Sexual Safety Framework for Approved and Designated Centres 2025

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Foreword

Safeguarding residents and service users from harm, including sexual harm as a result of abuse is a central priority within the Health Service Executive's (HSE) overall approach to safeguarding and safety. The HSE Patient Safety Strategy, Safeguarding Policy and Child Protection and Welfare Policy sets out our commitments, procedures and processes through which we aim to protect people from harm.

Unfortunately, even with strategies, policies and procedures in place incidents of a sexual nature continue to occur in our mental health, disability and older persons services. Ireland is not unique in this regard, health and social care providers around the world have recognised the risk of sexual harm to residents and service users in these settings. There is evidence in Ireland and internationally about the types of incidents that occur, who is affected, in which services, and how such incidents can be prevented.

In the HSE, lessons for prevention and improvement come from surveillance of resident and service user safety, from the regulation of approved and designated centres, from safeguarding data and from serious case reviews. Notably, the Brandon and Emily Reports from the National Independent Review Panel each pertained to incidents of a sexual nature, including at the most extreme end of the spectrum, the rape of a resident who was in our care. As an organisation we have a moral and statutory responsibility to those affected to prevent the recurrence of such incidents.

Following the publication of the Emily Report, the HSE convened a Sexual Safety Task and Finish Group to produce guidance for staff on the management of incidents of a sexual nature. The overarching aim of the document is to contribute to a robust and consistent approach to the prevention of incidents of a sexual nature and should they occur to ensure an immediate and comprehensive response. The guidance seeks to ensure that the person affected is always the priority and their safety, medical and psychological care needs are effectively assessed and responded to. To help achieve this aim a National Safeguarding Network has been launched which will hold education events and issue supporting tools on an ongoing basis to build staff capability in this area. I would emphasise the requirement for all staff to complete adult safeguarding and child protection and welfare training at a minimum, and encourage those working in approved or designated centres to join the National Safeguarding Network.

The Task and Finish Group was chaired by Sarah Mahon, Principal Social Worker from the HSE's National Safeguarding Office and project managed by Sarah Moynihan, Access and Integration Quality and Patient Safety Manager. The group had multidisciplinary membership including medical and nursing specialists from Sexual Assault Treatment Units as well as representatives from the services in scope. In addition, the Task and Finish Group engaged with a wide range of advocacy, resident and service user representative organisations. I would like to sincerely thank everyone who contributed.

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Managing Incidents of a Sexual Nature in Approved and Designated Centres

Part A Background and Introduction

This Sexual Safety Framework has been produced to promote improved operation of the **HSE (2020) Incident Management Framework (IMF)**, when incidents of a sexual nature occur in HSE or HSE funded approved and designated centres. While the document focuses primarily on the operation of the IMF it also refers to other policies and guidelines that may need to be operated concurrently, e.g. Safeguarding Vulnerable Persons at Risk of Abuse, National Policy and Procedures (HSE, 2014a), National Guidelines on Referral and Forensic Clinical Examination Following Rape and Sexual Assault (Ireland), 5th Edition (Sexual Assault Response Team [SART], 2023), Child Protection and Welfare Policy (HSE, 2019a), Trust in Care (HSE, 2005), Open Disclosure Policy (HSE, 2025) and HSE Enterprise Risk Management Policy and Procedures (HSE, 2023a). This guidance document is not a substitute for any of the aforementioned policies which should be referred to in full.

The intention of this guidance document is to assist staff in operating the extant IMF (2020) and any other relevant policies effectively when an incident of a sexual nature occurs or when historical incidents of a sexual nature require management retrospectively. This guidance document has been produced in response to the inconsistency with which incidents of a sexual nature are currently managed across the HSE, this has been demonstrated by internal HSE patient safety surveillance, independent reviews such as Brandon Report (HSE, 2021a) and Emily Report (HSE, 2023b) and also by regulators.

Language

The language used in health and social care to describe incidents of a sexual nature affecting adults has not been harmonised, and so can be confusing, unlike in the case of child protection. Language has not been harmonised either internationally or between agencies delivering health and social care to adults. University College Cork (UCC) were commissioned by the HSE to examine the language in practice. Below are headline findings from the report.

The team from UCC noted that the published academic literature reviewed highlighted a gap in the use of the term sexual safety incident and a significant lack of consensus when it came to defining the terms relevant to sexual safety incidents within the context of health and social care. This lack of agreement has far-reaching consequences, particularly in terms of identifying, reporting, estimating prevalence rates, and conducting research in this area.

The reviewed academic papers did not provide specific definitions for the term “sexual safety incident”. Surprised by this, the researcher conducted a brief second search for definition + “sexual safety incident” and only two studies emerged Jackson (2020) and Manthorpe *et al.* (2011). The Jackson study referred specifically to the Care Quality Commission’s (CQC) definition of sexual safety.

Sexual harassment was referred to in the literature in the context of the legal workplace discrimination definition with a focus on the behaviour of patients toward staff specifically. However, sexual harassment does not have to apply specifically to the patient – staff interaction. It was recommended that the Irish legal definition be adopted by the Task and Finish Group. Sexual harassment is defined in section 14A(7)(a)(ii) of the Employment Equality Act 1998, as amended (EEA), as

> *“any form of unwanted verbal, non-verbal or physical conduct of a sexual nature, being conduct which… has the purpose or effect of violating a person’s dignity and creating an intimidating, hostile, degrading, humiliating or offensive environment for the person”.*

Whilst sexual assault was defined by Smith *et al.* (2018) as "non-consensual sexual contact of any kind", this is a term that has a legal basis in Ireland. Sexual assault is defined in section 2 of the Criminal Law (Rape) (Amendment) Act 1990 as being "the offence of indecent assault upon any male person and the offence of indecent assault upon any female person" and comprises touching the victim without consent in an indecent manner or in indecent circumstances. Aggravated sexual assault is sexual assault involving serious violence or the threat of serious violence. The definitions of a range of sexual violence terms have been published by the Department of Justice (2021) and this is also a useful reference point.

There is a clear lack of consensus in the literature regarding the definition of sexualised behaviour and various labels including "inappropriate sexual behaviour," "improper sexual behaviour," "sexually disinhibited behaviour," and "hypersexuality" are used interchangeably to describe extreme sexual behaviour in the context of dementia specifically. The definition proposed by Bartelet *et al.* (2014), emphasising that extreme sexual behaviour refers *to "verbal or physical sexual behaviour that is disproportionate, unacceptable, or disinhibited, often interfering with daily activities and occurring at inconvenient times or places with unwilling partners"* is comprehensive and noted to be potentially useful.

Various definitions of peer-to-peer behaviours were also discussed with "resident-to-resident aggression" (R-RA),"resident-to-resident elder mistreatment" (R-REM), and "resident-to-resident abuse" (R-RA) as put forth by McDonald *et al.* (2015), Castle *et al.* (2015), and Teresi *et al.* (2020) most frequently occurring. While these terms largely overlap, there are nuances to note. R-RA and R-REM both describe negative, aggressive, and intrusive interactions between long-term care residents that would likely be unwelcome in community settings and potentially cause physical and psychological distress. R-RA, however, is explicitly defined as *"aggressive behaviours between residents"* (Castle *et al.* 2015).

Other terms are relevant in the context of sexual safety in designated settings and these need to be considered. The umbrella terms of abuse and elder abuse are broad and can refer to sexual acts depending on the definition accepted. Definitions of sexual abuse, sexual victimisation, sexual neglect and sexual violence were therefore also considered by the Task and Finish Group, in addition to the final set of terms defined below (p.6-7), which are the single set of definitions to be used within the HSE going forward.

Abuse, as defined by Dixon *et al.* (2013) and Gill *et al.* (2019), is a broad and multifaceted concept that encompasses various forms of harm or distress inflicted on vulnerable individuals. It can take the shape of physical, verbal, psychological, sexual, or financial mistreatment, either as a single occurrence or repeated acts. Crucially, abuse occurs within relationships based on trust, including formal care arrangements, and may lead to physical or mental damage.

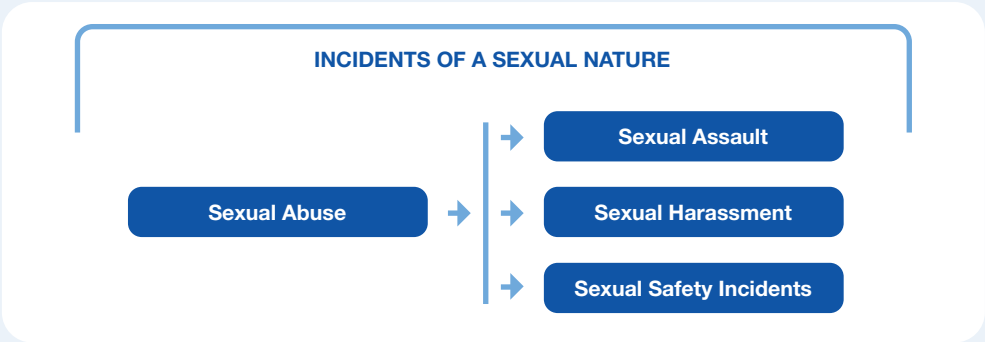
Nobels *et al.* (2021) references the World Health Organisation's (WHO) definition of sexual victimisation, which encompasses any non-consensual sexual act committed by any person, regardless of their relationship to the victim or the setting. This includes sexual harassment, non-penetrative sexual abuse, and (attempted) rape. Furthermore, Nobels *et al.* (2021) discuss the introduction of "sexual neglect" into the definition of elder abuse and neglect in Canada. They define sexual neglect as the failure to provide privacy, respect an individual's sexual orientation or gender identity, treating older adults as asexual, or preventing them from expressing their sexuality.

This inclusion recognises that disregarding the sexual rights and identities of older adults can be considered an act of violence. It reflects a broader understanding of elder abuse, acknowledging that it extends beyond physical harm to encompass the violation of personal autonomy and dignity in the context of sexual expression and identity. In addition to the context of sexual neglect in the older person's services, the Task and Finish Group recognised that the same principle, the failure to vindicate the rights of someone to express their sexuality can apply equally to disability and mental health services. Therefore, to promote a rights-based approach to sex, sexuality and relationships the term sexual neglect as defined hereunder will be adopted by the HSE.

Having considered all of the available evidence the terms below, and their definitions, were agreed upon for use by the HSE's Sexual Safety Task and Finish Group informed by research commissioned for that purpose conducted by UCC. These terms were chosen because:

1. These terms have a health and social care lens rather than a criminal justice lens when possible
2. They take account of extant definitions in the HSE policies referred to, and in law when required
3. They help explain how a single incident may meet more than one definition (See *Figure 1*)

Figure 1: Language Used to Describe Incidents of a Sexual Nature



Terms and Definitions

Patient is a term to describe a person to whom a health service is being provided (HSE, 2020).

Patient safety incident is defined by the Civil Liability (Amendment) Act 2017 as an incident which occurs during the course of the provision of a health service which either:

(a) has caused an unintended or unanticipated injury, or harm, to the patient, or

(b) did not result in actual injury or harm to the patient but was one which the health services provider has reasonable grounds to believe placed the patient at risk of unintended or unanticipated injury or harm, or

(c) unanticipated or unintended injury or harm to the patient was prevented, either by "timely intervention or by chance", but the incident was one which the health services provider has reasonable grounds for believing could have resulted in injury or harm, if not prevented.

Incidents of a sexual nature refers to any incident which meets the definitions of either sexual abuse, sexual assault, sexual harassment or sexual safety incidents. Incidents of a sexual nature is therefore an umbrella term.

➔ **Sexual abuse** is defined by Safeguarding Vulnerable Persons at Risk of Abuse, National Policy and Procedures (HSE, 2014a) as including rape and sexual assault, or sexual acts to which a person has not consented, or could not consent, or into which he or she was compelled to consent.

➔ **Sexual assault** is defined by the HSE (2023c) as any sexual act that a person did not consent to, or are forced into against their will. This includes rape.

➔ **Rape** has two legal definitions in Ireland.

- Rape is defined in section 2 of the Criminal Law (Rape) Act 1981 as being an offence committed by a man if he has unlawful sexual intercourse with a woman who at the time of the intercourse does not consent to it, and at that time he knows that she does not consent to the intercourse or he is reckless as to whether she does or does not consent to it.
- Rape is also an offence under Section 4 of the Criminal Law (Rape)(Amendment) Act 1990 where it is defined as a sexual assault that includes (a) penetration (however slight) of the anus or mouth by the penis, or (b) penetration (however slight) of the vagina by any object held or manipulated by another person.

- For the purposes of health and social care provision these two legal definitions are translated into clinical practice under a single HSE definition. The HSE definition of rape is when a person does not consent and someone puts their penis into (penetrates) a person's vagina, anus (bottom) or mouth and / or puts any object into a person's vagina (HSE 2023c).

➔ **Sexual harassment** is defined by the Department of Justice (2021) as any form of unwanted verbal, non-verbal or physical conduct of a sexual nature, being conduct which has the purpose or effect of violating a person's dignity and creating an intimidating, hostile, degrading, humiliating or offensive environment for the person.

➔ **Sexual safety incidents** are defined by the NHS Sexual Safety Collaborative (2023) as incidents where an individual may have witnessed or experienced something of a sexual nature that does not fit into the categories of sexual harassment or assault, and which made the person feel uncomfortable and/or sexually unsafe.

Sexualised behaviour refers to "verbal or physical sexual behaviour that is disproportionate, unacceptable, or disinhibited, often interfering with daily activities and occurring at inconvenient times or places" (Bartelet *et al.*, 2013).

Sexual neglect is the failure to provide privacy and respect an individual's sexual orientation or gender identity. Treating older adults, people living with a disability or people living with mental illness as asexual or preventing them from expressing their sexuality.

Person of concern is any person whose behaviour, in this instance sexualised behaviour, poses a risk of harm to themselves or any other person.

Person subject to an allegation of abuse (PSAA) refers to any person against who an allegation of abuse is made by any other person.

In this document, which has a focus on mental health and social care as opposed to physical healthcare, the terms **service user and resident** are used hereunder as alternatives to patient given the services in scope.

- **Service user** refers to an adult or child who is receiving care within a HSE or HSE funded approved centre, whether voluntary or involuntarily.
- A **resident** refers to an adult or child who is living, or temporarily receiving care within a HSE or HSE funded designated centre.

Person affected refers to service users or residents that may be affected as a consequence of an incident occurring. Persons can be affected either directly of indirectly.

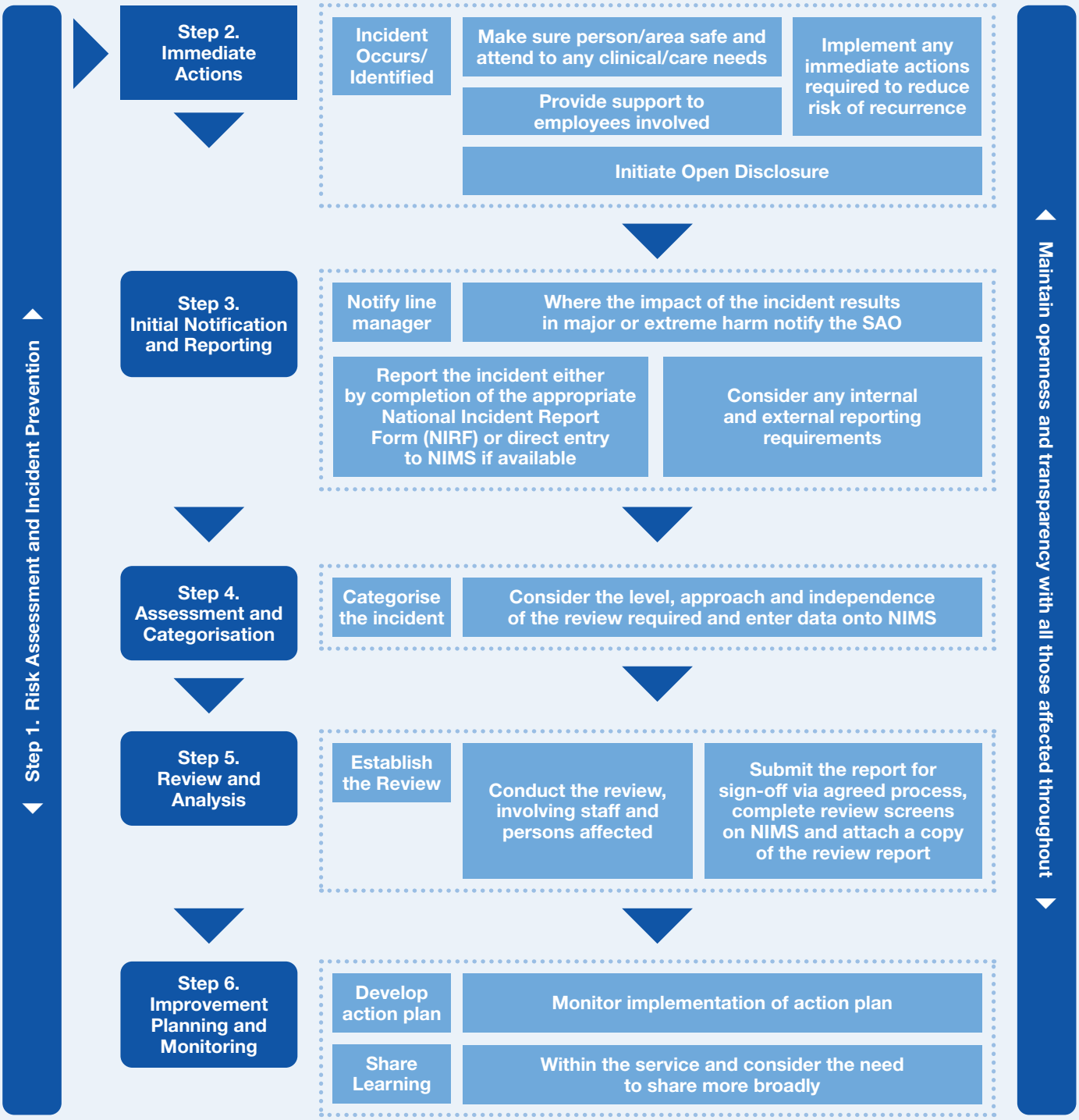
Requirements for the Management of Incidents of a Sexual Nature

Within HSE and HSE funded approved and designated centres, there are statutory and organisational obligations to prevent, identify, respond, report, review and learn from incidents within prescribed timeframes. Incidents of a sexual nature are a subset of these incidents. This document outlines the fundamental actions and considerations when managing a witnessed or unwitnessed incident of a sexual nature within an approved or designated centre in mental health, older persons and disability settings. It provides guidance for staff on how to ensure an effective immediate response, and then how to navigate the integrated and when appropriate multi-agency response required. This can be confusing because there are multiple potential reporting requirements and routes required concurrently for single incidents. The implementation of these guidelines should however result in the immediate prioritisation of the safety, medical and psychological care needs of the person affected by an incident of a sexual nature. It is important to reiterate that this document is intended for use as practice guidance and is not a substitute for the policies cited throughout.

