

# CLINICAL POLICY

## Sexual Safety Policy

*Printed or downloaded copies of this document are not controlled – In exceptional circumstances where hard copies or downloaded versions are required, these will only be valid on the day printed or downloaded – please always ensure that the most up-to-date version is accessed through the [Policy section of GHC Intranet](#). If any updates or changes to this document are required, please contact the Clinical Policy Group on: [clinical.policies@ghc.nhs.uk](mailto:clinical.policies@ghc.nhs.uk) prior to making any amendments. Documents are password protected to prevent any unauthorised changes.*

Policy Number	CLP154
Version:	V2
Purpose:	The Trust is committed to providing a safe and secure environment for those who use services, respecting their privacy and dignity, and preventing sexual abuse.
Consultation:	The Trust Positive and Safe Group have been consulted
Approved by:	Clinical Policy Group
Date approved:	13/02/2025
Author / Reviewer:	Reviewed by: Sally Ashton, Advanced Nurse Practitioner (Bank Nurse)
Date issued:	21/02/2025
Review date:	01/02/2028
Audience:	All staff within the Gloucestershire Health and Care NHS Foundation Trust ('the Trust')
Dissemination:	The policy will be published on the GHC intranet, and its update will be listed on the Clinical Policy update bulletin
Impact Assessments:	This Policy has been subjected to an Equality Impact Assessment. This concluded that this policy will not create any adverse effect or discrimination on any individual or particular group and will not negatively impact upon the quality of services provided by the Trust.

### Version History

Version	Date Issued	Reason for Change
V1	19/01/2022	This is a new policy for GHC NHS Foundation Trust
V1.1	11/11/2022	Interim review – minor amendment to training and standard template changes – review date extended to full 3 years from issue
V2	21/02/2025	Reference made to recent related national NHS E guidance regarding Sexual Misconduct in the workplace and local policies currently in development, plus learning from local data/incidents.

## SUMMARY

The Trust is committed to providing all patients with a safe and secure environment when they are admitted to inpatient facilities, seen as outpatients on NHS premises or seen in the community. It is vital that the privacy and dignity of our patients is respected at all times and that sexual abuse is prevented.

Sexual Safety refers to the respect and maintenance of an individual's physical and psychological boundaries.

This policy relates to the care of all adults or children as patients receiving physical health or/and mental health services from the Trust. Whether they are in hospital or cared for in the community, or as outpatients, including community hospitals and Minor Injuries and illness Units (MIU's), and whether they are in hospital under a section of the Mental Health Act 1983 (MHA), an informal admission under mental health services or a patient cared for in the community (mental health or community health services). It also relates to patients who are on Section 17 leave, or under Section 117 aftercare (both under the MHA). The policy applies to both children and adults. Those referred to as children will be considered as anyone who has not yet reached their 18th birthday.

Further information about children under 18 is included in the Trust's Safeguarding Policies.

Everyone has equal rights to access single sex facilities and services in line with their gender identity. Protection from sexual harassment and any incidents or allegations of rape, sexual assault or harassment will be investigated by staff for any service user irrespective of their gender identity or/and as a member of the LGBTIQ+ community.

## TABLE OF CONTENTS

	Section	Page
	<a href="#"><u>Sexual Safety Action Card</u></a>	
1	<a href="#"><u>Introduction</u></a>	3
2	<a href="#"><u>Purpose</u></a>	3-4
3	<a href="#"><u>Scope</u></a>	4-5
4	<a href="#"><u>Duties</u></a>	5
5	<a href="#"><u>Mental Capacity Act Compliance</u></a>	5-6
6	<a href="#"><u>Key Principles of Sexual Safety</u></a>	6-7
7	<a href="#"><u>Policy on Sexual Safety</u></a>	7-9
8	<a href="#"><u>Prevention of Incidents – Risk Assessment, Sexual History Taking and Safeguarding</u></a>	9-12
9	<a href="#"><u>Management of Sexually Disinhibited Patients</u></a>	12-13
10	<a href="#"><u>Management of Sexual Gratification Needs and Access to Pornography</u></a>	13-14
11	<a href="#"><u>Sexual Activity Between Patients on an Inpatient Unit</u></a>	14-16

12	<a href="#">Guidance for when an Allegation has Been Made</a>	16-20
13	<a href="#">Children, Capacity and Best Interests</a>	20-22
14	<a href="#">Complaints Against Members of Staff</a>	22-23
15	<a href="#">Definitions</a>	23-27
16	<a href="#">Process for Monitoring Compliance</a>	27-28
17	<a href="#">Incident, Near Miss Reporting and Duty of Candour</a>	28
18	<a href="#">Training</a>	28-29
19	<a href="#">References</a>	29
20	<a href="#">Associated Documents</a>	29
Appendix A	<a href="#">Sexual History Taking – Mental Health Services</a>	30
Appendix B	<a href="#">Myths about Rape</a>	31-32
Appendix C	<a href="#">Advance Directives and Advance Decisions</a>	33

## 1. INTRODUCTION

- 1.1 Sexual safety refers to the respect and maintenance of an individual's physical (including sexual) and psychological boundaries (NSW: Sexual Safety of Mental Health Consumers Guidelines).
- 1.2 This policy relates to the care of all patients, adults or children, whether they are in hospital, or a patient cared for in the community, or as outpatients. If there are concerns regarding the sexual safety of a child under 18, refer to the Trust Safeguarding Children and Young Persons Policy and Gloucestershire inter-agency safeguarding children's procedures.
- 1.3 The Trust is committed to providing all patients with a safe and secure environment when they are admitted to in-patient facilities or when they are seen as outpatients on NHS premises. It is vital that the privacy and dignity of our patients is always respected, and that rape, sexual exploitation/assault, and sexual harassment is prevented.
- 1.4 Everyone has equal rights to access single sex facilities and services in line with their gender identity. Protection from sexual harassment and any incidents or allegations of rape, sexual assault or harassment will be investigated by staff for any service user irrespective of their gender identity or/and as a member of the LGBTIQ+ community.

## 2. PURPOSE

- 2.1 This policy aims to promote good practice, to protect all Trust patients and to strike a balance between conflicting interests by protecting those who are vulnerable while ensuring that patients' rights are respected in setting out the responsibilities of healthcare professionals in relation to sexual safety.
- 2.2 The Trust is committed to keeping patients, visitors and staff safe, maintaining privacy and dignity and preventing unwanted behaviour of a sexual nature including sexual abuse and sexual violence occurring.

- 2.3** An additional non-clinical policy ‘Sexual Safety in the Workplace’ is in development for the protection of GHC employees and will connect with this policy.
- 2.4** In sexual matters, as in many other areas of clinical care, a sensitive approach is required where each case is individually considered bearing in mind the professional, ethical and practical aspects of each situation and cultures of those within our care. However, legislation is in place and all people are obliged to act within the law at all times.
- 2.5** The policy is intended for use in all Gloucestershire Health and Care NHS Trust services (GHC), across all settings and age groups. The policy is intended to embed sexual health considerations as a part of everyday care. It outlines potential sexual safety issues, thereby providing an evidence base and succinct information with which to guide the service response including service planning, employee education and training and development of tailored local response procedures.
- 2.6** This policy applies to all sexual relationships including the full spectrum of definitions of sexuality including heterosexual and LGBTQI+ (LGBTQI+ stands for lesbian, gay, bisexual, transgender, intersex, queer/questioning, asexual and many other terms such as non-binary and pansexual).
- 2.7** This policy will:
- Define what is meant by sexual abuse including sexual offences such as rape and sexual assault as well as other sexual crimes.
  - Guide you through actions you are obliged to take if sexual abuse happens either in hospital or in the community.
  - Define core elements of a sexually safe service and provide standards for sexual safety.
  - Define risk and guide you how to assess for it, and what actions to take.
  - Reference Adult and Children Safeguarding procedures in the context of sexual safety.
  - Clearly explain the notions of ‘capacity’ and ‘Best Interests’ as they relate to this context.
  - Signpost you to actions you are obliged to take in response to allegations of sexual offences against staff as per the local policy.
  - Explain how to work collaboratively with police and what to expect.

### **3. SCOPE**

- 3.1** This policy applies to all Trust staff and volunteers who work with or care for children and / or adults receiving services from the Trust. Separate Trust policies cover specific aspects of allegations of staff misconduct, such as employee support and wellbeing, raising matters of concern, harassment and bullying, investigation, suspension and disciplinary action, and these should be referred to as appropriate. Reference may also be made to the Gloucestershire Child Protection and Safeguarding Procedures and Multi-Agency Policy and Procedures for Safeguarding Adults at Risk which apply to the staff of all agencies

who work with children and vulnerable adults respectively.

