OFFICE OF THE HEALTH OMBUDSMAN

Health service investigation—snapshot report

Investigation focus: Unregistered support staff and addressing sexual safety and potential risks for vulnerable consumers (July 2024).

Wider learnings and recommendations for service improvements

The investigation highlights the opportunity for health services to:

a) recognise the risk that unregistered support staff may present to vulnerable consumers, and to include as a risk on their risk registers;

b) develop and implement professional boundary training for unregistered support staff that addresses the vulnerability of patients in acute mental health wards including potentially disinhibited patients and the obligations of staff to maintain professional boundaries;

c) have clear processes in place to consider and document decisions regarding notifications to external agencies including the Crime and Conduct Commission, and conducting Public Interest Disclosure assessments; and

d) ensure internal investigations and resultant decision making for serious conduct matters are robust, appropriately documented, and defensible.

Background

The *Health Ombudsman Act 2013* indicates a health service includes a support service for a service that is, or purports to be, a service for maintaining, improving, restoring or managing people's health and wellbeing. The Health Ombudsman is responsible for receiving and dealing with health service complaints including those that involve unregistered support staff or unregistered practitioners.

The Health Ombudsman opened an investigation to review a health service entity's management of a sexual assault allegation made by a vulnerable consumer in a mental health facility against an unregistered support staff member.

Issues investigated

The Health Ombudsman conducted the investigation to identify potential health service issues and provide opportunities for improvement in the systems and processes within the health service.

Issues identified included the adequacy of safety protocols, the appropriateness of the entity's response to an internal review into the allegations, and the implementation of outcomes resulting from the internal review.

Key findings

The health service appropriately responded to the disclosure by providing support to the patient, escalating the complaint to relevant executive/s, and assessing and responding to ongoing risk assessments, in line with Queensland Health Sexual health and safety guidelines.

The health service complied with reporting requirements to the Chief Psychiatrist however, the incident was not reported to the OHO by the health service, noting that the OHO receives all complaints in Queensland about health services and health service providers, including registered and unregistered health practitioners. The health service delayed mandatory reporting of the potential corrupt conduct to the Crime and Conduct Commission and failed to conduct a Public Interest Disclosure assessment.

The incident highlighted a risk that unregistered support staff may present to vulnerable patients when staff have not been afforded targeted training in ensuring appropriate professional boundaries.

The health service missed opportunities in the internal review to request information from an external third party that, if provided, would have further informed the conduct investigation.