The HSE Incident Management Framework (2020)

All incidents regardless of their impact or category require management in line with the **HSE Incident Management Framework's** six steps (2020). It is suitably acknowledged within the IMF (HSE, 2020) that in certain situations where disciplinary or other organisational actions are warranted, alternative pathways or simultaneous processes for reviews/investigations may be required in a service's overall response to an incident. The incident management process includes six steps (*Figure 2: Overview of the Incident Management Frameworks Six Steps*) which are used to structure the remainder of this guidance document.

Figure 2: Overview of the Incident Management Frameworks Six Steps



Part B Incident Management – Incidents of a Sexual Nature

Incident Management Step 1: Risk Assessment and Incident Prevention

The overriding aim of the incident management process is to prevent incidents from occurring in the first instance. In order to achieve this the risk of an incident occurring and the controls necessary to prevent the occurrence need to be understood. In the case of incidents of a sexual nature, there are many factors which may contribute to the manifestation of risk of an incident of a sexual nature occurring – i.e. contributory factors. Such factors need to be considered from both clinical and corporate risk management perspectives. To outline some of the potential contributory factors which may need to be considered the Yorkshire Contributory Factors Framework, as described in the HSE IMF (2020), is a useful tool.

The different types of factors potentially contributing to the risk of incidents of a sexual nature occurring are broadly:

- Situational factors
- Local working conditions
- Organisational factors
- External and general factors

Situational Factors

Staff and Residents/Service Users

In order to optimise the prevention of incidents of a sexual nature both staff and resident/service user factors factors need to be considered. Staff must firstly be alert to the possibility of incidents of a sexual nature occurring where they work. This is best achieved by:

- Ensuring that staff have completed safeguarding training.
- Sharing periodic data on site incident reporting with staff and discussing local issues and trends.
- Including sexual safety as a specific topic on new staff induction within the broader quality and safety element of induction and orientation.
- Setting and understanding boundaries between staff and residents/service users, and between peers.
- Participation in the HSE's National Safeguarding Network.
- Having regard to the rights of all people, particularly those living in residential care to conduct safe and meaningful relationships, and to express their sexuality.
- Ensuring that staff have access to up-to-date individual care plans which are comprehensive with regard to sex, sexuality and relationships.

Approved Centres – (Inpatient Mental Health Services)

It is a requirement of the HSE that people admitted to approved centres are safeguarded, including from incidents of a sexual nature. Internationally, mental health inpatient services have the highest frequency of reported incidents of a sexual nature. The requirement to safeguard people within approved centres is therefore paramount given the well-established risk of such incidents occurring. The requirement to safeguard mental health service users existed prior to the establishment of specialist safeguarding operations in older persons and disability services. The existence of a separate policy for those care groups should not be taken to mean the longstanding requirement to protect mental health service users from avoidable harm has changed. While the HSE expects to expand its safeguarding operations to all services as soon as possible, in the interim we continue to have an inherent obligation to protect and safeguard mental health service users.

With respect to people being admitted to an approved centre a structured clinical risk assessment and management plan is required. These documents consider among other factors risk of harm to self, and risk of harm to others. These should include sexual harm, and should be conducted and incorporated when developing a comprehensive and trauma informed individual care plan. Important elements to consider with regard to the risk of incidents of a sexual nature are the person's history and current presentation with respect to sex, sexuality and relationships.

In addition to individual assessments and management plans, the dynamic within the approved centre between everyone present should be considered in real time. This is impacted by the mix of service users present, the built environment in which care is provided and the team on duty at a given time. A useful resource is the **handbook on relational security** developed by the National Health Service (NHS) which discusses these factors and their assessment in more detail.

Designated Centres for Older People (Community Nursing Units)

Moving from one's own home to a new home in a community nursing unit (CNU) is a significant change in a person's life. It is incumbent on the HSE that while we operate the extant safeguarding policy to prevent incidents of a sexual nature from occurring, we achieve a balance between protection and autonomy. It is therefore critical that during this time of change we support people to maintain their relationships, including intimate and/or sexual relationships as they wish – in privacy and with dignity.

We must be guarded in our approach to prevent sexual neglect caused by unconscious or conscious ageism, disablism or any other form of prejudice based on a person's circumstances or characterises (e.g. sex, gender identity, religion, sexuality). We must be mindful also of the history of sexual harm in Ireland and the possibility that older people may have been impacted by sexual violence at any time in their lives prior to coming to live in one of our community nursing units. Therefore, again, a trauma informed approach is required based on a comprehensive history regarding sex, sexuality, and relationships. Conditions commonly associated with ageing such as dementia must not negate this aspect of assessment and care planning.

Designated Centres for People with a Disability

Ireland has commitments under the UN Convention on the Rights of People with Disabilities, which came into force in Ireland in April 2018. It places an onus on state bodies such as the HSE to "take effective and appropriate measures to eliminate discrimination against persons with disabilities in all matters relating to marriage, family, parenthood and relationships, on an equal basis with others". This means that the HSE have an obligation to once again balance the protection of residents with the autonomy residents are entitled to when they make choices about sex, sexuality and relationships.

It is important to recognise that establishing whether a person can consent to a sexual relationship or any other kind of sexual activity involves knowing how the person makes decisions and how they communicate this. For this to be possible each resident must have a person-centred plan including information on how the person communicates, and what supports the person needs to be able to make informed decisions.

It is also important that residents are supported in an individualised manner to learn about and understand their sexuality, and the different ways it can be expressed. This should include basic concepts such as their right to engage in or refuse to engage in sexual activity, the difference between sexual and non-sexual touching, the differences between positive intimate relationships and harmful ones etc.

Local Working Conditions

Local working conditions on a given day, night or shift may increase or decrease the likelihood of incidents occurring. This includes incidents of a sexual nature. Managers at all levels, e.g. people in charge during shifts, their line managers, site and regional managers should be alert to changes in working conditions and the requirement to take action should they assess there is an increased risk of incidents occurring. Indicators of changed working conditions relate primarily either to the work, the workload, or the available workforce.

This may include for example a high sickness absence on a given day with an associated lack of availability to achieve the required level of supervision, or the unavailability of staff or the availability of staff who are well acquainted with the residents or service users. Likewise, factors related to the service users or residents can impact the ability to manage risk in real-time. This may include for example a change in the level of dependency or acuity relating to individuals, or in total. Emergency situations may also attract the attention of large numbers of staff to one part of the approved or designated centre and during such events supervision in the remainder of the built environment may be impacted. It is necessary therefore that contingency measures for responding to changes in local working conditions are understood in advance as part of the overall proactive approach to enterprise risk management.

Organisational Factors

Organisational factors which contribute to our ability to prevent incidents occurring are wide ranging and include the built environment, capacity management and the availability of policies and procedures. With respect to incidents of a sexual nature, the built environment is related to the risk of occurrence by virtue of being either an enabling or a limiting factor.

This may include for example the ability to have single-sex rather than mixed-sex approved centres, the ability to easily maintain line of sight of residents, and the ease with which communal areas in both designated and approved centres can be staffed. It is important that staff are alert to the ways in which the built environment they work in can either enable or limit their ability to manage risk in real-time. This can be achieved for example by increased monitoring of areas (e.g. environmental checks) or by providing awareness to staff including new and agency staff during orientation, of areas where incidents have previously occurred or on “blind spots”. This being with a view to ensuring risk associated with any particular part of the approved or designated centre is effectively managed if it cannot be engineered out – which is preferable.

The built environment is also finite in respect of the number of beds and or residential places within it. Over-occupancy, and/or atypical admissions have the potential to increase the risk of incidents of a sexual nature occurring. Approved and designated centres must not be operated above capacity. The admission of children to adult approved centres must not take place. The admission of people with a known history of sexualised behaviour and/or offending to designated centres must be the subject of specific multidisciplinary planning and risk management guided by relevant policy including Safeguarding (HSE, 2014a).

External and General Factors

These contributory factors pertain to national level policies, and the safety culture at organisational and approved and designated centre levels. The impact of a dense and at times conflicting policy landscape can mean that staff are focused more on compliance with policy than on people. This is especially true when multiple policies and multiple reporting requirements apply simultaneously to one incident. While compliance with policy is important, as policy is itself a protective measure, the overarching message of this guidance is to prioritise the immediate care of any person affected by an incident of a sexual nature. This is important when any incident of a sexual nature occurs, but especially so when a service user or resident has been sexually assaulted in an approved or designated centre. **Staff's immediate response must ensure the safety of the person affected and provide appropriate medical and psychological care.** The flowchart in *Figure 3: Immediate Response to Incidents of a Sexual Nature (also found in Appendix 1(a))* will guide staff on how to make the care of the person affected their main priority while having regard for the multiple policies and reporting requirements.

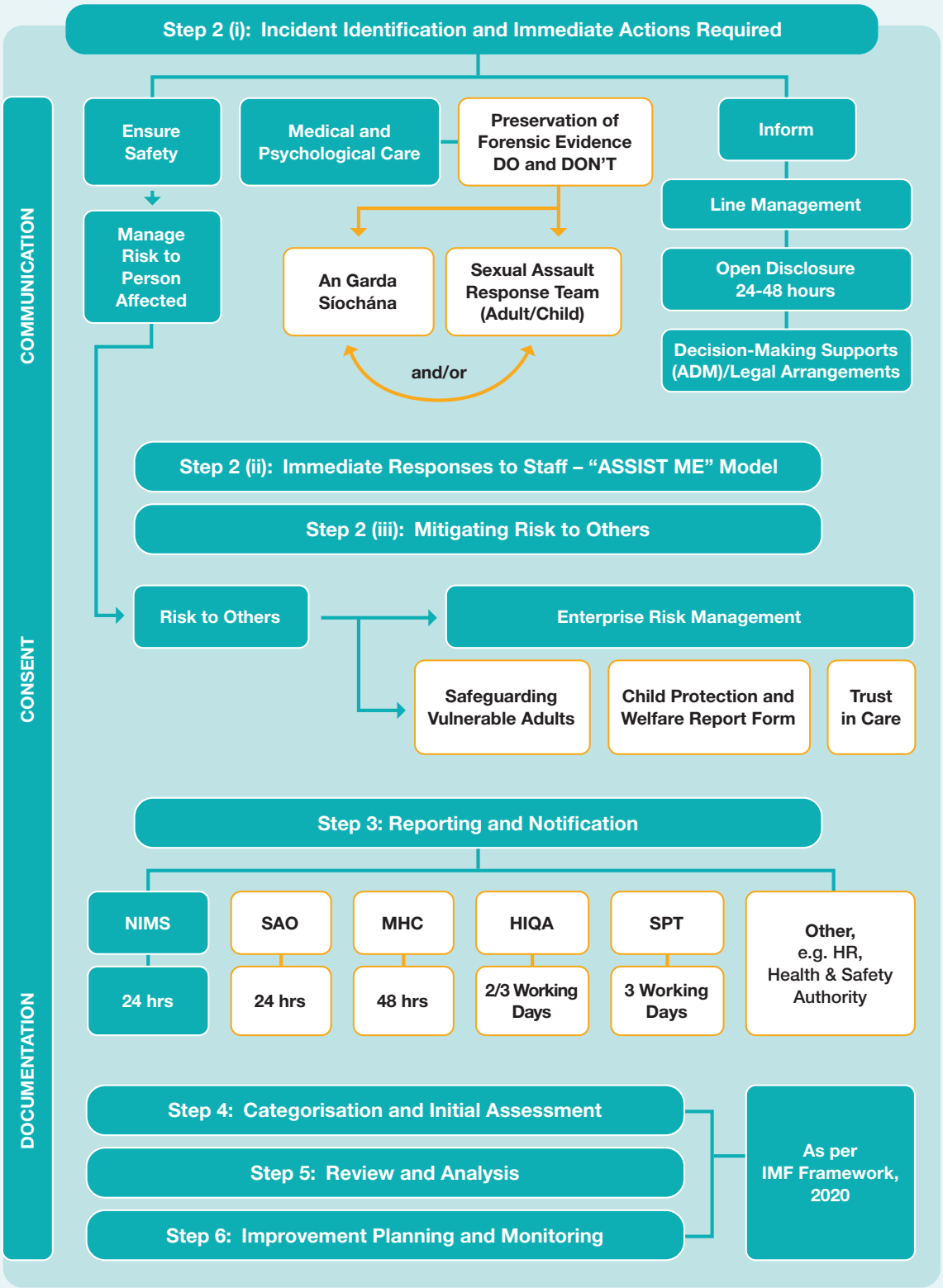
A safety culture is focused on the aspects of organisational culture that relate to resident and service user safety. It is defined as a pattern of individual and organisational behaviour, based upon shared beliefs and values that continuously seeks to minimise harm, which may result from the process of care delivery (Kristensen & Bartels, 2010). The HSE (2019b) Patient Safety Strategy (2019-2024) makes six high level commitments through which our safety culture is meaningfully demonstrated, and all of these commitments are applicable to the prevention of incidents of a sexual nature. The commitments and how they apply to incidents of a sexual nature are set out below.

Patient Safety Strategy Commitment	Actions for Approved & Designated Centres
Empowering & Engaging Residents & Service Users to Improve Safety	Staff will work in partnership with residents and service users to ensure a rights-based approach to sex, sexuality and relationships, which will safeguard against sexual abuse while respecting people's autonomy.
Empowering and Engaging Staff to Improve Safety	All staff must complete safeguarding training, and every approved and designated centre will be a member of the HSE Sexual Safety Network.
Anticipate & Response to Risks	Staff will effectively manage the risk of incidents of a sexual nature occurring by operating the HSE Enterprise Risk Management Policy at centre level.
Reduce Common Causes of Harm	Staff will proactively engage with sexual safety incident reporting data from their unit, to plan and implement strategies to prevent recurrence of peer-to-peer incidents.
Measure & Learn to Improve Safety	Staff will monitor sexual safety at centre level over time, to identify trends, ensure continuous learning and improvement in safety.
Leadership & Governance	Regional and local clinical and corporate leaders will review aggregate sexual safety data and continually monitor the effectiveness of preventative strategies at Community Health Network, Integrated Health Area and Regional Health Area levels.

The flowchart below in *Figure 3: Immediate Response to Incidents of a Sexual Nature (also found in Appendix 1(a))* sets out the steps required in the management of the immediate responses to incidents of a sexual nature. The steps within the flowchart are then explained thereunder.

Figure 3: Immediate Response to Incidents of a Sexual Nature

This flowchart is for practice guidance and is not a substitute for the HSE Incident Management Framework (2020)



These actions MUST always be taken, for all incidents of a sexual nature.

In addition for witnessed, alleged or suspected sexual assault/abuse and sexual harassment all actions required on a policy and/or statutory basis in the specific circumstances MUST be taken. These requirements are detailed in the Sexual Safety Framework, and the policies and legislation referenced therein.

Incident Management Step 2: Incident Identification and Immediate Actions Required

Step 2: Incident Identification and Immediate Actions Required addresses:

(i) Incident identification and immediate responses to person(s) directly affected and their relevant person(s)

(ii) Immediate responses to staff

(iii) Mitigating risk to others

(i) Incident Identification

In a two-year period 2021 and 2022, 907 incidents of a sexual nature were reported on the National Incident Management System (NIMS) from HSE Mental Health, Disability, and Older Persons Services. Over half of these (53%) occurred in Mental Health settings, with 35% occurring in Disability Services and the remaining 12% occurring in Older Persons Services. It is positive to see these incidents being reported. For incidents to be reported they must first be identified. Staff must therefore be alert to the possibility of incidents occurring, and the various ways in which such incidents may be identified.

As a fundamental starting point, all staff must be aware that incidents of a sexual nature can happen **anywhere** and **anytime**. Staff must also be aware that such incidents can affect **anyone** regardless of age, gender, gender identity, sexual orientation, mental or cognitive state and any other characteristic or circumstance. For staff to be aware of the types of incidents that may occur they must complete safeguarding and child protection and welfare training.

The below table lists some of the examples of incidents of a sexual nature taken from relevant HSE policies (Safeguarding Vulnerable Persons Policy at Risk of Abuse, National Policy and Procedures (HSE, 2014a), Trust in Care, (HSE, 2005) and HSE Child Protection and Welfare Policy (HSE, 2019a)).

Examples of incidents of a sexual nature:
• Sexual assault – including rape.
• Intentional touching, fondling, or molesting.
• Exposure of sexual organs or any sexual act intentionally performed in the presence of a resident or service user.
• Incest (mother, sister, daughter or granddaughter, father, brother, son or grandson).
• Staff exposing residents or service users to pornography or other sexually explicit and inappropriate material.
• Non-consensual taking or sharing of intimate images.
• Consensual sexual activity between a resident or service user and staff member.
• Sexual exploitation of a child or vulnerable adult, including any behaviours, gestures or expressions that may be interpreted as being seductive or sexually demeaning to a resident or service user.
• Sexual activity involving an adult and a child under 17 years even if the child states it was consensual.
• Sexual activity involving a child and a child under 17 years even if the child states it was consensual.
• A resident or service user being secretly observed in the bedroom or bathroom.
• Inappropriate and sexually explicit conversations or remarks.
• “Jokes” or stories that are offensive and inappropriate. “Dirty jokes” or “dirty stories”.
• Exposure or disinhibited behaviours of a sexual nature even if it is not targeted.