**3.2** This policy should be read in conjunction with the Policy and Procedure for Managing Allegations against professionals who work with children and adults, as well as the Policy and Procedure on Handling and Resolving Complaints and Concerns. Allegations may be made by colleagues, service users, their relatives and carers, or members of the public. The Trust recognises that colleagues and volunteers are themselves vulnerable and have a right to expect that complaints or allegations about their behaviour will be investigated professionally and objectively and that appropriate support is available.

**3.3** The policy clarifies the roles and responsibilities of those involved and sets out the processes to be followed to ensure that appropriate action can be taken without delay. Whilst the primary concern is for the safety and welfare of any child / adult it is also important to ensure that allegations are dealt with sensitively and fairly for the individual who is the subject of an allegation.

## **4. DUTIES**

### **4.1 General Roles, Responsibilities and Accountability**

**Gloucestershire Health and Care NHS Foundation Trust (GHC)** aims to take all reasonable steps to ensure the safety and independence of its patients and service users to make their own decisions about their care and treatment.

In addition, **GHC** will ensure that:

- All employees have access to up-to-date evidence-based policy documents.
- Appropriate training and updates are provided.
- Access to appropriate equipment that complies with safety and maintenance requirements is provided.

**Managers and Heads of Service** will ensure that:

- All staff are aware of and have access to policy documents.
- All staff access training and development as appropriate to individual employee needs.
- All staff participate in the appraisal process, including the review of competencies.

**Employees (including bank, agency and locum staff)** must ensure that they:

- Practice within their level of competency and within the scope of their professional bodies where appropriate.
- Read and adhere to GHC policy
- Identify any areas for skill update or training required.
- Participate in the appraisal process.
- Ensure that all care and consent comply with the Mental Capacity Act (2005).

## **5. MENTAL CAPACITY ACT COMPLIANCE**

**5.1** Where parts of this document relate to decisions about providing any form of care treatment or accommodation, staff using the document must do the following: -

- Establish if the person is able to consent to the care, treatment or accommodation that is proposed? (Consider the 5 principles of the Mental Capacity Act 2005 as outlined in

section 1 of the Act. In particular principles 1,2 and 3) [Mental Capacity Act 2005 \(legislation.gov.uk\)](#).

- Where there are concerns that the person may not have mental capacity to make the specific decision, complete and record a formal mental capacity assessment.
- Where it has been evidenced that a person lacks the mental capacity to make the specific decision, complete and record a formal best interest decision making process using the best interest checklist as outlined in section 4 of the Mental Capacity Act 2005 [Mental Capacity Act 2005 \(legislation.gov.uk\)](#).
- Establish if there is an attorney under a relevant and registered Lasting Power of Attorney (LPA) or a deputy appointed by the Court of Protection to make specific decisions on behalf of the person (N.B. they will be the decision maker where a relevant best interest decision is required. The validity of an LPA or a court order can be checked with the Office of the Public Guardian) [Office of the Public Guardian - GOV.UK \(www.gov.uk\)](#).
- If a person lacks mental capacity, it is important to establish if there is a valid and applicable Advance Decision before medical treatment is given. The Advance Decision is legally binding if it complies with the MCA, is valid and applies to the specific situation. If these principles are met it takes precedence over decisions made in the person's best interests by other people. To be legally binding the person must have been over 18 when the Advance Decision was signed and had capacity to make, understand and communicate the decision. It must specifically state which medical treatments, and in which circumstances the person refuses and only these must be considered. If a patient is detained under the Mental Health Act 1983 treatment can be given for a psychiatric disorder.
- Where the decision relates to a child under the age of 16, the MCA does not apply. In these cases, the competence of the child must be considered under Gillick competence. If the child is deemed not to have the competence to make the decision, then those who hold Parental Responsibility will make the decision, assuming it falls within the Zone of Parental control. Where the decision relates to treatment which is life sustaining, or which will prevent significant long-term damage to a child under 18 their refusal to consent can be overridden even if they have capacity or competence to consent.

## 6. KEY PRINCIPLES OF SEXUAL SAFETY

- Everyone is entitled to be sexually safe.
- All services should take appropriate action to prevent and respond quickly to sexual safety incidents.
- All services should support patients to adopt behaviours and practices that will contribute to their sexual safety.
- The Sexual Safety Standards as outlined in this policy are adopted by everyone.
- The physical environment is designed to support sexual safety.
- Any disclosures about incidents will always be taken seriously and addressed promptly with empathy and compassion.

- Staff will foster a compassionate and open culture that encourages reporting of incidents relating to sexual safety.
- Patients, their families and carers are given clear information regarding their rights and how to report incidents.

## **7. POLICY ON SEXUAL SAFETY**

**7.1** Any behaviour which can be defined as sexual harassment or abuse is unacceptable and all our patients have the right to live free from fear of abuse or harassment.

**7.2** The Care Quality Commission (2018) notes that mental health admission wards are a high-risk environment and produced recommendations to include:

- Clearer guidance to staff, training so that staff can better support the sexual wellbeing of patients.
- Strengthening of the incident reporting system.
- Investment in the physical and therapeutic environment of wards so that they better promote sexual safety.

Negative attitudes that view sexual needs as a sign of weakness/indulgence can cause sexual needs to be ignored and therefore remain un-assessed, particularly with people with disabilities or mental illness.

**7.3** Everyone has the right to a private life (and hence a sex life) under Article 8(1) of the [European Convention on Human Rights](#) (as enacted by the Human Rights Act 1998). However, this is a qualified right and can be interfered with if to do so is lawful and proportionate. The Trust's position is that the vulnerability of its patients, and the need to manage safe clinical environments, justifies interference with this right on the terms set out in this policy, in accordance with Article 8(2).

**7.4** Services are responsible for promoting sexual safety through operational policies and procedures which:

- Support the client's right to physical and psychological safety.
- Encourage the monitoring of professional boundaries.
- Encourage and provide professional development for this subject matter.
- Provide guidance in responding appropriately to disclosures of sexual assault and/or breaches in boundaries.

**7.5** Providing an environment that promotes sexual safety and prevents sexual assault encompasses a range of strategies for implementation by services. These include:

- Risk assessment including assessment of vulnerability.
- Identifying and responding to sexually disinhibited/sexualised behaviour.

- Provision of a safe physical environment.
- Accurate record keeping, documentation and management when risks are identified.

**7.6** This policy acknowledges that the impact of sexual abuse upon people's mental health is 'core business' for the Trust. It affects 70% or more female patients and a significant number of male patients. It is the clinical responsibility of all practitioners and clinicians.

**7.7** A key theme of this policy is to maintain the privacy and dignity of all patients. Compliance with the development of single sex in-patient facilities is essential to minimise the risk of sexual safety incidents. Sexual activity between patients in a hospital setting is strongly and actively discouraged due to the inappropriateness of the environment, proximity of other individuals, and therefore the compromise of dignity for all.

### **7.8 Core Elements of Sexual Safety**

All staff have a responsibility to ensure that they and the services that are offered promote good sexual safety and should include:

- A safe physical environment.
- Cultural awareness and understanding, respecting cultural differences and practices of individuals from diverse backgrounds.
- Recognition that everyone has the right to sexual safety.
- Assessment of types of abuse that an individual may be at risk of harm and their potential to harm others.
- Have the skills to take a sexual history at an appropriate time – see Section 8.3.
- Maintain their own and monitor others professional boundaries.
- Manage sexualised and/or sexually disinhibited behaviour and prevent sexual activity in an inappropriate context or setting.
- Have the skills to respond appropriately to sexual harassment or sexual assault.
- Have systems and processes in place to ensure proper recording and reporting of all sexual safety incidents.

**7.9** The potential impact of consensual sexual activity in an inappropriate context or setting will vary based on the individual circumstances involved, but could involve:

- Sexual exploitation.
- Damage to self-esteem and other relationships.
- Sexually transmitted infections.

- Pregnancy.
- Vicarious trauma.

**7.10** Witnessing sexual activity, can be traumatic for others within the service setting, particularly those that have previously experienced sexual assault or harassment.

**7.11** The Trust have agreed to work towards achieving the following sexual safety standards which originated from New South Wales (NSW) Ministry of Health in Australia and are endorsed by the Sexual Safety Collaborative (National Collaborating Centre for Mental Health) 2020:

<b>Standard 1</b>	I respect myself.
<b>Standard 2</b>	I treat others with respect and dignity.
<b>Standard 3</b>	I understand that sexual activity with another person should be for mutual pleasure and never used for punishment or through coercion.
<b>Standard 4</b>	I do not try to talk to someone else into engaging in sexual activity or harass another person sexually.
<b>Standard 5</b>	I try to be aware of how my behaviour makes others feel and will change my behaviour if someone tells me it makes them uncomfortable, or I will ask for help with this if I need to.
<b>Standard 6</b>	I respect the rights of others to space and privacy to fulfil their sexual needs through self-stimulation/masturbation.
<b>Standard 7</b>	I understand that fulfilling my own sexual needs through self - stimulation/masturbation must be conducted privately and discreetly.
<b>Standard 8</b>	I will speak up if I have been hurt, harassed or assaulted physically or sexually.
<b>Standard 9</b>	I will speak up if I see or hear about someone else being hurt, harassed or assaulted either physically or sexually.

