the guideline to develop local practice and governance processes for comprehensively addressing sexual safety.

Chief Psychiatrist reporting process

Overview

All bed-based clinical mental health service providers (including those in hospital, custodial and community settings) must report sexual safety incidents via the Victorian Health Incident Management System (VHIMS). Services are then required to extract this information from VHIMS and provide it to the Office of the Chief Psychiatrist (OCP) monthly.

In addition, sexual safety incidents with a VHIMS Incident Severity Rating (ISR) of 1 or 2 must be reported to the OCP within 24 hours for ISR 1 or 72 hours for ISR 2. Attending to the safety and immediate needs of those involved is the priority, and reporting must be completed within the mandatory timeframes.

Step 1: Report all sexual safety incidents on VHIMS

All sexual safety incidents must be reported on VHIMS. Frontline staff should enter incidents in line with local processes and protocols. If not sure whether something meets the threshold for a sexual safety incident enter it and it can be adjusted when reviewed if required.

A separate incident must be entered for each involved person. These incidents can be linked to reduce data entry.

Incidents must be identified in VHIMS as sexual safety incidents. This will usually be through the '**Event type**' field, although fields may be titled differently at different services (refer to 'Tips for using VHIMS/' on page 10).

To ensure the OCP can extract relevant data from the VHIMS reports the following naming convention must be followed exactly when completing the 'Summary' field.

Naming conventions for incident summary
Provide the following information in this format. **Category of incident – Voluntary or Compulsory or Staff** **Category of incident has the following options** (please do not use other categories): • Sexual Activity • Sexual Harassment • Sexual Assault • Sexual Other **Indicate if the person was a Voluntary or Compulsory consumer (this refers to the consumer's status under *Mental Health and Wellbeing Act 2022*) or a staff member with:** • V [representing voluntary] • C [representing compulsory] • S [representing staff/OHS incident] ***Example*** **The summary section should appear in this format:** • Sexual Activity – C • Sexual Harassment – V • Sexual Other – S

Step 2: Escalating serious incidents to the OCP

ISR 1 and ISR 2

Report ISR 1 and ISR 2 rated incidents directly to the OCP for clinical review. Nurse unit managers, quality and safety managers, sexual safety coordinators or similar should manage this step. Services can contact the OCP by phone at any time to clarify this process.

The OCP may contact services directly to discuss ISR 1 and ISR 2 rated incidents. (For more information about how to apply ISRs to sexual safety incidents, refer to 'Assigning Incident Severity Ratings' on page 11).

ISR 1 – A serious sexual safety incident that has caused substantial harm

For incidents classified as ISR 1 (including incidents that have been upgraded to ISR 1 following further investigation), staff must escalate internally via local protocols and escalate via **phone to the OCP on (03) 9096 7571** within 24 hours or the next business day. A data extract from VHIMS of this single event must also be uploaded onto the OCP SharePoint site within 72 hours.

ISR 2 – A sexual safety incident resulting in moderate harm and requiring increased levels of care

For all incidents classified as ISR 2, staff must escalate internally via local protocols and alert the OCP within 72 hours by uploading a VHIMS extract to the OCP SharePoint site.

ISR 3 and 4

ISR 3 – A sexual safety incident that results in minimal harm with no additional care required

ISR 4 – A sexual safety incident was avoided, or no harm was caused

ISR 3 and ISR 4 rated incidents must be reported via VHIMS (Step 1) and included in the VHIMS extract sent monthly to the OCP (Step 3).

Step 3: Send a monthly VHIMS extract to the OCP

Frontline staff must complete a VHIMS report and submit to their local sexual safety coordinator or quality and safety coordinator or manager with responsibility for reporting. Do not submit directly to the OCP.

Managers must export data from all sexual safety incidents reported in VHIMS into the OCP Sexual Safety Data Template (Excel) at the end of each month. This monthly data must be provided to the OCP via SharePoint by the 23rd day of the following month. This data will include incidents with ISR ratings of 1–4 including ISR 1 and ISR 2 rated incidents that may have been previously escalated to the OCP.

The monthly report to the OCP is used for data monitoring purposes only.

This information is not clinically reviewed unless there is an apparent risk or discrepancy.

Supporting information

Definitions – sexual safety incident categories

Every sexual safety incident must be recorded as one of the following categories. Reports that list other categories will be returned to services for correction.