How are Incidents of a Sexual Nature Identified?

Incidents of a sexual nature are identified because they are **witnessed by staff, disclosed to staff or identified by staff who recognise signs and symptoms**.

A disclosure can be a complete detailed account of events or an ambiguous, incomplete and partial disclosure of events. It is important to be aware that disclosures of incidents of a sexual nature can be complex and understandably not always forthright. Information may be revealed in fragments, not in chronologically order and different elements may be communicated to a range of different people (Esposito, 2015). A resident or service user may drop hints and clues that abuse is happening without revealing it outright and they may test reactions and responses to information they provide and only fully open up over a period of time. Disclosure can be viewed as a process and that process can vary considerably.

It is important staff are aware of and open to the different ways that a resident or service user may disclose an incident of a sexual nature and that they are supported and responded to appropriately. Disclosures involve interactions, and those interactions are not only supported by the initiative of the person affected but also by the awareness and responses of others (Paine and Hansen, 2002).

In wider society, there are high rates of non-disclosure and delayed disclosure in relation to sexual offences in Ireland (Central Statistics Office, 2023). The HSE (2014a) and The Centre of Expertise on Child Sexual Abuse (2021) outlined barriers to disclosing sexual abuse. Some common barriers cited include:

- Fear that they will not be believed.
- Fear of having to leave the service (which is their home in some cases).
- Fear of an alleged abuser.
- Fear of upsetting relationships.
- Shame and/or embarrassment.
- Limited verbal and other communication skills.
- A lack of capacity to understand and report the abuse.
- A lack of clarity as to whom they make a disclosure to.
- A lack of awareness that what they are experiencing is abuse.

Given the many barriers to making a direct disclosure, it is important that staff are able to recognise signs and symptoms of sexual abuse. Staff need to be attentive to physical, emotional and behavioural changes in residents and service users that may indicate sexual abuse is happening or has happened. A resident or service user displaying one sign does not necessarily mean that they are being sexual abused, however if one or more of these signs are present and unexplained staff need to carefully consider the possibility of sexual abuse. At all times staff should act to have unexplained signs and symptoms reviewed by the multidisciplinary team to identify the cause. Some examples of potential indicators from relevant policies and literature are presented in the tables below – (HSE, 2019a, HSE, 2014a, Centre of Expertise and Child Sexual Abuse, *2021*, Vrolijk-Bosschaart *et al.*, 2018 and Al Odhayani, Watson & Watson, 2013). These lists are not exhaustive.

Examples of Potential Indicators of Child Sexual Abuse	
Physical	**Emotional & Behavioural**
• Torn, stained or bloody clothing and/or underclothing • Bruises, lacerations, redness or swelling in genital, vaginal, anal area or mouth • Bleeding or discharge from the genital, anal area or mouth • Unusual or excessive itching or pain in the genital, vaginal or anal area • Bruising on the thigh, buttocks, upper arms, breasts, and neck • Pregnancy • Blood in urine or faeces • Persistent or recurring pain during urination and/or bowel movements • Sexually transmitted disease/infections • Urinary tract infections or vaginal infections • Pain, discomfort or difficulty when walking or sitting • Wetting and soiling accidents unrelated to toilet training	• Unexplained changes in behaviour and personality • Socially or emotionally withdrawn • Fearful and anxious • Uncharacteristically aggressive • Become clingy or seeming insecure • Becoming secretive • Changes in eating habits • Knowledge of adult issues inappropriate for their age • Sexually inappropriate behaviour for their age • Bizarre, unusual and sophisticated sexual knowledge • Use of explicit language • Age-inappropriate sexual play or acts with toys, self, others • Tries to make self as unattractive as possible • Always choosing to wear clothes that cover their body • Attaches very quickly to strangers/new adults • Observes/shares sexual images online • Sleep disturbances • Regressing to younger behaviours • Fear of certain places e.g. bedroom or bathroom • Dislikes or fears a particular person and tries to avoid spending time alone with them e.g. “I don’t like uncle” • Running away or going missing • Having unexplained gifts such as toys, money, mobile phone, expensive clothes

Examples of Potential Indicators of Sexual Abuse in Adults and Older Persons	
Physical	**Emotional & Behavioural**
• Torn, stained or bloody clothing and/or underclothing • Bruises, lacerations, redness or swelling in genital, anal area or mouth • Bleeding or discharge from the genital, vaginal, anal area or mouth • Unusual or excessive itching or pain in the genital, vaginal or anal area • Bruising on the thigh, buttocks, upper arms, breasts, and neck • Sexually transmitted diseases/infections • Urinary tract infections or vaginal infections • Pregnancy in a person who may lack decision-making capacity to consent to sexual intercourse • Pain, discomfort or difficulty when walking or sitting • Deliberate self-harm injuries • Sudden onset of confusion, wetting or soiling • Incontinence that is unrelated to a medical diagnosis	• Unexplained changes in behaviour and personality • Signs of post-traumatic stress disorder (PTSD) • Depression • Socially or emotionally withdrawn • Fearful, anxious and/or panic attacks • Increased agitation • Sleep disturbances • Suicide attempts • Changes in self-image • Dissociative symptoms • Overall deterioration in health • Feelings of shame and guilt • Not wanting to receive help with personal care • Exhibiting significant changes in attitude and behaviour towards sexual activity • Explicit use of sexual language or a preoccupation with anything sexual • Sexual dysfunction • Apprehension about relationships or fear of intimacy • Dislike of specific places, smells, sounds, situations or people

Immediate Response

When an incident of a sexual nature is identified, an immediate response is required. **The priority is the immediate safety and the medical and psychological care of the person affected.** This is critical regardless of the means of identification of the incident, whether witnessed by staff, disclosed to staff or identified by staff who recognise signs and symptoms.

Discussing incidents of a sexual nature is complex and is often emotionally difficult, physically painful and re-traumatising for the resident or service user involved. Staff need to adopt a caring, sensitive, supportive and non-judgmental approach throughout the process of identifying and establishing facts. The verbal and non-verbal communication provided by staff can be instrumental in minimising psychological distress and empowering the resident or service user to feel safe to disclose the incident of a sexual nature. Following on from this paragraph there is a guide to help staff build readiness in responding to a resident or service user following an incident of a sexual nature. This guide of Do's and Don'ts is taken from across the relevant existing policies (Safeguarding Vulnerable Persons Policy at Risk of Abuse, National Policy and Procedures (HSE 2014a), HSE Child Protection and Welfare Policy, (HSE 2019a) and National Guidelines on Referral and Forensic Clinical Examination Following Rape and Sexual Assault (Ireland), 5th Edition (SART, 2023) and Centre of Expertise on Child Sexual Abuse (2021)). This list is not exhaustive.

Responding to an Incident of a Sexual Nature	
Do	**Don't**
✓ **Listen, reassure and support**.	✗ Appear **shocked**.
✓ Give due regard to the resident or service user's **medical and psychological state**.	✗ Display **negative emotions**.
✓ Ensure the conversation happens in a **safe and private environment**.	✗ Make **judgements**.
✓ Have staff of the **gender** of the resident or service user's **choice** establish the facts.	✗ Make **assumptions**.
✓ **Listen carefully, attentively, and patiently.**	✗ Express any **opinions** about the alleged abuser.
✓ React **calmly**.	✗ Stray into the role of an **investigator**. You are not investigating the allegation.
✓ **Go at their pace.**	✗ **Pressurise** the resident or service user **to provide details**.
✓ **Take the allegations seriously.** You are not there to judge or establish the truth of the claims.	✗ **Ask leading questions** or **press for information**.
✓ Reassure the resident or service user regarding their **safety**.	✗ **Question** the resident or service user's **actions or decisions**. This creates disbelief and may re-traumatise.
✓ Reassure the resident or service user they have taken the **right action** in talking to you.	✗ **Minimise** the resident or service user's trauma by using words such as "well at least…"
✓ Encourage the resident or service user to voice their **feelings, concerns, and needs**.	✗ Give **sweeping reassurances**.
✓ **Use their language.**	✗ Promise to keep **secrets**.
✓ **Ask open-ended questions.** *Can you tell me more about that? Where did this happen? What did the person say/do?*	✗ Promise **confidentiality**.
✓ **Check** what you **heard is correct and understood**. Ask questions for **clarification**.	✗ Unnecessarily ask the resident or service user to **repeat** the disclosure multiple times.
✓ Establish the **incident timeframe and location**. These may need to be considered in line with preserving forensic evidence.	
✓ Reassure the resident or service user that their **response was normal**. There is **no typical response**.	
✓ If relevant assure the service user or resident that it's **not their fault**.	
✓ Reassure you will **only speak** to those who **need to respond** to this situation.	
✓ Ensure the resident or service user is **informed, understands and collaborates** in the steps that follow.	
✓ **Look after yourself.** After the conversation de-brief with a colleague, line manager or appropriate professional.	
✓ Write **a personal recollection of events per the HSE IMF** (if appropriate).	

Immediate Care of the Person Affected

This section focuses on the considerations and actions warranted for the person harmed or directly affected by the incident, e.g. a resident or service user who has been sexually assaulted. The immediate actions taken by staff following an incident will considerably affect how supportive and trustworthy a resident or service user views the service (Conway *et al.* 2011 as cited in IMF, 2020). **Staff must take immediate action to ensure the safety and the medical and psychological care of the person affected is prioritised.** This may include securing the environment, medical assistance, and assistance of An Garda Síochána and/or the Sexual Assault Team Unit (SATU) or the Child and Adolescent Sexual Assualt Treatment Unit (CASATU), as appropriate.

In a situation where the witnessed or disclosed incident of a sexual nature involves another resident or service user, staff have an equal responsibility to prioritise their rights, safety and medical and psychological care needs, in the context of implementing protective measures to ensure the safety of others and upholding any statutory and organisational responsibilities. The person of concern or person subject to an allegation of abuse may himself or herself be a child or vulnerable person as defined in the Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012.

Medical Care

Staff should arrange for the immediate provision of medical attention and the resident or service user's transfer to hospital if emergency care is warranted because this is either immediately apparent due to injuries sustained or after initial medical review locally (e.g. in a nursing home). Some approved and designated centres may be physically co-located with an Emergency Department and in this instance they may have their own internal communication procedures which should be consulted locally.

If immediate care at an Emergency Department is required, it is important for the AGS or staff to contact the Sexual Assualt Treatment Unit (SATU) or the Child and Adolescent Sexual Assault Treatment Unit (CASATU) as it may be possible for a Forensic Clinical Examiner to carry out a forensic clinical examination at the Emergency Department. The preservation of evidence is paramount during this time and the main considerations for staff and An Garda Síochána are outlined, as set out in The National Guidelines on Referral and Forensic Clinical Examination Following Rape and Sexual Assault (Ireland), 5th Edition 2023 (Sexual Assault Response Team, 2023).

Preserving Forensic Evidence Following Rape/Sexual Assault – *in line with Service User or Resident Consent*		
	Do	**Don't**
For All Types of Rape/Sexual Assault	✔ If possible the type of seat the person sits on should be plastic, leather or a leatherette type covering.	✘ Bathe/shower/douche. ✘ Consume food or drink, until oral samples have been taken.
Vaginal and anal rape/ sexual assault	✔ Save sanitary protection worn at the time of the assault or afterwards. ✔ If a condom was used. It should be retained.	✘ Pass urine and/or open their bowels, if possible. ✘ Wipe the genital/anal area after going to the toilet.
Oral Rape/ Sexual Assault		✘ Brush teeth or or wash out their mouth. ✘ Take fluid or food. ✘ Smoke.
Clothing (including bedding)	✔ Change out of clothes worn at the time of the rape/sexual assault as soon as possible. ✔ Place the items of clothing in separate paper bags (not plastic) and label. ✔ Underwear, worn after the incident, should also be collected, bagged in separate paper bag and labelled.	✘ Handle clothing however if clothing is handled it should be with gloved hands. ✘ If clothing has to be cut: • Don't cut through any damaged areas or breaks in a garment. • Don't cut through blood, semen or fluid marks.
Wounds and Blood/Saliva/ Semen Stains	✔ Blood, salvia or semen stains should have forensic swabs taken prior to cleaning. ✔ If possible, wound areas should have forensic swabs taken prior to wound cleaning.	
Forensic Exhibits/ Samples e.g. Weapons, Restraints, Tape, Bullets, Paint, Glass, Soil.		✘ Talk, cough or sneeze over any forensic exhibits/samples. Wear a face mask, if appropriate. ✘ Do not handle any forensic exhibits/ samples. If samples must be handled, then do so with gloved hands. ✘ If bullets are handled then use gloved hands – metal forceps should NOT be used.

As cited in National Guidelines on Referral and Forensic Clinical Examination Following Rape and Sexual Assault (Ireland), 5th Edition 2023, (SART 2023)

Preservation of Forensic Evidence Following an Alleged Rape or Sexual Assault

It is imperative that staff have an awareness and knowledge around protecting evidence and the evidence's fast decaying timeframe following a witnessed or alleged rape or sexual assault. Staff actions in relation to preserving evidence can have long-term consequences for the resident or service user's ability to achieve successful legal proceedings and for the potential protection of others.

Preserving evidence is only carried out in line with the residents or service user's valid consent and their medical and psychological health remains the utmost priority throughout the process.

In a situation that warrants a forensic clinical examination and/or the collection of forensic evidence from a scene, it is vital staff are equipped to support and inform the resident or service user in how to best preserve the evidence prior to An Garda Síochána (AGS) and/or the Sexual Assault Response Team (SART) gathering the evidence. Even if an incident is not immediately disclosed there may still be potential for forensic evidence to be collected or forensically examined and therefore staff need to be considerate of preserving potential evidence in certain situations of delayed disclosure or delayed discovery of possible sexual abuse.

There are timelines staff should have an awareness of in relation to protecting a resident or service user's medical wellbeing and for the collecting of forensic evidence. Some critical timelines set out by the Sexual Assault Response Team (2023) are listed below. In situations where these timelines have expired, staff can contact AGS and/or the SART for further advice and direction. These timelines do not include forensic examination of physical injuries due to possible sexual assault.

Forensic Evidence and Medical Care Critical Timelines

- Evidence of the presence of **semen** can be lost from the **mouth** within **6 hours**.
- Evidence of the presence of **semen** can be lost from the **rectum** within **24 hours**.
- Evidence of the presence of **semen** can be lost from the **vagina** within **24 hours**.
- Evidence of the presence of **semen** on skin can last **until washing**.
- Evidence of the presence of dried **seminal staining** on **clothes** can last **until washing**.
- Preventative treatment for **sexually transmitted diseases** should be commenced **as soon as possible**.
- **HIV** preventative treatment is only prescribed within **72 hours** of an incident.
- To be most effective, **emergency contraception** should be administered as soon as possible, however it can be administered **within 120 hours** of an incident.
- **Alcohol and other substances** begin to reduce in the body within **24 to 48 hours**.

Psychological Care

The sooner a resident or service user receives psychological support the more beneficial it can be (Mohta *et al.* 2003). Psychological support incorporates a variety of activities that can go some way in meeting the resident or service user's immediate emotional safety and longer-term therapeutic needs (SART, 2023). Psychological support can potentially come from several different sources. Psychological support sources among others can include; family, friends, healthcare staff, rape crisis personnel, helplines, counselling services, religious personnel, AGS and SART. Also advocacy services play an important role in enabling people to know their rights and in ensuring they are equipped with all the relevant information to autonomously make informed choices. It is important for staff to have an awareness of the services available locally to ensure they appropriately cater to the needs of the person affected. The National Rape Crisis Centre – 24-hour helpline number is: 1800778888. Website: https//www.drcc.ie.

Healthcare staff may provide the following practical psychological support following an incident:

- Advocate for the resident or service user to ensure their needs are identified and their choices are respected.
- Provide the resident or service user with crisis intervention and support e.g. a trusted staff member of their choosing remaining with them.
- Refer to other services and teams as required.
- Serve as an information resource for relevant external support services.
- Participate in the resident or service user's care planning with them, to help them ensure their will and preference is represented.

If the person affected is an adult who has decision-making capacity staff should offer to contact a family member, friend, advocate or any other person they choose. Who the resident or service user decides to contact as an immediate support person, should be an appropriate support and it is important staff do not make any presumptions with regards to this. This is an important step in providing choice and attempting to help the resident or service user feel as psychologically safe as possible.

Notwithstanding the above, staff should be alert to the possibility of the presence of coercion or control as the person affected may name a person of concern or person subject to an allegation of abuse as their support person. Staff should seek advice from their manager and/or members of the MDT e.g. a social worker, An Garda Síochána or Safeguarding and Protection Team when in any doubt.

The disclosure of an incident of a sexual nature is not only psychologically significant for the person affected but it can also be extremely distressing for the families, friends or parents/legal guardians of the resident or service user, with the potential for long-term effects on their mental health (Hill, 2001). Therefore, it is imperative their distress is not overlooked and psychological support is provided by the service itself via providing information on appropriate external support services. Providing support to residents or service users care network is also an indirect way of supporting them. The person affected can often feel responsible for the distress exhibited by their family following sexual abuse, and by providing supports to their family it can subsequently reduce their own distress (Warrington *et al.*, 2017).

Informing Line Management, Appointed Decision-Making Supporters and Legal Arrangements

The staff member who identified the incident must take responsibility to inform their line manager within the service or organisation without delay. The staff member is not responsible for assessing whether a disclosed incident occurred or not but is obliged to report suspected or alleged incidents to ensure appropriate follow-up actions. Line managers should be informed as soon as practicable after an incident has been identified. This action is required by the IMF (2020), Safeguarding Vulnerable Person at Risk of Abuse Policy (HSE, 2014a), Child Protection and Welfare Policy (HSE, 2019a) and Trust in Care (HSE 2005). In any circumstances where a staff member feels unable for any reason to report an incident to the immediate manager, (e.g. the immediate line manager is the person of concern) they should then report the matter to a more senior member of management.