## **8. PREVENTION OF INCIDENTS – RISK ASSESSMENT, SEXUAL HISTORY TAKING AND SAFEGUARDING**

**8.1** A key aim of the Trust is to avoid patients, visitors and staff being put at risk of sexual harm by, as far as possible, avoiding the circumstances occurring under which such an assault might take place. As part of the usual risk assessment procedures, an initial and on-going assessment of vulnerability and potential to harm is required for every service user of a Mental Health / Learning Disability service. Risk of sexual abuse, potential for sexual activity and sexual disinhibition should be assessed as part of the risk assessment carried out on all patients.

**8.2** Information for patients and carers should be available on all units about their rights and responsibilities and the sexual safety standards should be adopted by all areas of the Trust, some of which are displayed visibly as Ward Charters in the clinical area.

### **8.3 Sexual History Taking**

All assessments must explore any history/experience of physical, sexual, domestic or emotional abuse at any time in the patient's life, to develop appropriate care and support in line with national policy. It is appreciated that this must be done with the utmost sensitivity to avoid re-traumatisation, e.g. information may be obtained over several sessions/ conversations.

As part of any assessment all staff should determine whether taking a wider sexual history is relevant and forms part of their assessment process. This will be more applicable to some service areas rather than others. Appendix A provides more information about taking a sexual history in Mental Health / Learning Disability services.

A basic sexual history will include exploring whether the patient has a diagnosis of HIV, whether they are aware of their Hepatitis B and Hepatitis C status, history of other sexually transmitted infections (STIs), pregnancies, medication and contraception, abuse, impairment and vulnerability issues, past offences and/or incidents, physical frailty issues, existence of an Advance Decision etc., e.g. if they should become sexually disinhibited. See [Appendix C](#).

The evaluation could be aided by considering a history of sexual assault, a history of inappropriate sexual behaviour during previous admissions, a history of violence, and diagnostic history and the effect of medication on their sexual drive/function.

The Vulnerable Access Nurse Team as part of the GHC Sexual Health services may be able to advise/support staff with taking a sexual history. Clinical Policy CLP137 can be found here [Vulnerable Access Nurses Team Sexual Health \(VANS\) Physical Health \(CLP137\) - Interact](#).

#### **8.4 Risk Assessment**

Risk assessment upon admission must include an evaluation of the likelihood that an individual might engage in sexual activity during hospitalisation and particularly activity of an inappropriate sexualised nature.

Where a risk of committing sexual assault or rape, or to be at risk of unwanted sexual approaches, steps to reduce such risks should be taken and should be clearly identified and explicitly documented in the care plan if the person is an inpatient.

Example of such steps include:

- Increasing observation levels.
- Use of a single room to maximise privacy and safety.
- Placing patients near the nursing station.
- Providing patients with information promoting sexual safety and wellbeing. An entry should be made in the clinical records to the effect that information has been provided, discussed and understood.
- Sex Education - this may be incorporated into the Care Plan especially for vulnerable patients, and patients may be informed of alternatives to sexual intercourse, including

masturbation. Depending on the patient's beliefs and personal dynamics, they may be informed that masturbation serves as a safe outlet for channelling normal sexual drives, provided it is done privately and at an appropriate time and place. If sexual issues have been identified, then it is important that this area is addressed, and appropriate referrals made to address this need.

On admission, as part of risk assessment, the potential to harm others needs to be undertaken. If risk exists, further assessment should include:

- Previous history/reports of sexual violence, including rape, sexual harassment, sexual exploitation and sexual assault.
- Violent behaviour.
- Abusive language.
- Threats and intimidation.
- Disinhibition.

If a service user who is known to have caused sexual harm presents for admission and a victim is also receiving treatment at the same service, the former must be admitted to another ward or site.

Patients and visitors should not be allowed in sleeping areas/bedrooms without the patient's valid informed consent and without prior agreement from the nurse in charge on entering the ward. Visiting areas, where appropriate, should be used as the appropriate venue for contact.

Staff should wear name badges and visitors should always be identified. Where possible, there should be provision for single gender day space. If there is a concern that sexual interaction is taking place, unless a specific care plan is in place in relation to that sexual interaction, the intervention procedure noted under the section Sexual Activity between Inpatients as per Section 11 of this policy must be followed.

If, because of the risk assessment, a service user is deemed to be vulnerable to abuse, due to being sexually disinhibited, staff should consider carrying out an assessment to see whether the service user has capacity to decide to engage in sexual relations. This should be followed up when the service user is well enough to discuss making an Advance Statement ([Appendix C](#)) about their preferences and wishes about future management prioritising their sexual safety.

If at any stage a capacity assessment is completed in relation to sexual activity, a detailed record of the assessment and the outcome must be recorded clearly in the service user's records. A test for capacity in relation to sexual activity is not necessary for all patients.

Where a risk management plan has been developed to manage a patient's sexual safety this should be transparently shared with the patient.

## 8.5 Staff Awareness

Staff should be aware that people who commit sexual abuse and sexual exploitation might use coercion, grooming and manipulation, not only overtly violent behaviour. Sexual assault can involve a one-off opportunistic event or a series of on-going aggressive attacks. Staff should be mindful that coercion may inter-relate with substance misuse. Staff should always be vigilant and aware that certain less well observed areas present higher risk in terms of incidents occurring e.g. outside or garden areas/bedrooms/toilets.

## **8.6 Management Plans**

If a service user is assessed as being at risk of harming others, a specific management plan must be developed and implemented in order to protect patients and staff. All staff should be aware of the plan, which should be discussed at handover/team meetings and regularly reviewed. If on an inpatient unit, the management plan should consider the level of observation required and consider accommodation options in relationship to others on the ward.

## **8.7 Acute Sexual Threat of Service User**

If at any time a service user appears to constitute an acute sexual threat, there should be an immediate meeting of members of the multidisciplinary team (MDT) to agree an appropriate course of action. Close observation may be necessary in some cases and in some settings patients may have to be transferred to other wards/units where appropriate steps can be implemented to protect others.

## **9. MANAGEMENT OF SEXUALLY DISINHIBITED or SEXUALISED BEHAVIOUR**

**9.1** Within GHC, the most frequently reported sexual safety incidents involve sexual disinhibition where some patients exhibit sexualised behaviours as part of their illness or as a side effect of some medication. It can be confronting and embarrassing for the service user as well as those who witness the behaviour. It may also impact on the patients existing intimate relationships, their self-esteem and their reputation.

**9.2** Sexual disinhibition may involve an increase in sexual thoughts, activities and demeanour or a general disinhibition, which has a sexual element. Behaviours may include:

- Removing clothes inappropriately.
- Wearing inappropriate or revealing clothing.
- Being over-familiar, over-friendly or touching of others inappropriately including use of words/language.
- Hyper-sexuality, e.g. sexually provocative behaviour, masturbation in public, approaching staff, other patients and visitors for sex, engaging indiscriminately in sexual activities.

**9.3** Whilst sexual activity is a normal part of life, an acute episode of mental ill health or dementia may adversely affect that person's ability to make accurate judgements. A hospital or inpatient unit is not a normal social environment and therefore all staff have a duty of care to patients in this regard.

**9.4** Where a service user is exhibiting disinhibited behaviours, protection of the service user

and others from rape, physical and sexual assault and harassment is paramount. Whilst in this mental state, a service user may 'agree' to engage in sexual activity. However, informed consent cannot be given when the person does not have the requisite mental capacity to decide to engage in sexual relations. Equally a service user who is sexually disinhibited may attempt to coerce another vulnerable service user into sexually inappropriate behaviour. Sexual activity in these circumstances is not acceptable.

**9.5** Where a service user is assessed as being at risk due to sexual disinhibition, immediate measures should be taken to ensure safety and documented in the care plan. These may include:

- Admission to a single-gender ward in mental health services, if appropriate.
- Increasing observation level.
- Review of medication.
- Situate near the nursing station.

## **10. MANAGEMENT OF SEXUAL GRATIFICATION NEEDS AND ACCESS TO PORNOGRAPHY**

**10.1** 'Pornography' refers to material which is EITHER of a sexually explicit nature OR which depicts sexually or violently abusive acts or themes.

**10.2** 'Hard' pornography is any material that would not be considered for transmission under current broadcasting legislation.

**10.3** The Trust has a duty of care to patients, staff and visitors, which includes a duty to protect them from possible adverse effects of material that is pornographic.

**10.4** Patients may hire, purchase or possess any legally published material of a sexually explicit or otherwise pornographic nature, which could ordinarily be obtained from a general source – or is of a level of nudity/depiction of sexual acts which would be expected in such publications. This would include magazines available in standard newsagents or magazine shops, or their online equivalents, and is for personal use only, not to be shared with others or left in communal areas. Whilst permitting the possession of such material, reference should be made to restrictions below. This does not include specialist sex shops and mail order outlets as any other pornographic material discovered on the site, i.e. 'hard' pornography is prohibited and will be removed.