For more information about what constitutes a sexual safety incident in different settings please refer to the Chief Psychiatrist's guideline on improving sexual safety <https://www.health.vic.gov.au/chief-psychiatrist/improving-sexual-safety>

Term	Definition
Sexual Assault	According to the *Crimes Act 1958* definition of sexual assault, a person (A) commits an offence if: A intentionally touches another person (B); and the touching is sexual; and B does not consent to the touching; and A does not reasonably believe that B consents to the touching. Sexual assault may also include behaviour that does not include actual touching such as forcing somebody to watch pornography or masturbation. For more information, refer to s 40 of the Crimes Act.
Sexual Harassment	Unwelcome sexual behaviour that causes a person to feel offended, humiliated or intimidated, where a reasonable person could have anticipated that reaction in the circumstances. It includes an unwelcome sexual advance; an unwelcome request for sexual favours; any other unwelcome conduct of a sexual nature. It can be physical, verbal or written (*Equal Opportunity Act 2010 (Vic)*). Sexual harassment may or may not be against the law depending on the circumstances.
Sexual Activity	An activity may be sexual due to (a) the area of the body that is involved in the activity, including (but not limited to) the genital or anal region, the buttocks or, the breasts; or (b) the fact that the person engaging in the activity seeks or gets sexual arousal or sexual gratification from the activity; or (c) any other aspect of the activity, including the circumstances in which it is engaged in (Crimes Act, s 35D). Sexual activity may be consensual or non-consensual (refer to Crimes Act). Consensual sexual activity is not a crime. All sexual activity in mental health units is reportable.
Sexual – Other	A sexualised incident that does not fit any of the categories outlined above – for example, undressing in front of another person or sexually disinhibited behaviour that is not targeted.

Tips for using VHIMS/RiskMan

Health services use RiskMan or VHIMS CS to report incidents to VHIMS. There is variation in how these interfaces have been set up, and the field names are not uniform across health services.

To report sexual safety data accurately certain fields must be completed.

Event type

This field identifies sexual safety incidents and should be used to extract data to send to the OCP. This field may have a different name at some services – for example, 'Incident type'. To identify sexual safety incidents the following pathway should be followed:

VHIMS field	Response
Event type	Behaviour (for clinical incidents) *or* 'Aggression/Behaviour' for OHS staff incidents *or* 'Aggression/Behaviour' for OHS visitor incidents
Behaviour problem	Sexual aggression *or* Sexual inappropriateness

Identifying the alleged instigator (when relevant) and the affected person

In sexual safety incidents there may be an instigator (perpetrator) and affected person (victim), or there may be only affected persons and no instigator. It is important that each VHIMS entry identifies who the instigator and affected parties are when applicable.

VHIMS field	Response
Event type / instigator role	When you respond to 'Event type' as behaviour you will be prompted to include more information. One of the drop-down options is called 'Alleged instigator'. Selecting 'Alleged instigator' will trigger the need to enter more information including the instigator's UR.

Linking matters

A VHIMS report must be made for each person involved in an incident. For example, if there are two affected people, then two VHIMS reports must be made. To reduce the administrative load, and to improve the quality of the data, incidents can be 'linked'. This indicates that the two affected people were involved in the same incident. This action will result in many of the details of the second report automatically populating from the first report.

VHIMS field	Response
Create linked incident	Check that you want to create a linked incident and enter incident details as prompted.

Assigning Incident Severity Ratings

When sexual safety incidents are entered into VHIMS they are assigned an ISR, and managers can review the ISR. The following provides some guidance on how ISRs should be applied to sexual safety incidents. It is the responsibility of the managers (for example, nurse unit managers or quality and safety managers) who review reported incidents to ensure the ISR accurately reflects the incident's severity.

How ISRs are assigned

VHIMS has an algorithm based on three questions that trigger the ISRs. (These questions are slightly different for OHS matters.)

1. What was the level of harm sustained?
2. What level of care was required?

3. What treatment was provided?

When answering these questions staff should consider the level of psychological and physical harm and the impact that events may have on an affected person's current and future mental health and wellbeing. When considering the care and treatment that was required it is important to consider all the interventions that were used to respond to an incident, including psychological and interpersonal responses and any referrals (for example, to the Centre Against Sexual Assault) that were made.

What ISRs should be applied

When assigning the severity of an incident health service staff should take a trauma-informed approach and consider the level of harm, including psychological harm, to the involved parties informed by an understanding of past trauma.

Other questions that must be considered and may increase the ISR are:

- Was there a power imbalance between parties (for example, due to age, gender, history of trauma/increased vulnerability, social standing)?
- Was an involved party's behaviour affected by a history of trauma (for example, increased vulnerability or people-pleasing behaviour that could be interpreted as welcoming attention)?
- Was there a likelihood of coercion having occurred (for example, threatening behaviour or predatory behaviour)?
- Was the sexual activity transactional (for example, related to swapping of substances or medications)?
- Was the person experiencing sedating effects from medication?

The advice below is a guide only. Use clinical judgement to determine the most appropriate ISR. In many cases managers will need to discuss how to rate incidents with peers. If there is uncertainty, seek advice from the OCP.

ISRs for sexual safety incidents – bed-based clinical mental health service providers

Note: This is a guide only. Clinical judgement and a trauma-informed perspective must guide ISR allocation for sexual safety incidents.