If the person affected has a court appointed decision-making representative or other person appointed with decision-making authority then the appointed person must be informed of the incident immediately (immediately meaning when the incident has been witnessed, disclosed or identified). If the person affected is a child then their parents(s) or guardian(s) must also be informed immediately, with reasonable consideration given to the child's views and wishes.

An Garda Síochána (AGS)

In instances where a mandatory report to AGS is required, this must be made immediately. This includes a suspected, alleged, or actual sexual offence against a child or vulnerable person. Although legal and policy definitions differ when defining a vulnerable person, for the purpose of this document the legal definition is applied. As per the Department of Justice, a vulnerable person is a person who:

(a) (i) is suffering from a disorder of the mind, whether as a result of mental illness or dementia, or

(ii) has an intellectual disability,

which is of such a nature or degree as to severely restrict the capacity of the person to guard himself or herself against serious exploitation or abuse, whether physical or sexual, by another person,

or

(b) is suffering from an enduring physical impairment or injury which is of such a nature or degree as to severely restrict the capacity of the person to guard himself or herself against serious exploitation or abuse, whether physical or sexual, by another person or to report such exploitation or abuse to the Garda Síochána or both.

In other cases, when the person is not a child or a vulnerable person and has decision-making capacity, staff should sensitively and supportively encourage them to consent to the involvement of AGS when it is known, an alleged or suspected sexual offence has taken place. **Remember it is not necessary for staff to determine that an offence has actually occurred.** It is also important to remember that AGS can be contacted for advice when in doubt.

Adult residents or service users with decision-making capacity should be reassured that they themselves will decide whether or not to report an incident to AGS. However, this does not mean a guarantee of complete confidentiality because staff may have obligations to report related matters if they fall within the remit of relevant legislation e.g. Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012, the Children First Act 2015 etc.

A delay in reporting can reduce the opportunity for AGS to collect the best possible evidence and consequently enable a successful prosecution by the State. For example, forensic evidence may be lost from the person, CCTV may be no longer available, forensic evidence may be absent from the scene and possible witnesses may not be identifiable or available (SART, 2023). However, it is important to note delayed reporting does not affect the credibility of a resident or service user and there is no statute of limitation for serious sexual offences.

Contacting An Garda Síochána (AGS)

The approved or designated centres should contact the local Garda station if they need to make a report or to seek professional advice. All communication with AGS should be recorded accordingly, whether it's formal, informal, written or verbal. Reports of a criminal offence or suspected criminal offence must be submitted in written format and an acknowledgment of its receipt sought. Reports and any subsequent communications with AGS need to be adequately documented by the service. Documentation details should include the name, badge number, position and station of the Garda/Gardaí liaised with. Reports may warrant follow up by submitting a written report. Details of all Garda stations are available on the Garda website, www.garda.ie. AGS also have a dedicated phone line for reporting or querying child sexual abuse offences. The phone line is free and open on a 24-hour basis, 7 days a week, 365 days a year. The phone line number is 1800 555 222.

If an incident requires an immediate Garda response, contact the emergency numbers: 112/999. You can text 112 in an emergency if it is not possible to make a voice call. When contacting the AGS emergency number it is important to stay calm, stay focused and stay on the line. State the emergency service you require. You may be asked to provide details on what is or has happened, your name, location (eircode if possible) and telephone number.

Examples of emergencies include:

- A danger to life
- Risk of serious injury
- Crime in progress or about to happen
- Person subject to an allegation of abuse or Person of Concern is still at the scene or has just left.

The Role of An Garda Síochána (AGS)

It is the duty of AGS to fully investigate allegations of sexual offences reported to them, without exception. Gardaí are trained to investigate reports of sexual offences in a compassionate, sensitive and professional manner. There are numerous steps Gardaí take to support and facilitate a resident or service user making a report.

- Gardaí have a duty to be aware of and respond to the needs and wishes of the resident or service user at all times during the investigation.
- Gardaí will make every effort to have a Garda who is the gender of the resident or service user's choice allocated to the investigation.
- The investigation process will be explained thoroughly to the resident or service user.
- The resident or service user can be accompanied by a solicitor and/or another person of their choice when engaging with AGS.
- The resident or service user may be provided with specially trained interviewers.
- The resident or service user may be provided with an interpreter, if applicable.
- The resident or service user will be provided with available support services relevant to the sexual crime.
- The resident or service user will be provided with contact details of the investigating Garda and will be kept updated on the progress of the investigation on a regular basis, (AGS, 2023).

When a report of a suspected or criminal offence is made by a resident or service user, or on behalf of a person affected, AGS will advise and respond accordingly. If it is appropriate, they will attend the approved or designated centre. Upon doing so, they may be required to commence their investigation by taking notes and interviewing the resident in question, staff and any other relevant person. They may take detailed notes on the report, the complainant, the scene and collect forensic evidence.

An "Early Evidence Kit" may be used in cases of alleged rape/sexual assault when necessary. With every hour that passes following a report, physical evidence may deteriorate or be lost therefore an "Early Evidence Kit" may be used when there are time constraints (SART, 2023). It is mainly used in cases where:

- Non-consensual oral sex is reported/suspected to have been an element of the sexual assault and/or
- Toxicological examination may be required where it is reported/suspected that the rape or sexual assault was drug/alcohol facilitated (e.g. a drink may have been 'spiked').

When an investigation is complete, a file is submitted to the Office of the Director of Public Prosecutions (ODPP). A file will contain witness statements and relevant evidence obtained by AGS. It may also contain the Sexual Assault Response Team (SART) legal report. The file is what the OPDD base their decision on whether to prosecute or not. Prosecutions of rape offences and serious sexual offences are tried in the Central Criminal Court before a judge and jury.

An Garda Síochána and SATU Involvement Options

There are three options available to a resident or service user who is an adult or adolescent over 16 years of age, with decision-making capacity, attending the SATU (within 7 days of the incident) in relation to AGS involvement and forensic evidence, however; special consideration may need to be given to the Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012.

Option 1	Option 2	Option 3
Report the crime to AGS. The Gardaí can accompany the resident or service user to the appropriate SATU. The resident or service user will receive comprehensive medical, psychological, and forensic care. Any injuries will be documented and treated, and appropriate samples will be taken to aid the investigation.	If the resident or service user does not wish to report the sexual assault to AGS they may attend the appropriate SATU to receive medical and psychological care. No forensic samples will be taken. The resident or service user can change their mind at any time and involve Gardaí however, forensic evidence may be lost.	The resident or service user can attend the appropriate SATU without AGS involvement to obtain medical and psychological care and can have forensic samples taken and retained while the resident or service user considers whether or not to formally report Gardaí. The samples will be retained for one year unless a further year is requested in writing. Samples can be stored for a maximum period of two years prior to being destroyed.

The Sexual Assault Treatment Unit (SATU) and Child and Adolescent Sexual Assault Treatment Unit (CASATU)

The Sexual Assault Response Team includes the Sexual Assault Treatment Unit (SATU) and the Child and Adolescent Sexual Assault Treatment Unit (CASATU). The SATU and the CASATU both offer holistic, responsive and safe care for people who have or think they may have been raped or sexually assaulted. They provide medical care, forensic examinations, prevention and treatment of sexually transmitted diseases, emergency contraception, they co-ordinate psychological support and liaise with child protection and welfare and vulnerable adults services.

The **National Guidelines on Referral and Forensic Clinical Examination Following Rape and Sexual Assault (Ireland), 5th Edition 2023 (SART, 2023)** provides comprehensive details on the coordinated response and service available to those who have experienced sexual violence.

While a forensic exam can be conducted up to 7 days after a rape or sexual assault, the best time for forensic samples to be collected is within the first 72 hours (3 days) after the assault. For this reason, and because of the specialist advice and care available, the SATU or CASATU should be contacted without delay. The service will take referrals, offer advice and support when a disclosure relates to a witnessed or alleged rape or sexual assault in the past or present.

SATUs deliver care to those who are 14 years and above and the CASATU delivers care to those who are under 14 years. The CASATU may also accommodate adolescents aged 14-18 years who disclose previous child sexual abuse. It is a free and confidential service, with most services available 24 hours a day. There are multiple Sexual Assault Response Teams at various locations nationwide. The location and conatct details for these units are available **here: https://www2.hse.ie/services/satu/contact/**. Further information and resources on SATU and CASATU can be found on the website: **hse.ie/satu**.

Attending the SATU or CASATU

As previously stated, the SATU or CASATU should be contacted as early as possible following a witnessed or alleged rape or sexual assault, this can be to make a referral, or to seek advice. The service will provide advice on if and when attendance is necessary, or on occasion if required may attend the site where the resident or service user is to conduct an examination. Anyone can make contact with the service. This includes the person affected, a staff member or AGS.

If the resident or service user wants to attend the SATU or CASATU, An Garda Síochána can accompany them – if they wish for Gardaí to be involved at that time. Under these circumstances, the Gardaí will endeavour to protect the resident or service user's privacy and dignity by using an unmarked patrol car, wear plain clothes and avoid using areas where the person affected could be identified.

If the person affected requires assessment and treatment and AGS are not involved, based on an adult resident or service user's valid refusal to engage with them, then alternative arrangements must be made in a timely manner as advised by the SATU or CASATU. The resident or service user may be accompanied and supported (when required) by their preferred staff member, of the gender of the resident or service user's choice insofar as possible.

Forensic Examination Consent – Child and Adolescent

SATU staff do not require the consent of a parent/legal guardian for the purposes of medical treatment of children aged 16 and over. However, consent of a parent/legal guardian is required for forensic sampling, when a person is under 18 years of age. Capacity to consent in relation to child and adolescents and the National Consent policy is further discussed under the heading Consent Considerations (p.45).

Resident or Service User who Declines SATU Care

If the person affected declines to engage with the SATU for care and treatment, an appropriate medical practitioner may conduct an assessment and address the health and forensic needs of the resident or service user, as agreed and required. This may for example be the resident or service user's General Practitioner or a Non-Consultant Hospital Doctor (NCHD). It is preferable, unless validly declined, for a staff member of the gender of the resident or service user's choice to support the person affected during such examinations. Findings need to be recorded carefully, with particular regard to documenting any physical injuries. The SART (2023) have set out the following points for practitioners to consider if they are examining a person in this circumstance.

Considerations for non-SATU Medical Examinations Following Sexual Assault

- Document the history of sexual violence that has been disclosed.
- Use the resident or service user's own words in quotation marks, where possible. This account may be required to form the basis of a medico-legal report at a later date.
- Document the resident or service user's medical history.
- Head-to-toe survey, looking for evidence of injury.
- Systems examination.
- A genital examination so that any genital injury can be identified and treated, if appropriate.
- If the resident or service users would rather avoid a genital examination, then it is reasonable not to examine the genital area unless there is a high risk of the resident or service user suffering from a significant life-threatening genital injury.
- The resident or service user must be informed that potential evidence may be lost without the genital examination.
- Identify and treat medical needs or injuries.
- Assess the need for emergency contraception.
- Consider the need for antibiotic prophylaxis to treat sexual transmitted infections.
- Consider the need for HIV/Hepatitis Post-Exposure Prophylaxis following Sexual Exposure (PEPSE). The decision for this treatment is mainly based on the known or suspected risk of the alleged perpetrator being HIV or Hepatitis B positive and the form of sexual exposure that may have occurred.

Considerations for non-SATU Medical Examinations Following Sexual Assault

- If uncertain it may be advisable to seek urgent expert opinion from a Consultant in Infectious Diseases.
- Assess the resident or service user's psychological health. Consider the need for psychiatric review. Assess and manage the risk of self-harm.
- Ensure the resident or service user receives appropriate psychological support.
- Arrange follow-up care for Sexually Transmitted Infection (STI) screening and psychological support.
- Ensure Medical Council, organisational and obligatory reporting standards are met.

Fundamental Principles – Communication, Consent and Documentation

Communication, consent and documentation are three fundamental principles which must be embedded in the response to an incident of a sexual nature, throughout the entire caring, supporting and incident management process

Communication

Staff will need to continually communicate with the resident or service user in an open, honest, sensitive and transparent manner in order to keep them informed and to facilitate their decision-making following an incident of a sexual nature. Residents or service users may have ethnic, cultural, linguistic and/or literacy difficulties that impedes communication and during times of heightened levels of anxiety, comprehension generally diminishes (Robinson *et al.*, 2013).

The onus is on the service to tailor their communication to ensure the resident or service user is provided with adequate information, understands the information being presented to them and is supported to communicate. Therefore, it is important staff are cognisant of the resident or service user's general literacy, health literacy and the need to be flexible to meet the resident or service user's specific abilities and needs, at that specific time. Staff need to communicate with the same mindfulness and flexibility when conveying information to a resident's or service user's appointed decision-making supporter(s), legal representative(s), parent(s)/guardian(s) or nominated support person(s), as appropriate. A professional interpreter who adheres to the HSE's privacy notice may be necessary depending on the resident or service user's requirements.

Consent

An emphasis should always be placed on promoting resident and service users human rights and on respecting their autonomy, dignity, privacy, values and preferences in all aspects of their healthcare. Ensuring the prioritisation of individual choice and control is an essential component when providing trauma informed care as discussed by Berring *et al.* (2024).

Every adult resident and service user with capacity has the right to make decisions for themselves and choose their interventions following an incident of a sexual nature and their rights should be respected. It is recognised however, that in complex situations there may be competing duties and staff in approved and designated centres need to carefully consider the correct course of action in such cases with regard to their professional, organisational and statutory responsibilities. Decisions should be made with the person affected, the involvement of team members and external advisors as required e.g. the Sexual Assault Treatment Unit (SATU) and Safeguarding Protection Team (SPT). Professional legal advise should also be sought when required. Consent is further discussed under the heading Consent Consideration.

Documentation

Good healthcare records contribute to improved resident and service user care, quality, safety and trust (HSE, 2011, Mathioudakis, *et al.*, 2016). It is imperative records are up-to-date, accurate and are reflective of events, care and treatment. The documentation of any incidents of a sexual nature should be in line with the 'HSE Standards and Recommended Practices for Healthcare Records Management' (HSE, 2014b),

and with the 'Judgement Support Framework' (MHC, 2024a) or 'National Standards for Safer Better Healthcare' (HIQA, 2012) regulatory requirements as relevant. A resident or service user's clinical file or a section of their clinical file can be used during legal proceedings as evidence or in defence in relation to an incident of a sexual nature.

Insofar as possible record keeping should be contemporaneous. As soon as it is possible, healthcare staff will need to make a detailed written record of the facts, surrounding any incident of a sexual nature. This includes appropriate entries in the resident or service user's clinical file and when applicable a personal recollection of the incident. Staff must carefully document any and all conversation or conversations of disclosure, using the resident or service user's exact words. Staff must document what was seen, heard or observed. Phone calls, incident reports, meeting minutes and interagency contacts related to the incident must all be carefully recorded. The minimum requirements for all of these records are set out on the next page, taken from the aforementioned HSE Standards.

Minimum Requirements for Documenting an Incident of a Sexual Nature

- Record **when** the disclosure/conversation took place, or **when** you were **told about/witnessed** this incident/s.
- Record **who was involved** and any **other witnesses**, including other residents or service users and staff.
- Record exactly **what happened** or what you were told.
- Use the resident or service user's **exact words**.
- Include **as much detail** as possible.
- Keep it **factual**. Don't interpret what you saw or were told.
- Record any **other relevant information** e.g. previous incidents that have caused concern.
- Any **responses/actions** carried out.
- Record **consent** clearly, where applicable.
- Any **communications** with relevant persons and **when and how** they took place. e.g. Line managers, resident or service user's family, Decision Supporters, SATU, Gardaí.
- Any **reports and/or notifications** submitted **(NIMS, HIQA, MHC, TUSLA etc)**.
- Make sure all documentation is **legible** and of a **photocopiable quality**.
- Make sure you **print your name** and that it is **signed** and **dated**.
- Keep the record in the resident or service user's file **confidential**, storing it in a safe and secure place until needed.
- Write a personal recollection **as soon as possible**, to keep safely for yourself to rely on later, when applicable.

(ii) Immediate Response to Staff

This section addresses individuals who are not directly affected but who may be indirectly affected by what has happened, e.g. staff working in the designated or approved centre where an adverse incident has occurred. The importance of support for staff from line managers, colleagues and peers in the aftermath of incidents cannot be overstated. Staff may be considerably impacted, emotionally and functionally, following such incidents. The psychological effects of incidents on staff is well documented within the literature, where it is established that incidents can lead to a sense of guilt and isolation for many, (Seys D, 2013).

In the immediate aftermath of an incident, it is essential to identify the staff involved and to initiate communication and suitable support mechanisms. Timely discussion of the incident provides staff with a psychologically safe space to deliberate and process what happened and why it happened, (Seys D, 2013). In consideration of the scale of the incident, it may be important to consider the impact of the incident on other staff who were not directly involved but may have been affected by the event – such as other members of the team who have been caring for or supporting the person directly affected. When staff experience work related stress the **HSE Policy on the Prevention and Management of Work Related Stress (2023d)** must be followed.

Line managers responsible for the staff and service involved in an incident of a sexual nature have an obligation to provide direction, factual information and facilitate psychological supports. They may need to make contact with their staff to ensure that they do not feel isolated and that their support needs are appropriately met. Staff experience stressful incidents in different ways and their reactions vary, what may be upsetting for one staff member may not be for another, therefore it is important line managers check in with staff to understand their individual experiences. It may be necessary for line managers to assess the need for individual and/or group psychological supports. The detail of the supports offered and availed of should be documented.

An appropriate named staff member or line manager may be identified to act as a single point of contact for staff directly affected by the incident e.g. staff who witnessed a sexual assault, or received a disclosure of sexual abuse. This staff member is known as a Staff Liaison Person and their role is to ensure that staff receive support and are kept up to date throughout the incident management process including any review of the incident that may be required (HSE, 2020). The person allocated to this role should have the suitable skills and experience required to fulfil the role effectively.