**10.5** Subject to the exceptions described in restrictions below, any material, which contravenes the letter or spirit of the following statutes and/or their subsequent amendments, would constitute a prohibited item and must not be in the possession of any person on site.

[Obscene Publications Act 1959](#)

[Children and Young Persons \(Harmful Publications\) Act 1955](#)

[Indecent Displays, \(Control\), Act, 1981](#). d. Post Office Act, 1953.

**10.6** Staff must seek advice from senior staff if they discover on site pornographic material which causes them concern.

- 10.7** The use, storage or display of such material must respect the rights of other individuals not to be exposed to it without their consent. Patients must not share or view such material in the company of other patients. Material should not be publicly displayed, including in patients' bedrooms.
- 10.8** 'Soft' pornographic material, whether it be magazines, DVDs or other electronic mediums, may only be viewed by individual patients in the privacy of their bedrooms. Under no circumstances may it be viewed in communal areas.
- 10.9** Any pornographic material found in any area other than a patient's bedroom will be removed. If it is known to whom it belongs, it will be returned to the patient only if they agree to the appropriate storage of the material. Failure to do so will result in it being removed.
- 10.10** If considered necessary, appropriate action will be taken by the Multidisciplinary Team to protect patients and staff. The degree of monitoring necessary may vary according to patients' previous history and behaviour. Consideration will be given to alerting the Trust Accredited Security Management Service (ASMS).
- 10.11** The ASMS will consider contacting the police if any person appears to contravene the law in respect of pornographic material.
- 10.12** Exceptionally, material depicting sexual, violent or abusive themes may be shown or made available to patients where it is part of a programme of assessment or therapy agreed by the MDT and is used in accordance with the relevant codes of professional practice. Trust staff must ensure that such material is not prohibited under the law.
- 10.13** In respect of electronic media reference should be made to local IT procedures.

## **11. SEXUAL ACTIVITY BETWEEN PATIENTS IN A HOSPITAL SETTING**

Sexual activity between patients on an inpatient unit is to be strongly and actively discouraged. **See 7.7**

- 11.1** If patients engage in sexual activity with one another, and one of the patients lacks capacity, and the other does not, then a sexual offence is likely to have been committed.
- 11.2** The Sexual Offences Act 2003 (the 'Act') states that it is a criminal activity to engage in sexual activity with someone with a mental disorder impeding choice ([Section 30](#)).
- 11.3** There are also other offences in relation to someone with a mental disorder impeding choice (referred to as P below) within the Act, including:
- Causing or inciting P to engage in sexual activity (Section 31).
  - Engaging in sexual activity in the presence of P (Section 32).
  - Causing P to watch a sexual act (Section 33).
  - Using inducement, threat or deception to procure sexual activity with P (Section 34).
  - Causing P to engage in or agree to engage in sexual activity by inducement, threat or deception (Section 35).
  - Engaging in sexual activity in the presence of P (procured by inducement threat or

deception of P) (Section 36).

- Causing P to watch a sexual act by inducement, threat or deception (Section 37).

**11.4** Meanwhile the [Mental Capacity Act 2005](#) (MCA) also states that if you engage in sexual activity with a person who lacks capacity, it is a crime. Consequently, public authorities such as the NHS are required to “undertake the very closest supervision of that individual to ensure, to such an extent as possible, that the opportunity for sexual relations is removed”. *IM v LM & Others* ([\[2004\] EWCA Civ 37](#)) at paragraph 1. Sometimes such steps will amount to a deprivation of liberty ([D Borough Council v AB \[2011\] EWCH 101 COP](#); [A Council v H \[2012\] EWHC 49 \(COP\)](#)).

**11.5** The mental capacity assessment is to assess whether the person has capacity to decide to engage in sexual relations (this encompasses someone who initiates sexual activity as well as someone who is consenting or not to the advances of another). Clinicians should note that the test for capacity is activity specific and not person specific so to demonstrate capacity P needs to understand, retain, weigh and use the following information:

- a) The mechanics of the act and its sexual nature and character – i.e. that it is not a medical examination or procedure.
- b) That the other person must have the capacity to consent and must consent before and throughout sexual activity.
- c) That P can say yes or no to sexual relations and is able to decide whether to give or withhold consent.
- d) That sexual relations can lead to pregnancy.
- e) That there is health risks involved in sexual activity, particularly sexually transmitted infections, and that this risk can be reduced by using a condom.

It is evident that not all these considerations will apply in every case (for example, if sexual activity is between two people of the same biological gender, then pregnancy will not be a risk). However, staff must have a clear rationale for not addressing any of these factors, and this must be recorded in the capacity assessment form.

P is not required to have a more detailed knowledge of any of these factors than the capacitous person, but the capacity assessment must evidence that they are able to understand, retain (for at least a period), weigh and use this information in their decision to engage in sexual activity – including if this needs to be explained to them. If the person cannot do this, then consideration should be given to how they can be supported to do this, which may be through sex education. Where appropriate, staff may be required to advise where condoms are available.

**11.6** There is extensive case law in this area which has signalled a move from focusing on the narrow consideration of whether a person has capacity to consent to sexual relations, to questioning whether someone has the ability to choose whether or not to engage in sexual relations. i.e. not just whether they have the capacity to agree to sexual activity initiated by another person, but P’s capacity in the wider context of initiating relations with others. Fundamental to this is understanding that the other person must also consent. The case law also strives to strike a balance between supporting autonomy and protecting the vulnerable.

**11.7** Another consideration is whether the lack of knowledge is due to a lack of education or

due to the underlying impairment or disturbance in the functioning of the mind or brain.<sup>1</sup>

- 11.8** If staff see, or are aware that patients are engaging in sexual activity with other patients or visitors, either in a communal area or in a private area, such as a bedroom and no specific care plan is in place for that sexual interaction, staff should immediately speak to a colleague (**do not take action by yourself if possible**), and both should attend and take steps, in the most sensitive way possible, to get the parties to cease the sexual activities (i.e. loudly knocking on the door).
- 11.9** As soon as is reasonably practicable after the activity has stopped, an assessment of each service user's capacity to decide to engage in sexual relations should be carried out by suitable health professionals (where possible by clinicians who have established relationships with the patients) and the assessments documented in their clinical records. The incident and review of capacity should be reported to the relevant service manager and shared with the relevant Safeguarding lead practitioner.
- 11.10** If because of that assessment it is clear that one of the patients lacked capacity to decide to engage in sexual relations, the sexual assault procedure below should be followed, and contact made with the Trust Accredited Security Management Service (ASMS) who would advise on contacting the police.
- 11.11** Sexual activity between inpatients in a hospital setting is to be strongly and actively discouraged. If, having intervened, the capacity assessments confirm that both patients have capacity to decide to engage in sexual relations (and believe that they are in a relationship), the MDT including the respective patients' Responsible Clinician or consultant, must consider whether a care plan needs to be developed to avoid a potential infringement of a right under the European Convention on Human Rights (as enacted by the Human Rights Act 1998) for example Article 8 – Right to respect for private and family life. However, the hospital setting is not an appropriate environment for intimate sexual relationships, see 7.7. Where appropriate, staff may be required to advise where condoms are available.
- 11.12** Consideration must be given about the extent to which the relationship should be facilitated. Legal advice must be sought if such a care plan is being considered, including sexual interaction. If staff have had to intervene in the manner noted above, full documentation of the action taken and the basis for this must be made in the patient's notes. In addition, where an assault has been witnessed or an allegation has been made or there are concerns about the capacity of one of the individuals, the Sexual Assault Procedure will then have to be implemented including the procedure for contact with the police. If staff are unclear as to what action to take, they should immediately seek the advice of a senior manager, who can obtain legal advice if it is required.

## **12. GUIDANCE FOR WHEN AN ALLEGATION HAS BEEN MADE**

- 12.1** If an allegation of rape or sexual assault has been made in an inpatient setting, it is essential to place the alleged victim and/or the person alleged to have caused the harm under close observation, for example if there is an increased risk of self-harm. A risk assessment must be completed and added to the patient's clinical records.