ISR	Type of incident
ISR 1 – Severe ***A serious sexual safety incident that has caused substantial harm***	Major harm (psychological and/or physical) has occurred. For example, a serious sexual assault such as suspected or alleged rape (as defined by the Crimes Act) or statutory rape (illegal sexual activity between an adult and a minor). Sexual safety incidents that result in pregnancy.
ISR 2 – Moderate ***A sexual safety incident resulting in the consumer, visitor or staff requiring increased levels of care***	Significant harm has occurred (psychological and/or physical). Some instances of sexual assault – for example, non-consensual touching while clothed. Sexual activity that may result in pregnancy or transmission of a sexually transmitted infection and testing is necessary. Incidents where there is a suspicion that a sexual assault may have occurred although parties are not reporting this. Incidents where an affected party responds in a way that may indicate a sexual assault has occurred and had a substantial impact. This may present in

ISR	Type of incident
	a range of ways – for example, if an affected party is acutely distressed, appears numb, flat or dissociated, or is very controlled in their response. Incidents where there is suspected coercion, transactional sexual activity, predatory behaviour or a power imbalance between parties. Sexual activity involving one or more minors (under 18 years old) must be rated as at least ISR 2.
ISR 3 – Mild ***A sexual safety incident that results in minimal injury with no additional care required***	Temporary minor harm has occurred. Minor incidents of sexual harassment or sexual activity where there may be mild distress or psychological consequences. There is no need for medical treatment or testing following the incident. There is no indication of a significant power imbalance due to trauma history, mental state or sedation, for example.
ISR 4 – Near miss ***A sexual safety incident was avoided***	No harm has occurred. None of the involved parties are distressed. No harm or injury has occurred. No change in treatment required. A sexual safety incident has been avoided.

Frequently asked questions

To help decision making in sexual safety reporting, below are some examples of frequently asked questions. Frontline staff and managers should seek advice from colleagues, senior staff, the authorised psychiatrist or delegate or the OCP if unsure.

Q. Should touch – for example, hugging, kissing on the cheek or touching on the arm – which appears supportive and non-sexual be reported as a sexual safety incident?

A. No. Non-sexual touch should not be reported. Explain mutual expectations separately.

If the behaviour happens repeatedly or if either party appears to be uncomfortable, it can be reported as sexual activity.

Q. Should making sexually explicit comments towards another person – for example, sexual slurs, sexually explicit jokes – be reported as a sexual safety incident?

A. Yes, this is reportable as sexual harassment.

Q. Is touching another person around the genitals, buttocks or breasts when all parties agree the touch was accidental and non-sexual reportable?

A. This is not reportable the first time it occurs. Explain mutual expectations. Monitor all parties.

This behaviour will become reportable as sexual assault if it happens again. Note that it is extremely important to thoroughly document these incidents to ensure interventions are effective.

Q. Should disrobing due to disorientation or confusion be reported as a sexual safety incident?

A. No, this is not reportable unless there are other parties who are negatively impacted. However, if there are other parties who are distressed, this response should not be minimised and the incidents should be responded to and reported as 'Sexual Safety Incident – Other'.

Q. Is sexually inappropriate behaviour reportable when it is a symptom of a person's mental illness and not an indication of their intention to harm others?

A. Yes, in nearly all cases such behaviour should be reported regardless of the person's intentions.

Q. When and how often should we report sexually inappropriate behaviour that is repeated frequently?

A. Every instance of the behaviour should be directly and immediately addressed with the person. If the behaviour is considered to be mild or moderate in severity – for example, inappropriate sexual comments – it should be reported no more than once each day. The report should specify that the behaviour is repetitive and note what plan has been put in place to minimise any harm to others.

If the behaviour is high in severity, then each individual incident must be reported.

Q. Should we report a sexual assault when it is believed not to be reality-based but experienced by a person as a symptom of their mental illness?

A. Yes, such an incident should be reported because it is not the responsibility of unit staff to determine the truthfulness of the allegation. It is common for victim-survivors of sexual assault to have difficulty accurately describing what has occurred. This is more likely in mental health settings where people may be acutely unwell and are more likely to have experienced trauma.

However, the authorised psychiatrist may determine that available information does not lend any support to the occurrence of the allegation, or there may be information contradicting the possibility that an assault could have occurred.

If that is the case, the rationale for this decision must be clearly documented in the patient's file and in the sexual safety notification. Implement a trauma-informed *Sexual safety management plan* to minimise risk.

If further or different information later becomes apparent that indicates that the incident may have had some reality basis the incident should be responded to in line with the Chief Psychiatrist's guideline and reported in the usual way.

Q. Are there any differences in reporting sexual safety incidents in different aged-based services such as child/adolescent, young people, adult and older persons' services?

A. Not in principle. People of all age groups have the right to be safe while they are being treated at bed-based clinical mental health services. Therefore, all incidents must be taken seriously, regardless of the age of involved parties.

Note: It is important to pay attention to the vulnerabilities of certain age groups – for example, patients in child/adolescent units being under the legal age of consent, or patients in older persons' services being more likely to be victims of elder abuse, and in circumstances where there is a large disparity in age – for example, when a young person is admitted to an adult unit.