Staff who are involved in a serious incident may have a strong need for information after the event: What happened? Who was involved? Will there be an investigation? What will be required of them? Line managers and Staff Liaison Persons accurately conveying factual information about what has happened and the plans to address the situation can reduce staff's anxiety (HSE, 2012). There may be a need for regular update meetings with those involved as the situation evolves, particularly if there is an internal review of the incident or if AGS are conducting an investigation.

ASSIST ME Model

The ASSIST ME model was developed by the National Open Disclosure Office in the HSE, it is a useful tool for guiding managers and staff through the process of communicating and supporting impacted staff following a patient safety incident. The model was adapted from the Medical Protection Society's A.S.S.I.S.T. Model of communication. The ASSIST ME approach (HSE, 2021b) provides guidance on when impacted staff should seek medical advice and assistance:

- Experiencing difficulty with sleeping for more than 1 week.
- Response to the event is too intense or lasting too long.
- Experiencing intense physical reactions to reminders of the event e.g. pounding heart, rapid breathing, nausea, muscle tension, sweating.
- Experiencing suicidal feelings or symptoms associated with depression/despair.
- Feel unable to return to work because of the event.
- A response to the event is impacting on private life outside work and on the ability to cope generally with normal day to day activities.

Further details on the ASSIST ME model is available **here**.

The HSE Employee Assistance Programme (EAP) provides supports for staff following patient safety incidents. It supports employees with psychosocial issues that influence mental health. The service is free and available to all HSE employees. Forms of supports provided by the EAP service include:

- Counselling
- Consultation to managers on staff wellbeing and psychosocial issues
- Workshops on staff wellbeing issues
- Critical Incident Stress Management (CISM) Response - individual and group support and pre-incident training to reduce risk associated with traumatic incidents in the workplace

Further information on the EAP service is available at **www.hse.ie/EAPandMe**

(iii) Mitigating Risk to Others

In the immediate aftermath of an incident, once the risk to the person directly affected has been managed – it is then necessary to ensure the same risk is not posed to others. This will include taking immediate management actions without prejudice to anyone. These steps will vary on a case-by-case basis but should seek to ensure that the person of concern, or person subject to an allegation of abuse, does not pose a risk of harm to other residents and service users. The steps to be taken if the person of concern is a resident or service user themselves should include:

- Relocation of the person of concern to a private area, away from the person directly affected and other residents/service users.
- In the context where the person of concern may be a child or vulnerable person, their immediate medical and psychological care needs should be assessed and met.
- The person of concern should be offered the support of any appointed decision-making representative or other relevant support person e.g. advocate.
- An assessment should be made regards the risk of harm the person of concern poses to themselves and others, and as necessary new placement or transfer arrangements made.
- In no circumstances should a service user or resident who is a person of concern be returned to the location where an incident took place while the person directly affected remains there.
- An agreed and comprehensive safeguarding plan must be in place before a person of concern is placed in an area where they will be interacting with other service users. The safeguarding plan must take into account the nature of the incident (e.g. witness or alleged, harassment or assault etc.) as well as the mix of service users or residents in the location where the person of concern is to be cared for, among other risk and protective factors.
- The risk assessment and safeguarding plans should be the subject of multi-disciplinary team (MDT) input, in the case of designated centres the Safeguarding and Protection Team (SPT).

While less frequent, the person of concern or person subject to an allegation of abuse may be a member of staff. In such cases, without prejudice, immediate steps must be taken to ensure there is no risk to residents or service users. The **HSE's Trust in Care Policy (2005)** must be activated without delay.

Based on the information available, the manager should put protective measures in place. These protective measures are not disciplinary measures and may include:

1. Providing an appropriate level of supervision in a different unit to the one where the suspected or alleged incident occurred.
2. Assignment to non-contact roles (i.e. no contact with residents or service users).
3. Putting the staff member off duty with pay pending the outcome of the investigation.

While option 1 above is available to managers under the Trust in Care policy, it is essential that any manager choosing this option as a protective measure is satisfied that it will be sufficiently protective and are willing to take accountability for choosing this option.

The manager must immediately notify the staff member against whom the complaint is made of the details of the allegation and advise him/her that a preliminary screening process is being undertaken. The staff member must be advised in advance of his/her right to be accompanied at this meeting by a union representative or work colleague. In the interests of all parties Trust in Care primary screenings, and investigations as required, are carried out in a timely fashion. Staff should refer to the full policy for further information.

Incident Management Step 3: Reporting and Notification

The National Incident Management System (NIMS)

State authorities have a statutory requirement to report incidents to the State Claims Agency, as per the National Treasury Management Agency (Amendment) Act, 2000. The National Incident Management System (NIMS) is the system used by state authorities to report incidents to the State Claims Agency and for organisations own incident and risk management strategies. National Incident Report Forms (NIRFs) have been made available by the State Claims Agency to standardise reporting by State authorities.

It is the responsibility of the staff member who identified the incident of a sexual nature to complete the appropriate NIRFS or directly input the data into NIMS, in a timely manner, while having due regard for the immediate needs of the person affected. Incident reporting should be completed as soon as practicable or within 24 hours after the incident occurred or was identified (HSE, 2020). Staff must ensure they provide factual and complete information and inform line management of its completion.

Notifying the Senior Accountable Officer (SAO)

The Serious Reportable Events (SREs) HSE Implementation Guidance Document (HSE, 2015) defines SREs as "serious, largely preventable patient safety incidents that should not occur if the available preventable measures have been implemented by healthcare providers" (p. 2). Under section (6) Criminal Events, class (6c) "Sexual assault on a patient or other person within the grounds of a healthcare service facility" is identified as a SRE (HSE, 2015). SRE's must be reported to the SAO within 24 hours of occurrence or identification of the incident.

The line managers in whose service the incident of a sexual nature has occurred will have identified the level of harm resulting from the incident through establishing the facts and the NIRF / NIMS data submitted. The categorisation of incidents is further outlined under the heading: Step 4 and 5 Categorisation, Initial Assessment and Reviewing. Notification of Category 1 incidents to the SAO must occur within 24 hours of occurrence or identification of the incident. This timely reporting to the SAO provides assurance in relation to the appropriate immediate actions and the activation of the Serious Incident Management Team (SIMT), which will make an assessment of further actions required (HSE, 2020).

Notifying the Health Information and Quality Authority (HIQA)

Regulatory or statutory notifications are required to be submitted from designated centres to the regulator when events that are notifiable occur. Designated centres for older people (CNUs) must submit the required notifications within two working days and designated centres for people with a disability must submit the required notifications within three working days. Form NF06 must be completed and submitted to HIQA within either two or three days by the person in charge when there is alleged, suspected of confirmed abuse of a resident – this includes sexual abuse. The forms and guidance on managing notifiable events in designated centres can be found on the HIQA website.

Notifying the Mental Health Commission (MHC)

Regulatory or statutory notifications are required to be submitted from approved centres to the regulator when events that are notifiable occur. The notification must be made online via the Commission's Comprehensive Information System (CIS) within 48 hours, by the registered proprietor or person with delegated authority working within the approved centre, for any alleged or actual sexual assault on a patient or other person, within or on the grounds of a healthcare service facility.

While some of this text is taken from the criminal events section of the serious reportable events list, it is important to remember that mental health staff do not need to confirm that a criminal event has taken place before making the required notification to the MHC as per the **MHC Guidance on Quality and Safety Notifications** (2024b). It is essential to fully complete every field of the MHC notification with the required details.

Incident Management Step 4 and 5: Categorisation, Initial Assessment and Review

The purpose of categorising and assessing incidents is to assist with determining the level of review required. The level and approach to review must also be proportionate to the impact of the incident and the opportunity provided by the incident to identify learning that can be used to minimise the risk of a similar incident occurring in the future. The line manager in whose service the incident occurred will in reviewing the National Incident Report Form (NIRF) submitted to them, have identified the level of harm relating to the outcome of the incident. The level of harm experienced informs the categorisation of the incident. Incidents are categorised as follows:

Category 1 Major/Extreme: incidents rated as Major or Extreme as per the HSE's Risk Impact Table.

Category 2 Moderate: incidents rated as Moderate as per the HSE's Risk Impact Table.

Category 3 Minor/Negligible: incidents rated as Minor or Negligible as per the HSE's Risk Impact Table.

For further guidance on determining the level of harm associated with an incident please refer to the HSE Risk Assessment Table in the **Enterprise Risk Management Policy and Procedures** (HSE, 2023a).

Due to the level of harm incurred, Category 1 and Category 2 incidents require preliminary assessment to support a formal decision being taken in relation to review. Detail of the assessment and decision-making process must be recorded using the Preliminary Assessment Form (**IMF Guidance Section 8**). In relation to Category 2 incidents, the completion of Part A of this form is the responsibility of the Local Accountable Officer (LAO) in whose service the incident occurred. Part B is also completed by the LAO in consultation with the Quality and Patient Safety (QPS) Manager.

Category 1 incidents must be referred to a Serious Incident Management Team (SIMT) (**IMF Guidance Section 7**) for decision-making in relation to their management. Ideally, decisions relating to the review of Category 1 incidents should be made within 72 hours of occurrence of the incident and at latest must be made within one working week.

To assist with a responsive and timely approach to review and with building a culture of safety, reviews should be completed within the shortest possible timeframe. For Concise and Comprehensive Reviews this should not exceed 125 days from the time of occurrence of the incident. It is however accepted that in some circumstances this timeframe will not be achievable, for example when a Review Team is commissioned external to the region where the incident occurred.

Incident Management Step 6: Improvement Planning and Monitoring

Information on incidents of a sexual nature is available from a number of sources. It is incumbent on services to utilise their own data to inform local improvement, planning and monitoring of resident and service user safety. This includes data from the National Incident Management System (NIMS), completed review reports, regulatory notifications and local safeguarding data. In addition to local information, national review reports offer valuable opportunities for learning, for example the **Brandon Report** (HSE, 2021a) and **Emily Report** (HSE, 2023b). **Patient Safety Together** is a useful national platform to learn, share and improve patient safety incidents.

Whilst the IMF focuses on the issue of Incident Management when it comes to identifying areas for improvement, it is important to also consider these other relevant sources of information, for example, complaints, closed claims, inspection reports, etc. Information from all sources should be used to both inform the service's improvement plan and to monitor the impact of improvement actions taken.

Part C Policy and Legislative Considerations

Part C outlines policies and legislation which may apply when an incident of a sexual nature occurs. Always consult the full policy or Act. If in doubt about policy and / or legal obligations seek advice from for example line managers, specialists e.g. in Safeguarding, SATU, AGS or legal service providers through the agreed regional process.

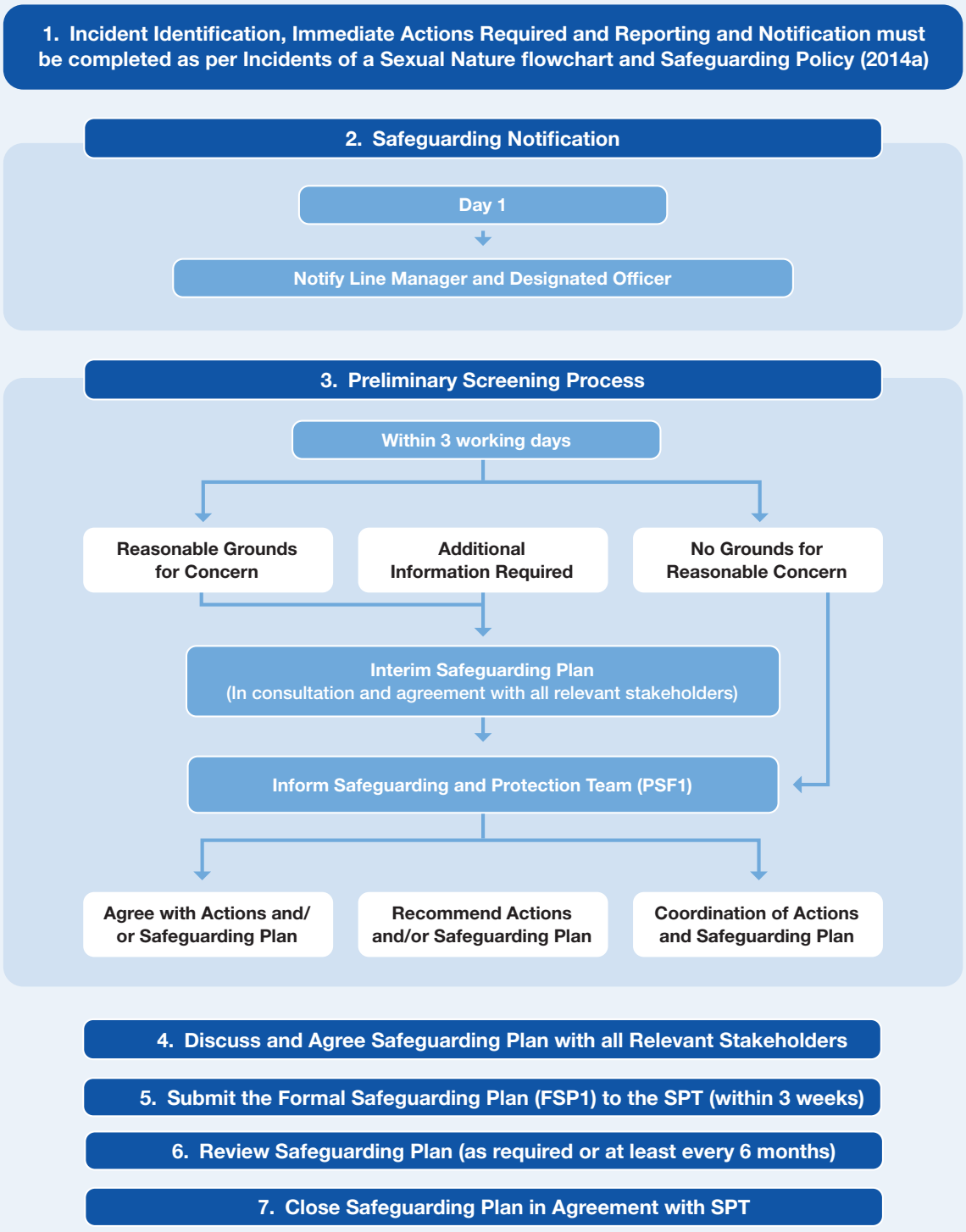
Policy Considerations

Safeguarding Vulnerable Persons at Risk of Abuse National Policy and Procedures (HSE, 2014a)

The HSE, for the purposes of the extant safeguarding policy, considers a vulnerable person to be an adult who may be restricted in capacity to guard himself/herself against harm or exploitation or to report such harm or exploitation. This may arise as a result of physical or intellectual impairment and risk of abuse may be influenced by both context and individual circumstances. This definition, and indeed the policy itself require revision – and the HSE will be undertaking this work in line with the recommendations of the **McIlroy Report** (McIlroy, 2023) on safeguarding operations in the HSE. The principles of the policy however remain relevant as they pertain to the recognition, response and reporting of suspected or actual abuse. While the extant policy has a remit across HSE provided and HSE funded older persons and disability services, the same principles are applicable to all settings. Staff should refer to the **Safeguarding Vulnerable Persons at Risk of Abuse National Policy & Procedures** (HSE, 2014a). A high-level flowchart is below at *Figure 4: Safeguarding Vulnerable Persons at Risk*, and can be found again in the *Policy Navigation Toolkit at Appendix 1(b)*.

Figure 4: Safeguarding Vulnerable Persons at Risk of Abuse

This flowchart is for guidance and is not a substitute for the HSE Safeguarding Vulnerable Persons at Risk of Abuse, National Policy and Procedures (2014a).

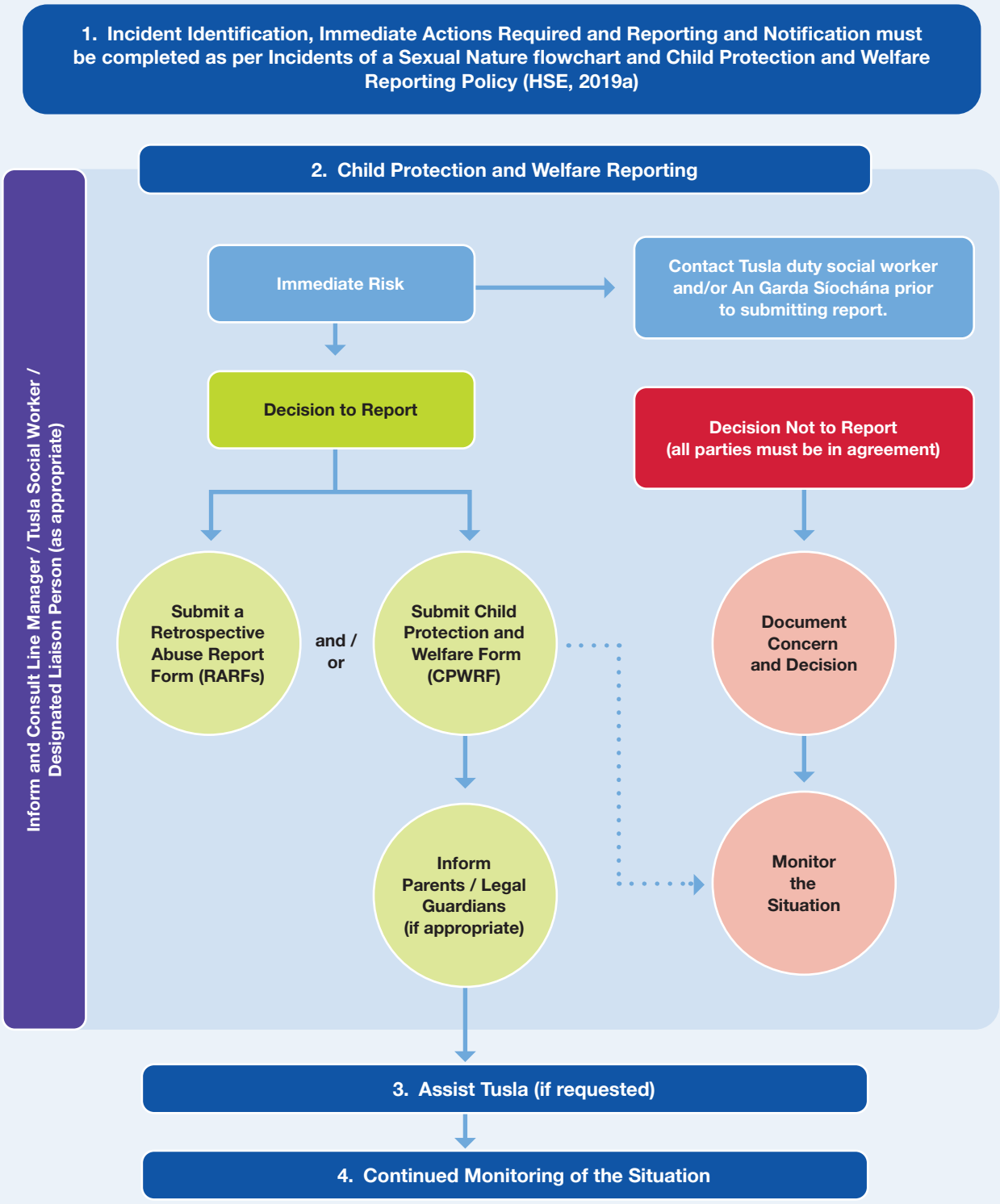


Child Protection and Welfare Policy (HSE, 2019a)

Every HSE staff member has a responsibility and duty of care to ensure that children/young people availing of, or attending a HSE service, are safe and protected from harm (physical/emotional/sexual abuse or neglect). The Children First Act 2015 places legal obligations on certain staff, known as mandated persons. The **HSE Child Protection and Welfare Policy (2019a)** sets out the roles, responsibilities and procedures assigned to ensure the effective safeguarding and management of child protection and welfare concerns in the HSE. It is one of a number of policies and procedures in the HSE that contribute to safeguarding children and young people. When an incident of a sexual nature affects a child or young person this policy should be referred to in full. A high-level flowchart is on the next page at *Figure 5: Child Protection and Welfare Reporting* and can also be found in the *Policy Navigation Toolkit at Appendix 1(c)*.