---

<sup>1</sup> PC v NC v City of York, [2013] Civ 487

- 12.2** Contact the Trust ASMS ideally immediately, who will advise regarding contacting the Police. Isolate the alleged victim from the alleged offender where possible.
- 12.3** If Trust ASMS are unable to respond, contact the Police and support the individuals to engage with the Police.
- 12.4** The gender of the nurse caring for the patient cannot be ignored. Staff must always remain aware of the sensitivities of patients. Following an allegation of sexual assault, sexual abuse or rape a patient may request to be cared for by a male or a female nurse, and as far as possible this should be respected. This may mean either a move to another ward or the patient being nursed by an unfamiliar member of staff; it is important that the patient is consulted about these changes.
- 12.5** If a person alleged to have caused the harm is also a service user of the Trust, support should be offered to that person, but care should be taken not to prejudice the quality of the evidence to be given by him/her to the police. It is very important that staff should not pre-judge the guilt or innocence of an alleged person. The Crown Prosecution Service has the ultimate responsibility for deciding whether to go ahead with a prosecution and will decide whether to prosecute based on the evidence supplied.
- 12.6** The alleged person's family and friends must not to be informed unless valid informed consent has been given by a capacitous patient.
- 12.7** The person alleged to have caused harm must be risk assessed in much the same way as an alleged victim using the Trust's Assessing and Managing Clinical Risk and Safety Policy.
- 12.8** In all situations an effective response to reports of sexual assault involves more than simply reporting the incident and includes the following:
- The patient who has disclosed the sexual assault should immediately be **provided a safe, quiet and private space**. Both patients should be kept apart from each other.
  - Recognition of the **rights and psychological** needs of someone who has been sexually assaulted.
  - Take reasonable steps to accommodate the client's expressed gender preference for personnel.
  - **Explore the disclosure** – let the service user tell staff in their own words and at their own pace about their experience and concerns. Once they feel able, staff should gently encourage the service user with the name of the alleged person who caused the harm, where and when the alleged assault or harassment took place and any injuries or other concerns that may require medical attention. Be careful **to only ask open questions** and not closed questions to prevent any risk of contamination of evidence.
  - Record this interview in detail, being mindful that it may be subsequently used as evidence in court. Ensure documentation of the incident reflects the client's own words. Any statements/comments made by patients regarding the sexual activity should be recorded in full in the clinical record and this information may be required by police

and/or safeguarding to inform any subsequent enquiry.

## **12.9 Preservation of Evidence**

- The Trust ASMS should be contacted for immediate advice regarding the preservation of evidence, and they will liaise with the Police who can offer further advice.
- In cases where there is thought to be physical evidence of a crime, or the act has been witnessed (e.g. sexual assault), where possible, leave the environment and items within untouched, this includes not making any efforts to clean or rearrange the scene. Secure the location.
- Avoid washing anything or throwing any items away. Ideally the alleged victim should be advised not to wash themselves or their clothes or change clothes at this point.
- Try to keep the environment free from other people or note who is in the environment.
- Where possible the alleged victim should delay urination or if necessary, urinate into a sealable plastic container, which is then marked with the date and time as evidence.
- Secure any CCTV footage of the incident area. Photographs should be taken only when necessary, for example, when vital evidence of a crime may be lost. They should be taken and saved on a work device, and it should be noted that photographs have been taken on the Datix report. The ASMS should be informed that the photographs have been taken, and they should be disclosed to the police when requested.
- Secure any other physical evidence that may assist police, including visitor's books for example.

## **12.10 Re-establishing and Maintain Safety**

Protection of other patients and staff is a priority, and support should be made available where necessary. Re-establishing safety is of paramount importance for the alleged victim, other patients and staff. Special consideration should be given to ensuring that a patient alleging sexual assault, sexual abuse or rape is separate from the person alleged to have caused harm, placed in a safe place and sensitively observed and reasons for the observations given. If an inpatient, the person alleged to have caused the harm should be moved to another ward rather than the victim. This helps to avoid the feeling of blame and/or self-blame that can sometimes be attached to the victim of this crime. In some cases, the alleged victim may ask to be moved to another ward. Where possible this request should be accommodated. It is important that an alleged victim is not placed back in the same room or bed where an alleged assault took place.

## **12.11 Offer Support and Options**

Commonly, people minimise their feelings about the assault or to feel they do not need assistance. Reassurance and support can help to validate the experience and assist them to take appropriate steps to deal with a sexual assault. Staff should calmly outline the options so that the service user can make an informed decision about how they want to proceed. The alleged victim should be allowed a support person of their choosing. Where appropriate, the risk of infection or pregnancy should be discussed, and testing

recommended.

### **12.12 Assess Capacity to Maintain Informed Decisions**

Ensure capacity is reassessed and is decision specific following the Mental Capacity Act Policy. The capacity to make informed decisions requires not only cognitive function but also the ability to process the information in a meaningful way.

### **12.13 Liaison with the Sexual Assault Referral Centre (SARC)**

Hope House SARC offers emotional and practical support; as well as medical care to anyone who has experienced sexual violence or sexual abuse. Patients are offered support based on their individual needs and can choose to use as much or as little of the service as they wish. Patients can access SARC via the Police and other professionals.

**12.14** The SARC service operates a 24/7 advice line, for members of the public and professionals. Anyone can refer into the service; regardless of when the incident has happened.

**12.15** To refer, call the 24/7 phone line (0300 421 8400) or click on the link to [Hope House SARC | Gloucestershire Care Services NHS Trust](#).

### **12.16 Recording the Incident**

All incidents must be reported on the Risk Management System (RMS), and the Trust incident reporting system, DATIX, as well as discussed with the MDT. A full record must be completed in the clinical record. A safeguarding concern must be completed, and the police must be informed via the Trust ASMS team, ideally.

### **12.17 Referral and Reporting**

If the service user/patient lacks mental capacity but alleges that a sexual incident has occurred, discuss with MDT, review clinical documentation and consider reporting to the police in their best interests.

### **12.18 Follow-Up for the Alleged Victim**

Ensure that on-going support is offered to the alleged victim, including access to counselling.

### **12.19 Witness Statements**

Clinical staff on duty at the time of an alleged sexual incident should record a detailed witness statement at the earliest opportunity – detailing what was observed – about the whole environment as well as behaviours and activities of those alleged to have engaged in the sexual incident, where they were at the time of the alleged incident, and precipitating or subsequent behaviours observed. Statements should be signed and dated and may be required to inform a subsequent police or safeguarding enquiry. The Trust ASMS will assist with this process.

### **12.20 Commencing Internal Investigations when the Police are Involved**

Clinicians must fully cooperate with any subsequent police, Safeguarding or Root Cause Analysis (RCA) enquiry processes. Where the Police are leading a criminal investigation,

their investigation will take precedence.

If a serious incident has been deemed to have occurred and requires investigation, the Trust ASMS will seek to reach an agreement, and receive written confirmation, between the Trust and the Police, as to when an internal investigation may commence. This can take the form of an email or letter.

### 12.21 What Happens If the Police Decline to Investigate?

Should the police decide not to proceed with any investigation, this should not affect any decision by the Trust as to whether to initiate its own enquiry into the incident.

If it has been stated by the police that there are no grounds for complaint (or that they cannot proceed through lack of evidence or because the evidence is of insufficient quality), this must be recorded in the patient's clinical records, and the relevant Clinical Director, Directorate Manager, Safeguarding Lead and Public Protection must be informed of the situation.

Where an incident has occurred, even where police decline to investigate, this will require both a STEIS (Strategic Executive Information System – used by the Trust's Experience, Safety and Risk Team) and Safeguarding process.

### 12.22 Repeat Allegations

There may be very rare instances when a patient continually makes allegations of sexual assault or rape against other patients or members of staff, which are malicious, or false, as a result of illness. This is an extremely sensitive situation to deal with given that such a person may be, or become in the future, a victim of an assault. In these circumstances, the procedure for contacting the police noted above must be followed, by referral to the Trust ASMS. **The decision whether to proceed with an investigation will rest with the police and not with any member of staff until it has been established by the police that there are no grounds to take it further.**

The Trust ASMS will aim to agree a management plan with Police where an individual patient repeatedly raises allegations of sexual assault or rape. Such plans must be in writing and signed by both a senior Police Representative and the Directorate Manager, Safeguarding Lead or their representative.

## 13. CHILDREN, CAPACITY AND BEST INTERESTS

**13.1** According to the World Health Organisation (WHO)<sup>2</sup>: “Child sexual abuse is the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society.”

**13.2** A child is a person under the age of 18 years, according to the [Family Law Reform Act 1969](#) and the European Convention on Rights of the Child. Only at the age of 18 is a person considered to have reached the ‘age of majority’ and treated as an adult. However, under

---

<sup>2</sup> [Report of the Consultation on Child Abuse Prevention](#), 29-31 March 1999, WHO, Geneva; page 15-16

the Sexual Offences Act 2003, a person aged 16 years and above can consent to sexual activity (including between people of the same sex). It is an offence for anyone to have any sexual activity with a person under the age of 16<sup>3</sup>.