Figure 5: Child Protection and Welfare Reporting

This flowchart is for practice guidance and is not a substitute for the HSE Child Protection and Welfare Policy (2019a).



Open Disclosure Policy (HSE, 2025)

Open Disclosure is defined as an "open, honest, compassionate and timely approach to communicating with patients or, where appropriate, their relevant person (or both of them) following patient safety incidents or notifiable incidents" (HSE, 2025, p. 9). It includes apologising and expressing regret for what has happened, providing information and reassurance in relation to ongoing care and treatment, consequential learning and the actions being taken to prevent similar incidents (HSE, 2025).

Communications with the person affected and /or their relevant person following an incident of a sexual nature should be initiated, as soon as is practicable and appropriate. The open disclosure process must commence within 24-48 hours of the incident occurring or of the service becoming aware of the incident, as per the **HSE Open Disclosure Policy (2025)**. Staff should refer to the policy in full. The open disclosure response must be proportionate to the level of harm experienced by the person affected (HSE, 2025). Any patient safety notifiable incidents require open disclosure reporting in line with the **Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023**.

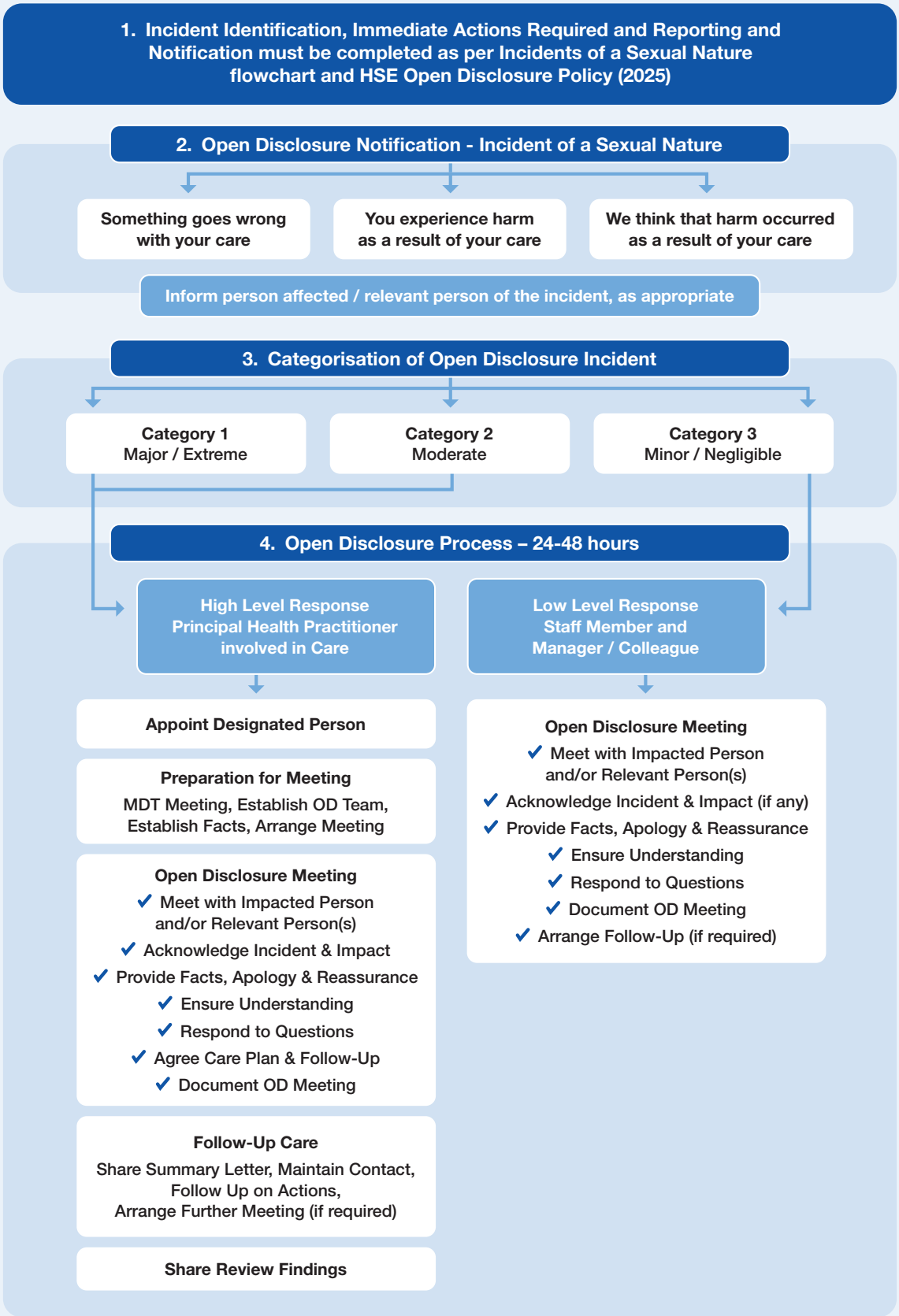
Open Disclosure must be initiated following an incident of a sexual nature if:

- Something went wrong with the resident or service user's care, e.g. a failure to safeguard
- The resident or service user experienced harm as a result, physical or psychological
- The service thinks that harm may have occurred as a result of the resident or service user's care.

The HSE Open Disclosure Office have developed a range of resources for both the public and for staff to learn more about Open Disclosure and for putting it into practice. Resources are available on the HSE Open Disclosure website **here**. A high-level flowchart is below at *Figure 6: Open Disclosure* and can also be found in the *Policy Navigation Toolkit at Appendix 1(d)*.

Figure 6: Open Disclosure

This flowchart is for practice guidance and is not a substitute for the HSE Open Disclosure Policy (2025).



Trust in Care Policy (HSE, 2005)

The **HSE Trust In Care Policy (2005)** sets out the procedures for managing allegations of abuse against staff. It should be activated immediately in order to protect residents, service users and to ensure natural justice and due process is afforded to persons subject to allegations of abuse. Staff should refer to the policy in full.

The HSE is committed to promoting the well-being of residents and service users and providing a caring environment where they are treated with dignity and respect. Health service employers are also highly committed to their staff and to providing them with the necessary supervision, support and training to enable them to provide the highest standards of care.

The aim of this Policy is two-fold:

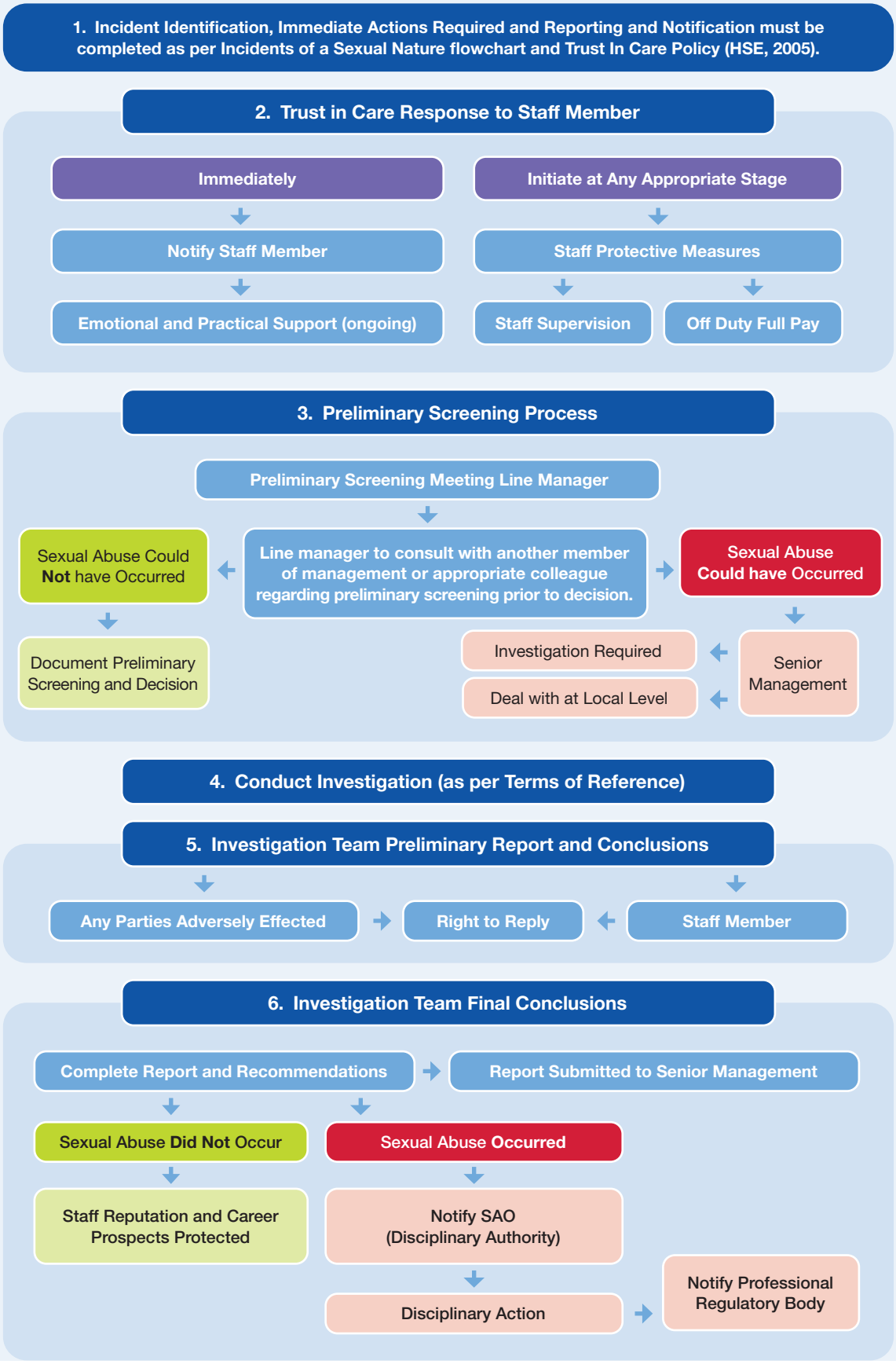
(i) Preventative: to outline the importance of the proper operation of human resource policies in communicating and maintaining high standards of care amongst health service staff:

(ii) Procedural: to ensure proper procedures for reporting suspicions or complaints of abuse and for managing allegations of abuse against health service staff in accordance with natural justice.

The Trust in Care policy should be referred to in full, but staff – particularly managers are reminded that immediate steps must be taken without prejudice to protect residents and service users when required. A flowchart of the entire Trust in Care process is on the next page at *Figure 7: Trust in Care* and within the *Policy Navigation Toolkit at Appendix 1(e)*.

Figure 7: Trust in Care

This flowchart is for practice guidance and is not a substitute for the HSE Trust in Care Policy (2005).



Consent Considerations

National Consent Policy (HSE, 2022)

Consent is "the giving of permission or agreement for a treatment, investigation, receipt or use of a service or participation in research or teaching" (HSE, 2022). It involves a process of communication about the proposed intervention in which the person has received satisfactory information to empower them in understanding the nature, potential risks and benefits of the proposed intervention. Consent is a fluid, on-going process rather than a one-off event and it can be withdrawn at any stage. It can be given in various forms; verbally, non-verbally, in writing, or by implication (HSE, 2022). In certain situations, it is best practice to get signed and witnessed consent from a resident or service user, especially if the intervention is complex, invasive or involves significant risk. Staff should refer to the **National Consent Policy (HSE, 2022)**.

Consent will need to be considered by staff at various stages throughout the HSE (2020) IMF's six steps, in particular during Step 2 – immediate actions, which is the primary focus of this guidance. Staff may need to balance the rights of the person affected and their own professional and legislative obligations when making decisions around incidents of a sexual nature. This section outlines some principles to aid decision-making. Whether staff are acting with or in the absence of a resident or service user's valid consent, it is imperative they are cognisant of the guiding principles and basic legal grounds underpinning their decisions.

Valid consent is obtained from a resident or service user when:

- The resident or service user receives sufficient and relevant information in a comprehensible way about the nature and potential risks and benefits of the proposed interaction, of any alternative intervention and of not receiving the intervention.
- The resident or service user is not acting under duress. Consent needs to be given freely.
- The resident or service user has the decision-making capacity to make the decision, even if they require support to do so, (HSE, 2022).

This section on some of the main principles of consent should be referred to in consultation with the relevant documents and legislation. Some of which include: The National Consent Policy HSE, 2022, Assisted Decision-making (Capacity) Act 2015, Mental Health Act 2001, Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012, Children First Act, 2015, section 23 of the Non-Fatal Offences against the Person Act 1997 and the Child Care Act 1991, and Safeguarding Vulnerable Persons at Risk of Abuse, National Policy and Procedures, (HSE 2014a). Each Act mentioned is available in full at **http://www.irishstatutebook.ie/**.

Assisted Decision-Making (Capacity) Act (as amended) 2015

A person may be deemed to lack capacity in making their own decisions due to a disability, life-long condition or acquired condition and, therefore, may require additional assistance and support to exercise their individual rights. The Assisted Decision-Making (Capacity) Act 2015, was amended by the Assisted Decision-Making (Capacity) (Amendment) Act 2022 and came into effect on the 26th April 2023, establishing a new legal framework for adults who may have difficulty making and communicating decisions about their personal welfare, property and affairs. Personal welfare decisions may include, accommodation, employment, education or training, participation in social activities, decisions on any social services and healthcare. Decisions not covered by the Assisted Decision-Making (Capacity) Act 2015 include; marriage, divorce or separation, **sexual relations** and serving as a member of a jury.

The Assisted Decision-Making (Capacity) Act 2015 ratifies Ireland's responsibility to comply with the UN Convention on the Rights of People with Disabilities (UNCRPD) which was signed by Ireland on the 30th of March 2007. It provides statutory guiding principles on rights, decision-making and autonomy and on a functional test of capacity (which is time and issue specific). The Assisted Decision-Making (Capacity) Act 2015 endorses the presumption of capacity and safeguards that the will and preference of the person and their beliefs and values, insofar as reasonably ascertainable, are considered, even when the person has been found to lack the decision-making capacity.

The Assisted Decision-Making (Capacity) Act 2015 created a new **three-tiered approach** to support people who have issues with making decisions. These included:

- **Decision-making assistance agreement.** A person can formally appoint a decision-making assistant. The person retains ultimate decision-making.
- **Co-decision-making agreements.** A person can appoint someone to make decisions on their behalf on a joint responsibility basis.
- **Decision-making representation orders.** The Circuit Court can appoint a representative to make certain decisions on behalf of persons who are unable to make such decisions on their own behalf.

The Assisted Decision-Making (Capacity) Act 2015 also allows individuals to plan for a time when they might lose capacity. These future planning arrangements include:

- **Advanced healthcare directives.** This arrangement enables a person to write down their wishes about future healthcare and treatment decisions in case they ever become unable to make these decisions. A person can legally document treatment they do not want and they can include requests for specific treatments however these preferences are not legally binding.
- **Enduring power of attorney.** This arrangement lets a person appoint someone (or a number of people) they trust as their attorney. The attorney's role is to act on the person's behalf to make certain decisions if they are unable to in the future. An attorney does not need to be a lawyer. A person can give their attorney the authority to act on their behalf about all or part of their affairs.

Decision-Making Capacity

The Assisted Decision-Making (Capacity) Act 2015 states "a person's capacity shall be assessed on the basis of his or her ability to understand, at the time that a decision is to be made, the nature and consequence of the decision to be made by him or her in the context of the available choices at that time".

A person with decision-making capacity can:

- Understand information and facts relevant to the decision;
- Retain that information long enough to make a voluntary choice;
- Use and weigh that information as part of the process of making the decision; and
- Communicate the decision by any means, including by assistive technology.

In a situation where a person's capacity is questioned, capacity will be assessed based on their ability to make

a specific decision at a specific time. This is called the 'Functional Test' of capacity and is outlined in further detail under the heading Functional Capacity Assessment.

The Decision Support Service (DSS) Code of Practice for Supporting Decision-Making and Assessing Capacity (DDS, 2023) provides guidance on supporting a person with capacity challenges to make a specific decision and on the process for assessing capacity.

Decision-Making Capacity Principles

There are some essential principles cited by the National Consent Policy (HSE, 2022) that staff need to apply when supporting and considering a resident or service user's capacity to provide consent:

- For every resident and service user there is a **presumption of decision-making capacity** unless it is established that that is not the case.
- Staff should **support** the resident and service user as much as possible to make their own decisions.
- A resident or service user is only considered to lack decision-making capacity and unable to give consent after **all practicable steps to help them** to make the decision **have failed**.
- Decision-making capacity is based only on the **specific decision** that needs to be made, at the **specific time** the decision is required (this is known as the 'functional' approach to capacity), e.g. deciding about involving Gardaí, or attending a Sexual Assault Treatment Unit following a sexual assault.
- **It does not matter** if the resident or service user's **capacity is temporary**, if it **fluctuates**, or if the resident or service user **retains the capacity** to make other decisions.
- A resident or service user cannot be deemed to lack decision-making capacity simply because there is a risk that they might make an **unwise decision**.
- If circumstances allow it, it may be necessary to give resident or service user **information and support over a period of time** in order to build and maximise their ability to make decisions for themselves.

When to Query Decision-Making Capacity

A resident or service user's decision-making capacity should not be in doubt and an assessment of capacity should not be completed without good reason. However, staff also need to be vigilant and not ignore clear evidence that a resident or service user lacks the capacity to make a particular decision. The HSE National Consent Policy (2022) outlines a number of factors which may cause staff to question a resident or service user's capacity to make a specific decision. These factors include when:

- Residents or service users are unable to **communicate** a clear and consistent choice;
- Residents or service users are making decisions that **seem out of character**, inconsistent with their known will and preferences or previously expressed wishes;
- Residents or service users are making a decision that seems objectively unwise – that is, one that **cannot be understood by reference to his or her individual circumstances** or wishes and beliefs – or irrational;
- The resident or service user's decision goes **against reasonable advice**, without justification;
- The resident or service user's decision may carry a **substantial risk or a potential long-lasting consequence** for the resident or service user.

When a resident or service user's capacity is in question, a healthcare professional must record their dealings with the resident or service user, including:

- The support staff provided,
- Whether a decision-making arrangement was in place and
- The steps taken before assessing capacity.

Functional Capacity Assessment

Functional capacity assessments are completed to resolve uncertainty where a resident or service user's capacity to make a decision is in doubt and a decision needs to be made. Functional capacity assessments should only be carried out when there is a valid indication to do so and in a timely manner. There may be occasions where staff might conclude that an intervention cannot or should not proceed irrespective of the person being found to lack capacity and, in this situation, there is no need for a capacity assessment.

The most fitting person to assess capacity is often a healthcare staff member who has the best understanding of the specific decision that needs to be made and/or who is most closely involved with the decision that needs to be made. On that basis, the responsibility for assessing capacity and documenting the assessment generally sits with the healthcare professional proposing the particular intervention and seeking the resident or service user's consent. In complex situations, it may be advisable to seek expert assistance or a second opinion from an appropriately qualified staff member. The Assisted Decision-Making (Capacity) Act 2015 set out classes of healthcare professionals in addition to medical practitioners who may provide capacity assessments. These include registered:

- Occupational Therapists
- Midwives
- Nurses
- Social Workers
- Speech and Language Therapists.

The healthcare professional assessing capacity must adequately prepare for the capacity assessment and seek the consent of the resident or service user undertaking the capacity assessment. The emphasis in a functional assessment of capacity is on how a person makes a decision and not on the outcome of the decision. The healthcare professional conducting a capacity assessment must include assessment and documentation of the following elements of decision-making capacity:

- Does the resident or service user understand information and facts relevant to the decision?
- Does the resident or service user retain that information long enough to make an intentional choice?
- Does the resident or service user use or weigh-up the information as part of the process of making a decision?
- Can the resident or service user communicate their decision?

If the resident or service user does not meet one or more of the elements of the functional assessment of capacity, the resident or service user is deemed to lack decision-making capacity.

Absence of Decision-Making Capacity

If an adult resident or service user lacks decision-making capacity staff must take reasonable steps to find out if anyone has the legal authority to make decisions on the resident or service user's behalf and if feasible staff should seek that person's consent. If it is considered that no one has the legal authority to make decisions on the resident or service user's behalf or if in an emergency when it is not practical to consult the resident or service user's legal authority the principle of necessity applies. The doctrine of necessity applies where a suitably qualified staff member needs to take urgent action for a resident or service user who lacks capacity to make a decision and the action is one that a reasonable person would take in the best interests of the person (HSE, 2022).

Examples of individuals that may have the legal authority to make decisions on behalf of an adult resident or service user under circumstances where the resident or service user is unable to make or communicate a decision or lacks decision-making capacity:

- Residents or service users who remain under the Ward of Court system.
- Service users detained under the Mental Health Act 2001.
- Residents or service users subject to a decision-making representation order by the courts.
- Residents or service users who have an Advance Healthcare Directive (ADH) that specifically and legally applies to the intervention in question.
- Residents or service users who have an enduring power of attorney that have legal decision-making authority over the specific intervention in question.

Young People's Consent to an Intervention – Aged under 16 years

Parents/legal guardians are generally considered to be best placed to make decisions in the best interests of their child. The general principle is that for the young person, parental/legal guardian consent is required, however the right of the young person to express their views and to have these views given due weight in accordance with their age and maturity, should be considered (HSE, 2022). This relates to both consent to and refusal of an intervention.

The HSE National Consent Policy (2022) states the consent of one parent/legal guardian is usually considered sufficient when obtaining parental consent based on the prioritisation of the best interests of the child, however this is subject to the following exceptions:

- Where both parents/legal guardians have expressed a wish to participate fully in the decision-making for their child/young person.
- Where both parents/legal guardians have expressed a wish to participate fully in the consent process.
- When the intervention proposed is high risk or is likely to have profound consequences for the child/young person.

Young People's Consent to an Intervention – Aged 16-17 years

Section 23 of the Non-Fatal Offences Against the Person Act 1997 prescribes that a person over the age of 16 years can give consent to surgical, medical or dental treatment and it is not necessary to obtain consent for it from his or her parent(s)/legal guardian(s). It is viewed that the young person is consenting to expert advice. It is also however recognised that the legal basis for this has not been definitively established in the Irish Courts (SART, 2023). The HSE National Consent Policy (2022) adopts the position that the consent of a person aged 16 and 17 years (who has decision-making capacity) is sufficient. It is however good practice to involve parent(s)/legal guardian(s) in healthcare decision-making for a young person, if the young person consents to this involvement. The principles of valid consent, decision-making capacity and the functional approach to the assessment of capacity apply to young people aged 16 years and 17 years (HSE, 2022). These principles were outlined above under the relevant headings. If a young person is found to lack the capacity to consent on the basis of the functional test, his or her parents may give consent on his or her behalf until the young person reaches the age of 18 years (HSE, 2022).

Young People's Refusal of an Intervention – Aged 16-17 years

Refusal of treatment by a young person who is aged 16 years and 17 years and who has the capacity to make this decision is legally differentiated from consent to treatment. The court can overturn a young person's refusal to treatment, if it considers this to be in the young person's best interests (HSE, 2022). However, as previously stated the views of a young person should always be treated with respect in accordance with the young person's capacity, age and maturity. This means that even where healthcare staff consider the intervention to be in the young person's best interest and the young person's parent(s)/guardian(s) consent to the intervention, the intervention should not proceed if the young person refuses this treatment or intervention (HSE, 2022).

Reasonable efforts should be made to deliberate the young person's refusal with all relevant parties, including third-party mediators, if appropriate in order to reach an agreement. Failing to reach a consensus, an application could be made to the High Court to adjudicate on the refusal (HSE, 2022).

In an emergency situation where there is no time to make an application to the court for guidance and there is an immediate risk of death or serious injury or profound, irreversible consequences to the young person the principle of necessity applies (HSE, 2022).

The Mental Health Act 2001 and Young People's Consent

Some young people are admitted to approved centres under the **Mental Health Act 2001** and where this happens, their admission and treatment is covered by the statutory requirements of the Mental Health Act 2001. An application for an involuntary admission under the Mental Health Act 2001 is made by the HSE to the District Court. An application will usually only be made where the young person's parent(s)/gaurdian(s) do not consent to voluntary admission or where the young person objects to voluntary admission even though the young person's parent(s)/gaurdian(s) consent (HSE, 2022).

Where a young person has been involuntarily admitted under the Mental Health Act 2001, neither parental consent nor the consent of the young person is legally required for treatment for the young person's mental disorder (HSE, 2022). Instead, decisions about treatment are made by the treating consultant psychiatrist in accordance with the Mental Health Act 2001 and in the best interest of the young person. However there are exceptions to this, with specific treatments outlined under the Mental Health Act 2001, e.g. 'psyhco-surgery' or 'electro-convulsive therapy'. It is encouraged and good practice to involve the parents or legal guardian insofar as this is possible and the young person's preferences should also be respected and considered in the decision-making process.

Legislative Considerations

The Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012 – Pertaining to an Adult

A vulnerable adult is an adult who may have limitations on their decision-making capacity to protect themselves from harm or exploitation or to report such harm or exploitation (HSE, 2014a). Susceptibility to abuse can be influenced by both individual vulnerabilities and the context in which they are cared for (HSE, 2014a). Legislation in recent years has included an increased responsibility on the wider community to safeguard children and vulnerable adults against sexual offences. The **Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012** provides that it is a criminal offence to withhold information about an offence including a sexual offence against a person under 18 years or a vulnerable person. A person shall be "guilty of this offence if he or she knows or believes that a Schedule 1 offence (including rape, sexual assault and other sexual offences) has been committed by another person against a child, and he or she has information which he or she knows or believes might be of material assistance in securing the apprehension, prosecution or conviction of that other person for that offence, and fails without reasonable excuse to disclose that information, as soon as it is practicable to do so to a member of the Garda Síochána" (Office of the Tánaiste, 1997 as cited in SART, 2023).

Legislation Pertaining to Children

The **Child Care Act 1991**, the **Children Act 2001**, the Mental Health Act 2001 and the Children First Act 2015 define a child as a person under 18 years, however there are some caveats considered in these Acts. All young persons have the right to participate in decision-making in relation to their care and treatment and it is important that respect for their autonomy is integrated into decision-making in the same way it is for adults. Respect for the autonomy of a young person involves the facilitation, wherever possible, of the young person to make his/her decisions. Involving a young person in decision-making may be different from obtaining consent depending on the capacity of the young person and the legal authority of the parents/legal guardians in the decision-making.

Although Irish law refers to a 'child' as someone under the age of 18 years, there are legal distinctions between someone under the age of 16 years and someone aged 16 and 17 years. There are also distinctions between consent to and refusal of an intervention (HSE, 2022). When obtaining consent from someone less than 18 years, various aspects of the legislation may need to be considered in conjunction with one another. The Child Care Act 1991 prescribes that due consideration must be taken of the wishes of the child as the child increases in age and understanding, as far as is practicable. The Children First Act 2015 regards the best interests of the child as the paramount consideration. As previously mentioned, section 23 of the Non-Fatal Offences Against the Person Act 1997 provides that a person over the age of 16 years can give consent to surgical, medical or dental treatment, however it does provide for the refusal of treatment.

Criminal Law (Sexual Offences) Act 2006

There are various separate but relevant criminal and child protection laws to consider regarding incidents of a sexual nature impacting a resident or service user who is a child or adolescent. The **Criminal Law (Sexual Offences) Act 2006** outlines the legal age of valid consent for sexual activity is 17 years. A child is not deemed to have capacity to consent to sexual acts if they are under 17 years. Any sexual acts where one or both parties are under the age of 17 years is illegal, however it may not always be regarded as child abuse (Department of Children and Youth Affairs, 2017).

Children First Act 2015

Under the **Children First Act 2015** a mandated person has a legal obligation to report to Tusla (Child and Family Agency), as soon as practicable, if they know, believe or have reasonable grounds to suspect, on the basis of information that he or she has received, acquired or became aware of in the course of his or her employment or profession that a child has been, is being or is at risk of being harmed. The **Protections for Persons Reporting Child Abuse Act 1998** makes provision for the protection from civil liability, or penalisation by an employer, for individuals who have communicated child abuse reports 'reasonably and in good faith' to Designated Officers of the HSE, Tusla or to any member of AGS.

Sexual abuse falls within a category of seriously affecting a child's health, welfare and/or development, therefore all concerns about child sexual abuse must be submitted as a mandated report to Tusla (HSE, 2019a). It is not necessary for staff to prove that sexual abuse has occurred, all that is required is that there is a concern. Under the Children First Act 2015 sexual abuse is defined as any sexual offence as specified in Schedule 3 of the Children First Act 2015, this list of sexual abuse offences can be found in *Appendix 2: Schedule 3 of the Children First Act 2015 (as amended by section 55 of the Criminal Law Sexual Offences Act 2017)*.

It is important to note that section 14(12) of the Children First Act 2015 states making a mandated report under the Children First Act 2015 does not discharge individuals of their obligation in making a report to An Garda Síochána under the Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012, or to any other person by or under any other enactment or rule of law.

The Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012 – Pertaining to Young People

As previously stated, the **Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012** provides that it is a criminal offence to withhold information about an offence including a sexual offence against a person under 18 years or a vulnerable person. The reporting principles of the Act mentioned above also apply to a person under 18 years. It is good practice to inform the young person's parent(s)/legal guardian(s) that a report is being made to An Garda Síochána, unless doing so would create a risk of harm (HSE, 2019a). As previously stated the provision of the Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012 is in addition to the reporting requirements under the Children First Act 2015.

Terms, Definitions and Abbreviations

Terms and Definitions

Category 1 incident	Clinical and non-clinical incidents rated as Major or Extreme as per the HSE's Risk Impact Table. e.g. a death is rated as extreme and categorised as a Category 1 incident.
Category 2 incident	Clinical and non-clinical incidents rated as Medium as per the HSE's Risk Impact Table.
Category 3 incident	Clinical and non-clinical incidents rated as Minor or Negligible as per the HSE's Risk Impact Table.
Designated Liaison Person	This person is a nominated resource person for any staff member or volunteer who has child protection concerns. The designated liaison person is responsible for ensuring that reporting procedures are followed, so that child welfare and protection concerns are referred promptly to Tusla.
Designated Officer	Each service (HSE and funded) providing services to people within the service who may be vulnerable will appoint a Designated Officer (HSE, 2014a).
Designated Person	A person who liaises with the health and social care service provider and the patient or relevant person (or both of them) in relation to open disclosure of a patient safety incident (Civil Liability [Amendment] Act 2017) or open disclosure of a notifiable incident (Patient Safety Act 2023), (HSE, 2025).
HSE Incident Management Framework (IMF)	Provides an overarching, practical approach based on best practice to assist all HSE and HSE funded providers to comply with HSE policy and to manage incidents.
HSE Incident Management Policy	It is the policy of the HSE and HSE funded agencies that all Incidents are identified, reported and reviewed so that learning from events can be shared to improve the quality and safety of services.
Incident	*'An event or circumstance which could have, or did lead to unintended and/or unnecessary harm. Incidents include adverse events which result in harm; near misses which could have resulted in harm, but did not cause harm, either by chance or timely intervention; and staff or service user complaints which are associated with harm. Incidents can be clinical or non-clinical'* (Incident Management Framework 2020).
Incidents of a sexual nature	Incidents of a sexual nature refers to any incident which meets the defintions of either sexual abuse, sexual assault, sexual harassment or sexual safety incidents. Incidents of a sexual nature is therefore an umbrella term.
Incident Review	Incident Review Involves a structured analysis and is conducted using the best practice methods, to determine what happened, how it happened, why it happened, and whether there are learning points for the service, wider organisation, or nationally.

Open disclosure	Open Disclosure is defined as an "open, honest, compassionate and timely approach to communicating with patients or, where appropriate, their relevant person (or both of them) following patient safety incidents or notifiable incidents" (HSE, 2025, p. 9). It includes apologising and expressing regret for what has happened, providing information and reassurance in relation to ongoing care and treatment, consequential learning and the actions being taken to prevent similar incidents (HSE, 2025).
Patient	A term used to describe a person to whom a health service is being provided.
Patient Safety Incident	An incident which occurs during the course of the provision of a health service which either: (a) has caused an unintended or unanticipated injury, or harm, to the patient (b) did not result in actual injury or harm to the patient but was one which the health services provider has reasonable grounds to believe placed the patient at risk of unintended or unanticipated injury or harm, or (c) unanticipated or unintended injury or harm to the patient was prevented, either by "timely intervention or by chance", but the incident was one which the health services provider has reasonable grounds for believing could have resulted in injury or harm, if not prevented, (Civil Liability [Amendment] Act, 2017).
Person Affected	This refers to service users and residents that may be affected as a consequence of an incident occurring. Persons can be affected either directly or indirectly.
Person of Concern	Any person whose behaviour, in this instance sexualised behaviour, poses a risk of harm to themselves or any other person.
Person Subject to an Allegation of Abuse	Any person against who an allegation of abuse is made by any other person.
Principal Health Practitioner	Principal health practitioner in relation to a patient, means a health practitioner who has the principal clinical responsibility for the clinical care and treatment of the patient.
Rape	**Rape** has two legal definitions in Ireland. • Rape is defined in section 2 of the Criminal Law (Rape) Act 1981 as being an offence committed by a man if he has unlawful sexual intercourse with a woman who at the time of the intercourse does not consent to it, and at that time he knows that she does not consent to the intercourse or he is reckless as to whether she does or does not consent to it. • Rape is also an offence under Section 4 of the Criminal Law (Rape)(Amendment) Act 1990 where it is defined as a sexual assault that includes (a) penetration (however slight) of the anus or mouth by the penis, or (b) penetration (however slight) of the vagina by any object held or manipulated by another person. • For the purposes of health and social care provision these two legal definitions are translated into clinical practice under a single gender-neutral HSE definition. The HSE definition of rape is when a person does not consent and someone puts their penis into (penetrates) a person's vagina, anus (bottom) or mouth and / or puts any object into a person's vagina (HSE 2023c).