- 13.3** Children under the age of 13 are legally deemed incapable of consenting to sexual activity and therefore all incidences of sexual behaviour involving children under 13 will be considered as a criminal and child protection matter and must be reported.
- 13.4** Clinicians are to note that the following constitutes an offence and should refer to the Safeguarding Children Policy and Procedure (C).
- Engaging in sexual activity with a child
  - Causing or inciting a child to engage in sexual activity
  - Engaging in sexual activity in the presence of a Child
  - Causing a child to watch a sexual act
  - Engaging in sexual communication with a child
  - Arranging or facilitating sexual activity with a child.
- 13.5** Although use of the Internet and social media offers many positive opportunities for learning and communication, it may also increase the sexual risks to patients by allowing access to inappropriate or illegal internet pornography, sexual chat rooms, opportunities for grooming etc. Younger adults, adolescents and children, who are more likely to use the Internet and social media, may be particularly at risk. Clinicians need to be aware of patients' digital lives and how this contributes to risk assessment.
- 13.6** In the event of a child under 18 being involved as the alleged victim or alleged perpetrator, the Safeguarding Children Policy must be followed. The Safeguarding Advice line can be telephone on 0300 421 6969.
- 13.7** It is a criminal offence to engage in any type of sexual activity or relationship with a child less than 16 years of age. In Children under 16, then Fraser Guidelines should be used by all professionals to assess the child's maturity and intelligence to understand the nature and implications the advice and treatment offered. Health professionals should still encourage the young person to inform his or her parent(s) or get permission to do so on their behalf, but if this permission is not given, they can still give the child advice and treatment. If the conditions are not all met, however, or **there is reason to believe that the child is under pressure to give consent or is being exploited, there would be grounds to break confidentiality, and the safeguarding policy should be followed.** Further advice relating to issues of this nature can be sought from the Trust's Safeguarding Team.<sup>4</sup>
- 13.8** Where a child under the age of 13 is involved in a sexual activity then regardless of the child's expressed wishes or whether the clinician believes the child is Gillick competent to decide about sexual activity, this must be reported to the police and the police will consider this as a criminal offence. A multi-agency assessment of risk would be essential where a child, 13 or under, is engaged in a sexual relationship. This is an offence under the Sexual

---

<sup>3</sup> The Sexual Offences Act 2003 is more nuanced for some offences where the child is aged 13-15 years. See for example Sections 9, 10 and 11.

<sup>4</sup> Gillick v West Norfolk and Wisbech Area Health Authority and Department of Health and Social Security: HL 17 Oct 1985

Offences Act 2003<sup>5</sup>. A MARF (Multi Agency Request Form) must be completed and refer to safeguarding children's policy.

- 13.9** The [Children Act 2004](#) places statutory requirements on NHS Trusts to protect and safeguard the interests of children in their care.

### **13.10 Patients Over 16 Lacking Capacity**

A patient aged 16 who has capacity to decide to engage in sexual relations may engage in a sexual relationship; clinicians must always be mindful to consider whether the young person has provided valid informed consent or may be subject to coercion or abuse.

If the patient (regardless of their age or whether in a ward or community setting) who has reported the rape or assault lacks capacity, a decision may be taken to appoint an Independent Mental Capacity Advocate (IMCA).

The Mental Capacity Act makes it a duty for the NHS and Local Authorities to ensure that when a person who lacks capacity has no one to speak for them and there is a safeguarding issue, an IMCA is appointed. IMCAs can represent the interests of people (both victims and perpetrators) who lack capacity in cases of assault. Where an IMCA is unavailable, a Care Act Advocate should be offered.

### **13.11 Best Interests**

If the patient lacks capacity, the Mental Capacity Act requires that any act or decision made on behalf of the patient must be done in their best interests. That Act provides a Best Interests Checklist to assist in deciding what constitutes best interests.

The following points must be considered to enable the healthcare professional to decide what is in the best interests of the service user:

- No decision should be made based on an individual's age, appearance, condition or behaviour.
- All the relevant circumstances of the individual's case should be considered when deciding what is in their best interests.
- Is the person likely at some time in the future to have capacity in relation to the matter in question?
- If so, when is that likely to be? In some situations, this will be impossible to determine, but in others where, for example, the service user has temporarily lost consciousness as a result of the administration of an anaesthetic, an accurate prediction is more likely to be made.
- The person for whom the decision is to be made should be encouraged to be involved and participate as fully as possible in any decision or act done for him/her, this might involve using visual or other communication aids.

---

<sup>5</sup> Sexual Offences Act (2003) s5-8

- Consideration must be given as far as reasonably ascertainable to the person's past and present wishes and feelings, and the beliefs, values and any other factors that would be likely to be considered if the person had capacity. Healthcare professionals are required to make enquiries of relatives, carers and friends of the service user. Any written statements or advance decisions made while the patient had capacity must be considered.

**13.12** So far as is practicable and appropriate the following individuals must be consulted:

- Anyone identified by the service user as someone to be consulted.
- Anyone engaged in caring for the person or interested in their welfare.
- Anyone appointed as a Donee of a Lasting Power of Attorney.
- ANY Deputy appointed for the person by the Court of Protection.

#### **14. COMPLAINTS AGAINST MEMBERS OF STAFF**

**14.1** This policy will still apply. The Trust has a duty of care to all patients receiving services. It is the responsibility of every member of staff to never display sexualised behaviour towards patients. The [Sexual Offences Act 2003](#) Sections 30-44 set out the various offences committed against persons with a mental disorder, including offences committed by Care Workers. It is also a breach of the Trust's Code of Conduct and Professional Codes of Conduct for the person's regulatory body, for example the Nursing and Midwifery Council or the General Medical Council.

**14.2** Where a child makes an allegation, the Safeguarding Children Policy (CLP071) should be followed.

**14.3** Where an adult makes an allegation, the Safeguarding Adults Policy and Procedure (CLP101) should be followed.

**14.4** The Trust Managing Allegations Policy and Procedure (CLP152) should also be followed.

**14.5** 'Sexual Misconduct at work' policy is being developed in the Trust as per NHS E guidance.

#### **15. DEFINITIONS**

**15.1 Safeguarding – keeping people safe** - The Trust Safeguarding Guidance outlines the definitions of sexual abuse and sexual exploitation which are replicated here. Any sexual abuse or sexual exploitation concern must be raised as Safeguarding and the local safeguarding procedures must be followed.

<b>LGBTQI+</b>	Lesbian, gay, bisexual, transgender, intersex, queer/questioning, asexual and many other terms (such as non-binary and pansexual).  This policy applies equally to all spectrums of sexual orientation and gender identity.
<b>Sexual</b>	Rape, indecent exposure, sexual harassment, inappropriate looking

<b>Abuse</b>	or touching, sexual teasing or innuendo, sexual photography, subjection to pornography or witnessing sexual acts, indecent exposure and sexual assault or sexual acts to which the individual has not consented or was pressured into consenting. This includes situations where an individual cannot give informed consent to engage in sexual activity, including those affected by alcohol, illicit drugs or a disability.
<b>Sexual Exploitation</b>	<p>Involves exploitative situations, contexts and relationships where individuals at risk (or a third person or persons) receive 'something' (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of them performing and/or another or others performing on them, sexual activities. It affects children, men as well as women, and non-binary individuals. People who are sexually exploited do not always perceive that they are being exploited.</p> <p>In all cases those exploiting the individual child or adult have the power over them by virtue of their age, gender, intellect, physical strength and/or economic or other resources. There is a distinct inequality in the relationship. Signs to look out for are: not being able to speak to the child or adult alone; observation of the child or adult seeking approval from the exploiter to respond; and the person exploiting the child or adult answering for them and making decisions without consulting them.</p>
<b>Sexual Consent</b>	<p>Where an individual has the freedom and capacity to agree to sexual activity with other persons. It is important to note that individuals with mental health conditions may appear to consent to activity but may lack capacity due to their mental health condition.</p> <p>Consent must be given freely and not due to threats or emotional pressure (explicit or implicit). A person cannot be presumed to have consented to sexual activity because they are in a relationship with the other person; or because they have had sexual contact with them in the past.</p>
<b>Sexual Incident</b>	Sexual incidents: this includes any behaviour of a sexual nature that is unwanted, or makes another person feel uncomfortable or afraid. This includes assault and harassment. It also extends to being spoken to using sexualised language or observing other people behaving in a sexually disinhibited manner, including nakedness and exposure or self-stimulation which may have occurred in a private bedroom or bathroom.
<b>Sexual Safety</b>	In this policy, this is defined as feeling safe from any unwanted behaviour of a sexual nature, as defined in sexual incidents (above).
<b>Sexual Wellbeing</b>	In this policy, this is defined as feeling and being sexually safe in acute mental health inpatient environments, including being free from unwanted sexual activity, sexual harassment and sexual assault.

## 15.2 Sexual Offences - The [Sexual Offences Act \(2003\)](#) sets out definitions of sexual assault,

assault by penetration and rape, which are helpful in understanding those terms. All are prosecutable offences. Further information is provided below. The Sexual Offences Act also includes specific offences relating to persons with a mental disorder. Other Acts of Parliament (The Criminal Justice Act 1988 and the Protection of Children Act 1978) cover offences such as possession of extreme pornography and indecent images of children. Sexual harassment is also included below. All of the above are prohibited.

<b>Sexual Assault</b>	Sexual assault is defined by <a href="#">Section 3</a> of the Sexual Offences Act 2003 as intentionally touching another person, where the touching is sexual, and the other person has not consented to the touching, and the offender does not reasonably believe that the victim consents. This offence covers a wide range of behaviour including, for example, rubbing up against someone's private parts through the person's clothes for sexual gratification.
<b>Assault by Penetration</b>	This is where a person intentionally penetrates the vagina or anus of another person. This offence is committed where the penetration is by a part of the perpetrator's body (for example, a finger) or anything else, (for example, a bottle); where the penetration is sexual, so that it excludes, for example, intimate searches and medical procedures; where there is no consent to the penetration; and where the perpetrator does not reasonably believe that consent exists. This can be committed by a male or female (or a non-binary individual), against a male, female or non-binary individual.
<b>Rape</b>	<p>Rape occurs when:          Someone person (A) intentionally penetrates (with their penis) the vagina, anus or mouth of another person (B); when          B does not consent to the penetration; and          A does not reasonably believe that B consents.</p> <p>Under the terms of the Act, rape can only be committed when there is penile penetration (i.e. by a male or a trans woman who has not undergone gender reassignment surgery). However, it does not follow that the victim will in all cases be a female, as males can also be victims of rape.</p> <p>If a serious sexual assault (i.e. penetration) occurs with an object or another part of the body, then that is a crime under <a href="#">Section 2</a> – assault by penetration. This can be committed by anyone, regardless of gender.</p> <p>Sexual intercourse with a child under 13 (regardless of apparent consent) is also defined as rape under <a href="#">Section 5</a>.</p>
<b>Illegal Pornography</b>	It is a criminal offence to be in the possession of extreme pornographic images. This is set out in <a href="#">Section 63 (Part 5) of the Criminal Justice and Immigration Act 2008</a> . It will be a criminal offence to possess an image that depicts, in an explicit and realistic

	<p>way, the following:</p> <ul style="list-style-type: none"> <li>• An act which threatens a person’s life;</li> <li>• An act which results or is likely to result in serious injury to a person’s anus, breasts or genitals;</li> <li>• An act which involves sexual interference with a human corpse; or</li> <li>• A person performing an act of intercourse or oral sex with an animal.</li> </ul> <p><a href="#">Broadly, Section 64</a> excludes films classified by the British Board of Film Classification (BBFC), even if it contains images which would otherwise breach Section 63 above. However, this is not an absolute exclusion and in some cases, someone possessing images from a classified film may still be committing an offence under Section 63.</p> <p><b>The Trust prohibits the possession or accessing of all extreme pornographic material (whether or not it is taken from BBFC classified films) on its site and will alert the police if this activity is discovered or reported.</b></p> <p>If staff become aware that individuals have accessed illegal material offsite, then this will also be reported to the appropriate authorities.</p>
<p><b>Possession of Images</b></p>	<p>Possession of Indecent Photographs of Children: under Possession of Indecent Photographs of Children: under both the Sexual Offences Act 2003 and the <a href="#">Protection of Children Act 1978</a>, there are specific criminal offences concerning the possession of indecent photographs of children (under <a href="#">Section 160 of the Criminal Justice Act 1988</a> ). This includes images on computers and other devices such as tablets or smartphones.</p> <p>In relation to extreme pornographic images (of children or adults etc.). Under Section 63 of the Sexual Offences Act, ‘possession’ will include images on a smartphone, computer, tablet or other device.</p> <p><b>The Trust prohibits the possession or accessing of such material on its sites and will alert the appropriate authorities if this activity is discovered or reported.</b></p> <p>If staff become aware that individuals have accessed illegal material offsite, then this will also be reported to the appropriate authorities.</p>
<p><b>Offences Relating to those who have a Mental Disorder</b></p>	<p>The Sexual Offences Act 2003 contains a number of offences in relation to those who have a mental disorder. The definition of mental disorder under the Act is the same as under Section 1 of the Mental Health Act 1983, “any disorder or disability of the mind”.</p> <p>Sections 30-44 of the Sexual Offences Act set out the various offences committed against persons with a mental disorder. These</p>

	<p>are broadly split between three specific types; direct offences against the victim, inducements that cause an offence to be committed and offences carried out by carers of the mentally impaired. More specifically, these include:</p> <p><a href="#">Section 30</a>: Sexual activity with a person with a mental disorder impeding choice.</p> <p>Section 31: Causing or inciting a person, with a mental disorder impeding choice, to engage in a sexual activity.</p> <p>Section 33: Causing a person with a mental disorder, impeding choice, to watch a sexual act. (The act can be live or recorded, moving or still, and where the offender’s motive is one of sexual gratification.)</p> <p><a href="#">Section 34</a>: Inducement, threat or deception to procure sexual activity with a person with a mental disorder.</p> <p>Section 35: Causing a person with mental disorder to engage in or agree to engage in sexual activity by inducement, threat or deception.</p> <p><a href="#">Section 38</a>: Care Workers – sexual activity with a person with a mental disorder.</p> <p>Section 39: Care Workers – causing or inciting sexual activity.</p> <p>Section 40: Care Workers – sexual activity in the presence of a person with a mental disorder.</p> <p>Section 41: Care Workers – causing a person with a mental disorder to watch a sexual act.</p>
<p><b>Sexual Harassment</b></p>	<p>Sexual harassment is not defined as a sexual offence under the Sexual Offences Act 2003 but is usually defined in the context of sexual harassment in the workplace. Harassment more generally (including sexual harassment) is dealt with by the <a href="#">Protection from Harassment Act 1997</a>. <a href="#">Section 1</a> prohibits any course of conduct which amounts to the harassment of another, or which a person knows or ought to know amounts to the harassment of another.</p> <p>The accepted definition of sexual harassment includes unwelcome sexual advances, sexual verbal abuse, unwelcome requests for sexual favours, unwelcome conduct or innuendo of a sexual nature in relation to another person.</p>

**16. PROCESS FOR MONITORING COMPLIANCE**

Are the systems or processes in this document monitored in line with national, regional, trust or local requirements?	YES
---	-----

Monitoring Requirements and Methodology	Frequency	Further Actions
---	-----------	-----------------

<p>Sexual safety incidents are reviewed regularly, to ensure that quality and compliance with this and related policies is achieved and assurance of learning gained.</p> <p>The Trust Positive and Safe Group also provides a monitoring mechanism as per annual action plan and explores trends and themes of incidents through bimonthly reporting and meeting.</p> <p>NHS E guidance on Sexual Misconduct connects with this policy and will be further developed.</p>	<p>Bimonthly</p>	<p>The Quality Assurance Group (QAG) receives reports monthly for governance/assurance, concerning sexual safety incidents occurring in the clinical domain. This report includes data trends and themes plus narrative.</p>
--	------------------	--

## 17. INCIDENT AND NEAR MISS REPORTING

**17.1** To support monitoring and learning from harm, staff should utilise the Trust's Incident Reporting System, DATIX. For further guidance, staff and managers should reference the [Incident Reporting Policy](#). For moderate and severe harm, or deaths, related to patient safety incidents, Regulation 20 Duty of Candour must be considered and guidance for staff can be found in the [Duty of Candour Policy](#) and Intranet resources. Professional Duty of Candour and the overarching principle of 'being open' should apply to all incidents. [Guidance for reporting sexual safety incidents on Datix - Interact](#)

**17.2** Summary details of sexual safety incidents reported on Datix, and which constitute a patient safety event, will be transmitted via the LFPSE system to NHS England. The Learn from Patient Safety Events (LFPSE) service is a national NHS system for the recording and analysis of patient safety events that occur in healthcare. Commissioners can also access data that has been submitted via LFPSE, to better understand their local recording practices and culture, and to support local safety improvement work. Information transmitted via LFPSE is anonymised but does include the age, sex and ethnicity of the patients involved, as well as a description of the incident and an assessment by staff of any physical and psychological harm caused to patients.

## 18. TRAINING

**18.1** Changes to policy and procedure will be communicated to management and employees via appropriate channels. Information will be available via the Trust intranet.

**18.2** Training will be provided to line managers to enable them to effectively manage staff.

**18.3** 'Awareness raising' of changes to policy and procedure is provided to managers and employees via appropriate communications including information available on the intranet, and face to face, and via training.

**18.4** Sexual Safety Awareness Training is available via the Care to Learn platform in the form of a short video. A local GHC eLearning module has been piloted and will be amended for general use for all employees from 2025.

**18.5** NHS E have produced a short film and an eLearning module 'Sexual Misconduct at work' (2024) which will be linked to this policy alongside a local GHC 'Sexual Safety at work' policy, currently in development. This will complement existing resources. The links are below.

18.6 A local GHC Trust Policy 'Sexual Misconduct' is in development for use in 2025.

## 19. REFERENCES

[Sexual Safety of Mental Health Consumers Guidelines \(2013\) New South Wales \(NSW\) Ministry of Health \(Australia\)](#)

[Sexual Safety - Responsibilities and Minimum Requirements for Mental Health Services \(2013\) New South Wales \(NSW\) Ministry of Health \(Australia\)](#)

[Sexual Offences Act 2003. \(C2\) London: HMSO](#)

[An Independent Investigation into the conduct of David Britten at the Peter Dally clinic: A report for NHS London July 2008 \(recommendations\)](#)

[Sexual Safety and the NHS Sexual Safety Charter - Interact](#)

[NHS England » Sexual safety in healthcare – organisational charter](#)

## 20. ASSOCIATED POLICIES

This Policy should be read in conjunction with the following GHC policies and documents:

- Managing Allegations against Professionals who work with Children and Adults (CLP152)
- Relationships and Professional Boundaries Policy
- Managing Feedback from Patients and Carers (Including Complaints) Policy (CGP010)
- Sexual Assault Referral Centre (SARC) Operational Policy
- Assessing and Managing Clinical Risk and Safety Policy (CLP249)
- Duty of Candour Policy (CGP004)
- Health Records and Clinical Record Keeping Policy (CLP005)
- Speaking Up at Work Policy
- Operational Risk Management Policy
- Overarching Supervision Policy: Clinical and Non-Clinical Supervision (CLP116)
- Observation and Engagement Policy (CLP229)
- Disciplinary Policy and Procedure
- Incidents Reporting and Management Policy and Procedure (CGP001)
- Mental Capacity Act – An overview of the MCA for GHC Staff
- Safeguarding Children Policy (CLP071)
- Safeguarding Adults Policy and Procedure (CLP101)
- Vulnerable Access Nurses Service (CLP137)
- Sexual Misconduct (in the workplace, in development for 2025)

## Appendix A - Sexual History Taking – Mental Health Services

The Vulnerable Access Nurse Team as part of the GHC Sexual Health services may be able to advise/support staff with taking a sexual history. Clinical Policy CLP137 can be found here [Vulnerable Access Nurses Team Sexual Health \(VANS\) Physical Health \(CLP137\) - Interact](#)

Staff have a responsibility to record a sexual history as part of the assessment which is critical to enable staff to adequately support the service user. The appropriate detail of the sexual history will vary between services and the appropriate timing of taking the sexual history will vary between patients (it must be sensitive to the patients' feelings and needs and usually should wait until the service user is stable).

It is best to start the sexual history with less intrusive questions regarding presenting concerns and symptoms before asking more sensitive questions regarding sexual behaviour. Staff should create a comfortable atmosphere with a relaxed and friendly approach. Using 'bridging' questions, which link general life-style questions to sexual history questions or 'universal' questions (questions which are explicitly asked of all patients), may also help when introducing sensitive questions.

Staff should explain to the patient that history taking is not designed to create embarrassment or discomfort and that it should aid the best patient outcome. This may encourage them to feel safe talking about sexual behaviour and sexuality because it is then seen as a normal part of any professional consultation and important in their overall management.

Sexual history taking may need to be delegated to someone of the same sex or cultural background. The expression of an individual's sexuality and ability to discuss sexual health with other people is influenced by many factors, including the cultural environment where a person is raised and lives, social norms and environmental factors. Recognition of these influences on an individual's sexual development and behaviour is essential to understanding the patient's condition and ability to talk openly about these issues during history taking.

Staff should be aware of their own attitudes to sexuality and sexual expression. If you are uncomfortable, then the patient will be, so consider referring them to someone else.

Asking patients about sexual abuse/assault is important. It should be approached with care and sensitivity. They may never have been asked before or may be in contact with services because of a recent/past sexual assault. Patients may not recognise unwanted sexual experiences as 'assault'. Use prompts such as "Have you ever been forced to have sex against your will?" or "Have you had any unpleasant experiences with sex? If the patient identifies a history of sexual assault or abuse, offer appropriate follow-up and ensure a Staying Safe plan is developed. A referral for Safeguarding should be considered.

Staff have a responsibility to assess the sexual health of patients on admission/ initial assessment and on an on-going basis, to ensure they prevent the spread of infection and refer any current sexual health problems for treatment.

Should they have concerns about a service user's sexual health they must take appropriate action and refer to a specialist sexual health clinic for treatment or advise that the service user visit a local sexual health clinic.

## **Appendix B – Myths about Rape**

### **'Rape cannot happen between husband and wife' – False**

Rape within marriage and relationships whether straight or gay do occur. If your partner, husband or wife has forced you into having sex with them, the SARC and our Sexual Offences Investigative Trained officers (SOIT) will treat the matter as seriously as with all other rapes and sexual assaults.

### **'Most rapists are strangers' – False**

When most people think about how rapes occur, they imagine desolate dark alleyways late at night and the attacker being a stranger. The truth is that the majority of people who commit rape do know their victims and in some cases are relations, friends or work colleagues.

### **'Men cannot be sexually assaulted' – False**

Assault by penetration is when a person commits assault by penetration if they intentionally penetrate the vagina or anus of another person with a part of the body or anything else, without their consent. The perpetrator can be male or female, and so can the victim.

### **'She or he was raped because of the way they were dancing and the way they were dressed' – False**

No one should feel that they are to blame for a rape or sexual assault because of the way they were dressed or the way they were dancing. Our main concern is that the crime is reported and that you receive the specialist care you deserve. Nobody will judge you.

### **'Male rape is a gay crime' – False**

Sexual assault is ultimately about power, control or domination of the other person, rather than a sexual attraction to one specific gender.

### **'All rape victims have injuries' – False**

All rape victims' experiences are different. The scars may be emotional or physical. Whatever the case all rape and sexual assault are treated seriously by the police and the victim will be treated according to their specific needs.

### **'A rape victim always needs to say no to show they don't consent' – False**

There is a presumption that all rape victims need to say the word 'no' to state that they do not consent to sex. The reality is that some victims will 'freeze' during an attack. This is sometimes due to shock or fear of the attacker. The police will always consider these factors or anything else that prevented the victim from saying 'no'.

### **'My friend was raped, but I feel helpless because I can't report it' – False**

If someone you know has been raped, you can report it to the police. They will log the incident and ask you to try and persuade the victim to speak to us directly or attend a Sexual Assault Referral Centre (SARC). Third party reporting is particularly effective if the victim does not feel comfortable in speaking to the police initially or if there is a language barrier. In addition, you can make a report anonymously if you wish. This will help the police build up intelligence.

### **'The police won't believe me' – False**

The police take all rape and sexual assault reports seriously. No matter who you are, how long ago the assault happened, or how it took place, the police are committed to listening, understanding and helping through this difficult time whilst always listening to and respecting your

wishes.

**'You can only report rape to the police' – False**

You can report rape at the SARC, without having to speak to police. However, they will approach the police if you want them to. In addition, you can seek advice from charities and organisations who will discuss what kind of help is available to you - see related links.

**Rape and other sexual assault is an occupational hazard for sex workers – False**

Sex workers have the right to say no. Their work involves the agreement to provide specific services, not non-consensual sexual violence and other crime. They can be victimised by perpetrators of rape just like anyone else. The Police have brought to justice numerous perpetrators of rape against sex workers and takes crimes against sex workers very seriously. Sex workers can sign up for free to the independently run [National Ugly Mugs Scheme](#) to report crimes against them, help alert other sex workers, get advice about reporting to the police and get information about sex work projects who can provide support.

## Appendix C – Advance Directives and Advance Decisions

A basic sexual history will include exploring whether the patient has a diagnosis of HIV, whether they are aware of their Hepatitis B and Hepatitis C status, history of other sexually transmitted infections (STIs), pregnancies, medication and contraception, abuse, impairment and vulnerability issues, past offences and/or incidents, physical frailty issues, existence of an Advance Decision etc., e.g. if they should become sexually disinhibited.

Some patients may have made an Advance Directive or Advance Decision regarding their sexualised behaviour when in hospital.

Advance directives or decisions can only be made by a patient at a time when they have capacity, and for this reason, it is advisable that the appropriate community team facilitates this discussion.

Patients living with a mental illness may have previously experienced an episode of acute illness where they became sexually disinhibited. They may have consequently made an:

- Advance Directive (wish list, not legally binding but should be considered when discussing arrangements for care and treatment); *or an*
- Advance Decision (this is legally binding and is refusal of a specific treatment).

Examples of Advance Directives may include:

1. Requests to be accommodated in single sex provision when acutely unwell.
2. Requests the clothing a person is dressed in is modest/not revealing (i.e. when they are dressed by a member of staff).
3. Requests ensuring staff undertaking 1:1 observation are not of a specific gender as when patient is well, they are embarrassed by behaviour they may exhibit when acutely unwell.

Requests ensuring that they continue to be prescribed contraceptive medication and are supported to take this.