Relevant Person	Relevant person, in relation to a patient, means a person; (a) who is; (i) a parent, guardian, son or daughter, (ii) a spouse, or (iii) a civil partner of the patient, (b) who is cohabiting with the patient or (c) whom the patient has nominated in writing to the health services provider as a person to whom clinical information in relation to the patient may be disclosed (Civil Liability (Amendment) Act 2017) *Note: This definition must not be confused with the definition of "relevant person" in the Assisted Decision-Making (Capacity) Act 2015.*
Resident	In the context of the doucument, an adult or child who is living in, or temporarily receiving care within a HSE or HSE funded designated centre.
Review Commissioner	The person who commissions an incident review. For Category 1 incidents it is the Senior Accountable Officer (SAO) or person who has a direct reporting relationship to the SAO. For Category 2 incidents it is the Local Accountable Officer.
Senior Accountable Officer (SAO)	In context of the management of an incident, the Senior Accountable Officer is the person who has ultimate accountability and responsibility for the service within the area where it occurred.
Serious Incident Management Team (SIMT)	A Serious Incident Management Team is a standing group whose role is to oversee the management of all serious incidents relating to the service. A SIMT is also convened following notification of a Category 1 incident. It is chaired by the Senior Accountable Officer (SAO) or a person nominated by the SAO who has a direct reporting relationship to the SAO.
Serious Reportable Events (SREs)	These are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.
Service User	In the context of the document, an adult or child who is receiving care within a HSE or HSE funded approved centre, whether voluntary or involuntarily.
Sexual Abuse	Rape and sexual assault, or sexual acts to which the person has not consented, or could not consent, or into which he or she was compelled to consent (HSE, 2014a).
Sexual Assault	Sexual assault is any sexual act that a person did not consent to, or are forced into against your will. This includes rape (HSE 2023c).
Sexual Harassment	Sexual harassment is any form of unwanted verbal, non-verbal or physical conduct of a sexual nature, being conduct which has the purpose or effect of violating a person's dignity and creating an intimidating, hostile, degrading, humiliating or offensive environment for the person (Department of Justice, 2022).
Sexual Neglect	Failure to provide privacy and respect an individual's sexual orientation or gender identity. Treating older adults, people living with a disability or people living with mental illness as asexual or preventing them from expressing their sexuality.
Sexual Safety Incident	Incidents where an individual has witnessed or experienced something of a sexual nature that does not fit into the categories of sexual harassment or assault, and which made the person feel uncomfortable or feel sexually unsafe (National Health Service, 2023).
Sexualised Behaviour	Verbal or physical sexual behaviour that is disproportionate, unacceptable, or disinhibited, often interfering with daily activities and occurring at inconvenient times or places" (Bartelet *et al.*, 2013).

Staff Liaison Person	This person is a contact point at service delivery level for the staff member involved in an incident.
Statement of Findings	Within context of system analysis reviews, statements which describe the relationship between the contributing factors and the incident and/or outcomes.
System Analysis	A method of incident review involving the collection of data from literature, records, and individual interviews with those involved when the incident occurred and analysis of the data to establish the chronology of events that led up to the incident, identifying findings that the reviewer(s) considered had an effect on the eventual harm, the contributory factors and recommended actions to prevent future harm, as far as is reasonably practical.

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Abbreviations

AGS	An Garda Síochána
AHD	Advance Healthcare Directive
CASATU	Child and Adolescent Sexual Assault Team Unit
CIS	Comprehensive Information System
CISM	Critical Incident Stress Management
CNU	Community Nursing Unit
CQC	Care Quality Commission
DSS	Decision Support Service
EAP	Employment Assistance Programme
EEA	Employment Equality Act
HIQA	Health Information and Quality Authority
HSE	Health Service Executive
IMF	Incident Management Framework
LAO	Local Accountable Officer
MDT	Multi-Disciplinary Team
MHC	Mental Health Commission
NHS	National Health Service
NIMS	National Incident Management System
NIRF	National Incident Report Form
ODPP	Office of the Director of Public Prosecutions
PAF	Preliminary Assessment Form
PSAA	Person Subject to an Allegation of Abuse
QPS	Quality and Patient Safety
SAO	Senior Accountable Officer
SART	Sexual Assault Response Team
SATU	Sexual Assault Treatment Unit
SIMT	Serious Incident Management Team

SPT	Safeguarding and Protection Team
SRE	Serious Reportable Event
STI	Sexual Transmitted Infection
UCC	University College Cork
WHO	World Health Organization

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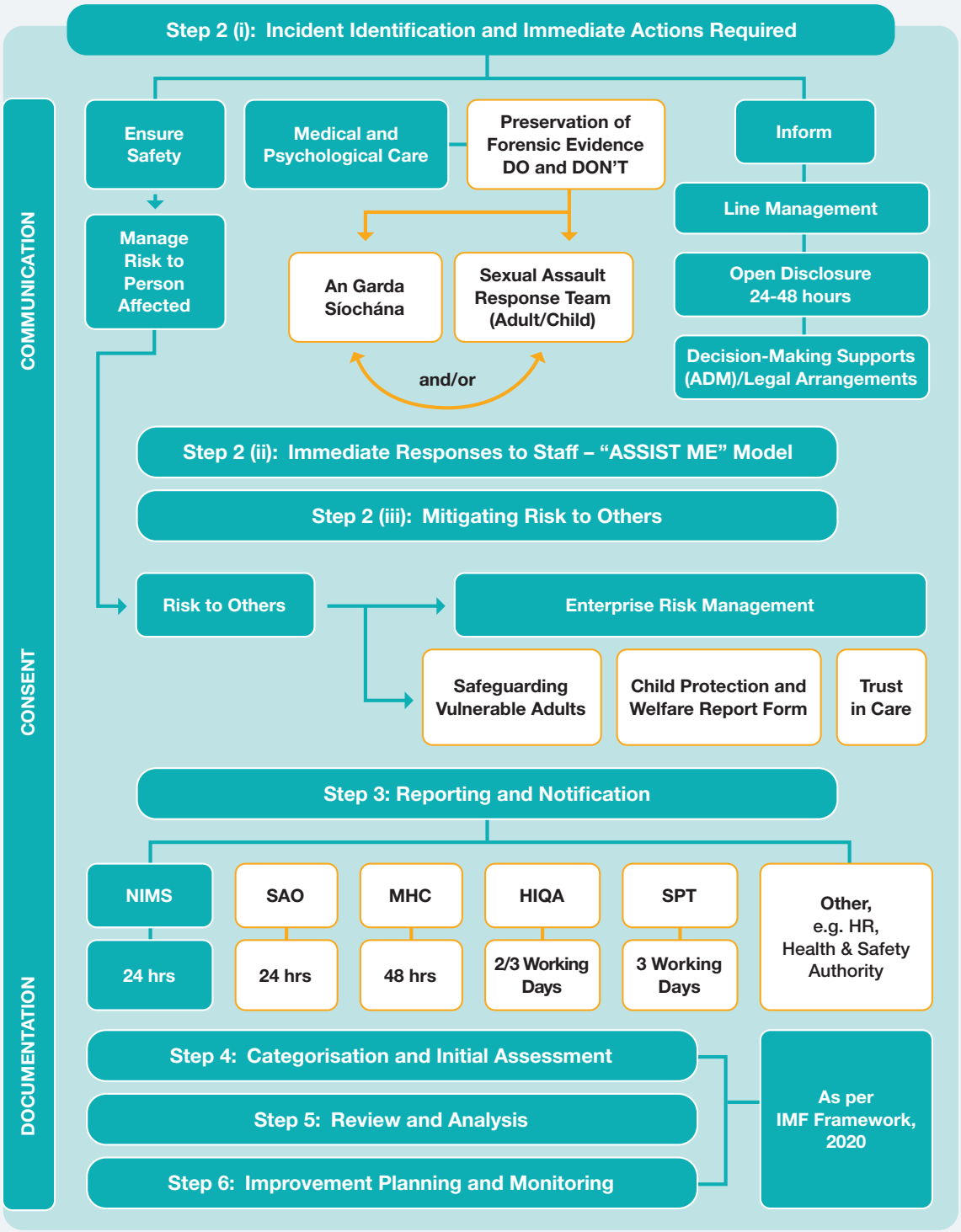
Appendix 1(a) Sexual Safety Policy Navigation Toolkit

Immediate Response to Incidents of a Sexual Nature

This flowchart is for practice guidance and is not a substitute for the HSE Incident Management Framework (2020)



These actions MUST always be taken, for all incidents of a sexual nature.

In addition for witnessed, alleged or suspected sexual assault/abuse and sexual harassment all actions required on a policy and/or statutory basis in the specific circumstances MUST be taken. These requirements are detailed in the Sexual Safety Framework, and the policies and legislation referenced therein.

Appendix 1(b) Sexual Safety Policy Navigation Toolkit

Safeguarding Vulnerable Persons at Risk of Abuse

This flowchart is for guidance and is not a substitute for the HSE Safeguarding Vulnerable Persons at Risk of Abuse, National Policy and Procedures (2014a).

1. Incident Identification, Immediate Actions Required and Reporting and Notification must be completed as per Incidents of a Sexual Nature flowchart and Safeguarding policy (2014a)

2. Safeguarding Notification

Day 1

Notify Line Manager and Designated Officer

3. Preliminary Screening Process

Within 3 working days

Reasonable Grounds for Concern	Additional Information Required	No Grounds for Reasonable Concern

Interim Safeguarding Plan
(In consultation and agreement with all relevant stakeholders)

Inform Safeguarding and Protection Team (PSF1)

Agree with Actions and/ or Safeguarding Plan	Recommend Actions and/or Safeguarding Plan	Coordination of Actions and Safeguarding Plan

4. Discuss and Agree Safeguarding Plan with all Relevant Stakeholders

5. Submit the Formal Safeguarding Plan (FSP1) to the SPT (within 21 days)

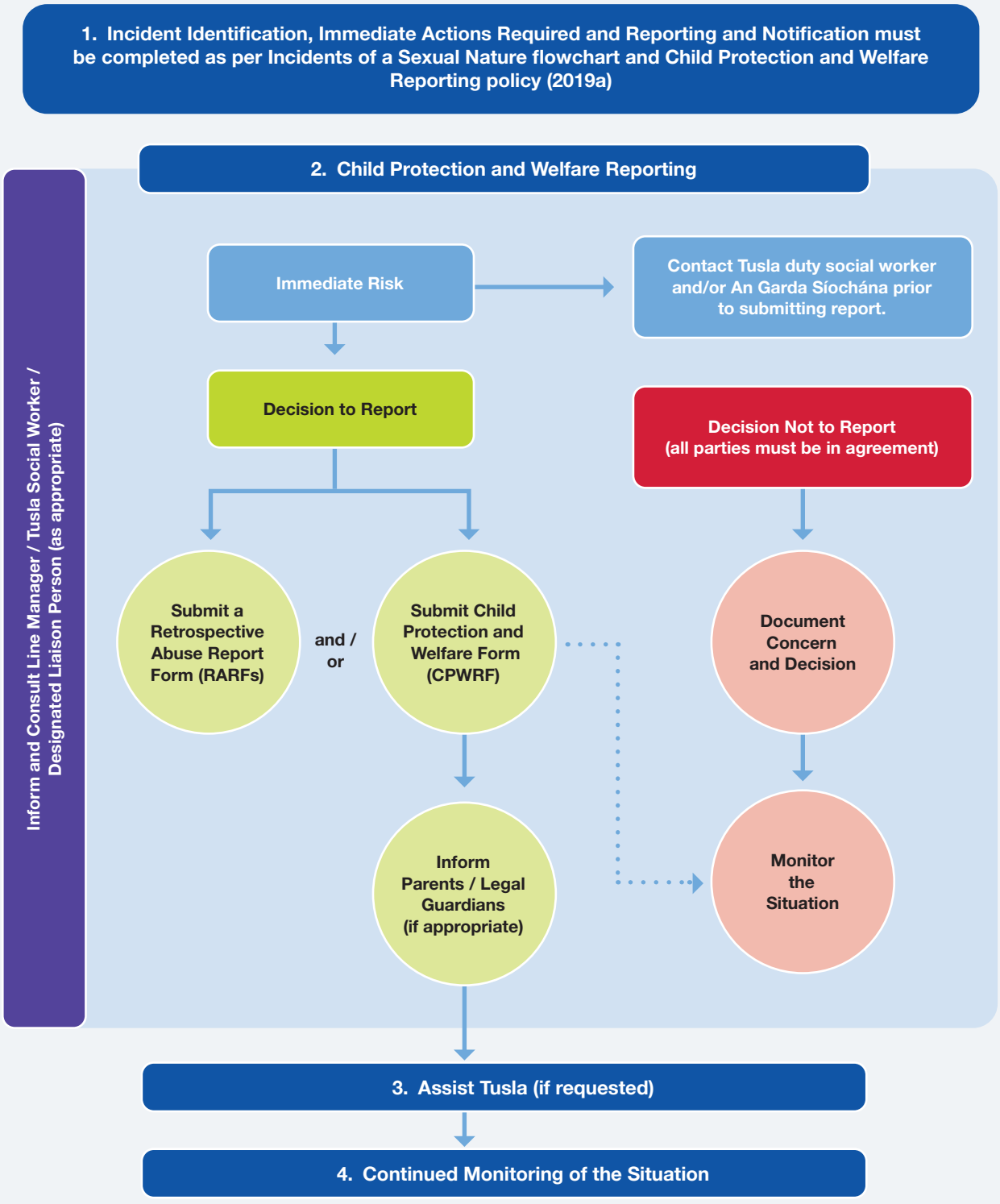
6. Review Safeguarding Plan (as required or at least every 6 months

7. Close Safeguarding Plan in Agreement with SPT

Appendix 1(c) Sexual Safety Policy Navigation Toolkit

Child Protection and Welfare Reporting

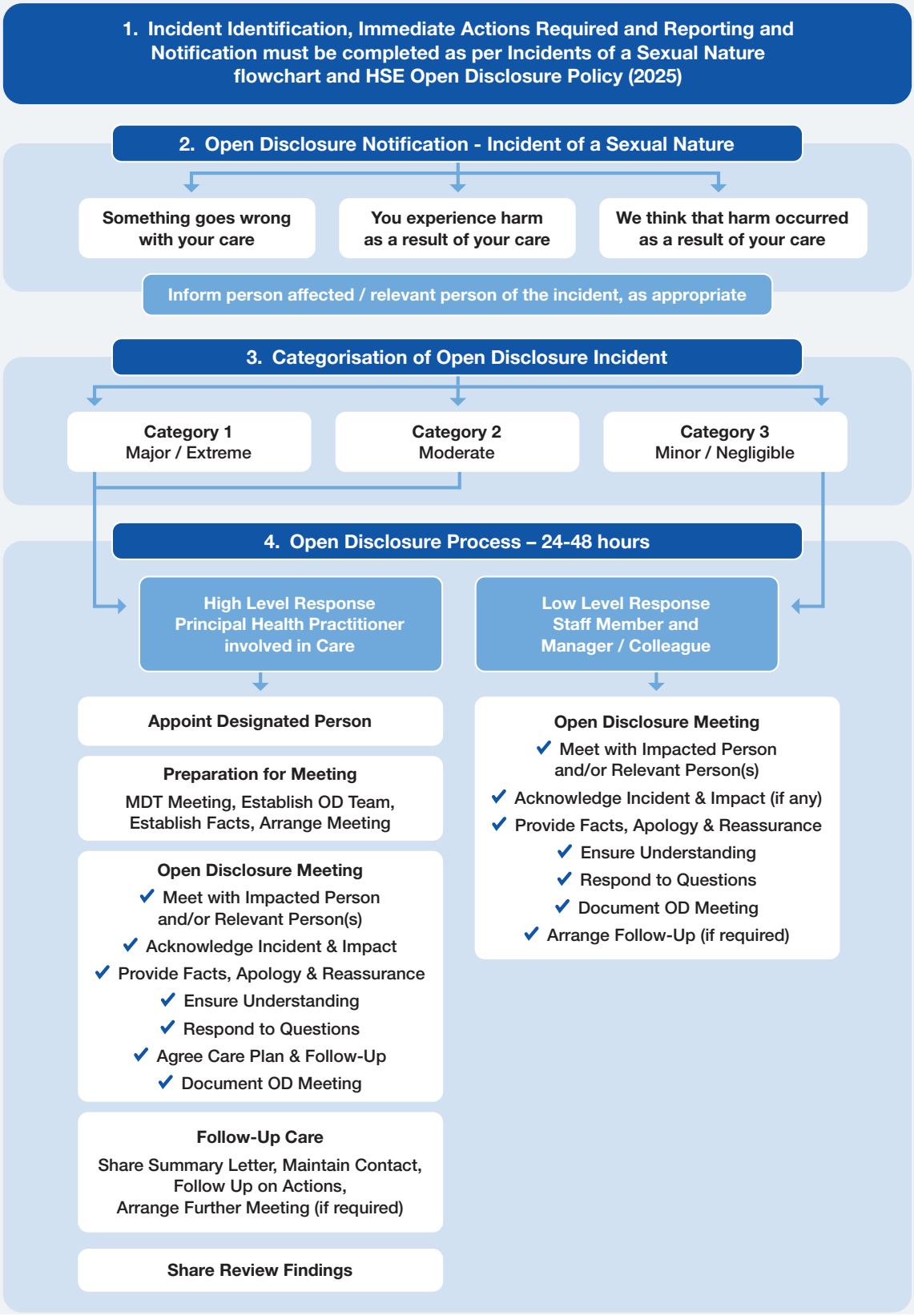
This flowchart is for practice guidance and is not a substitute for the HSE Child Protection and Welfare Policy (2019a).



Appendix 1(d) Sexual Safety Policy Navigation Toolkit

Open Disclosure

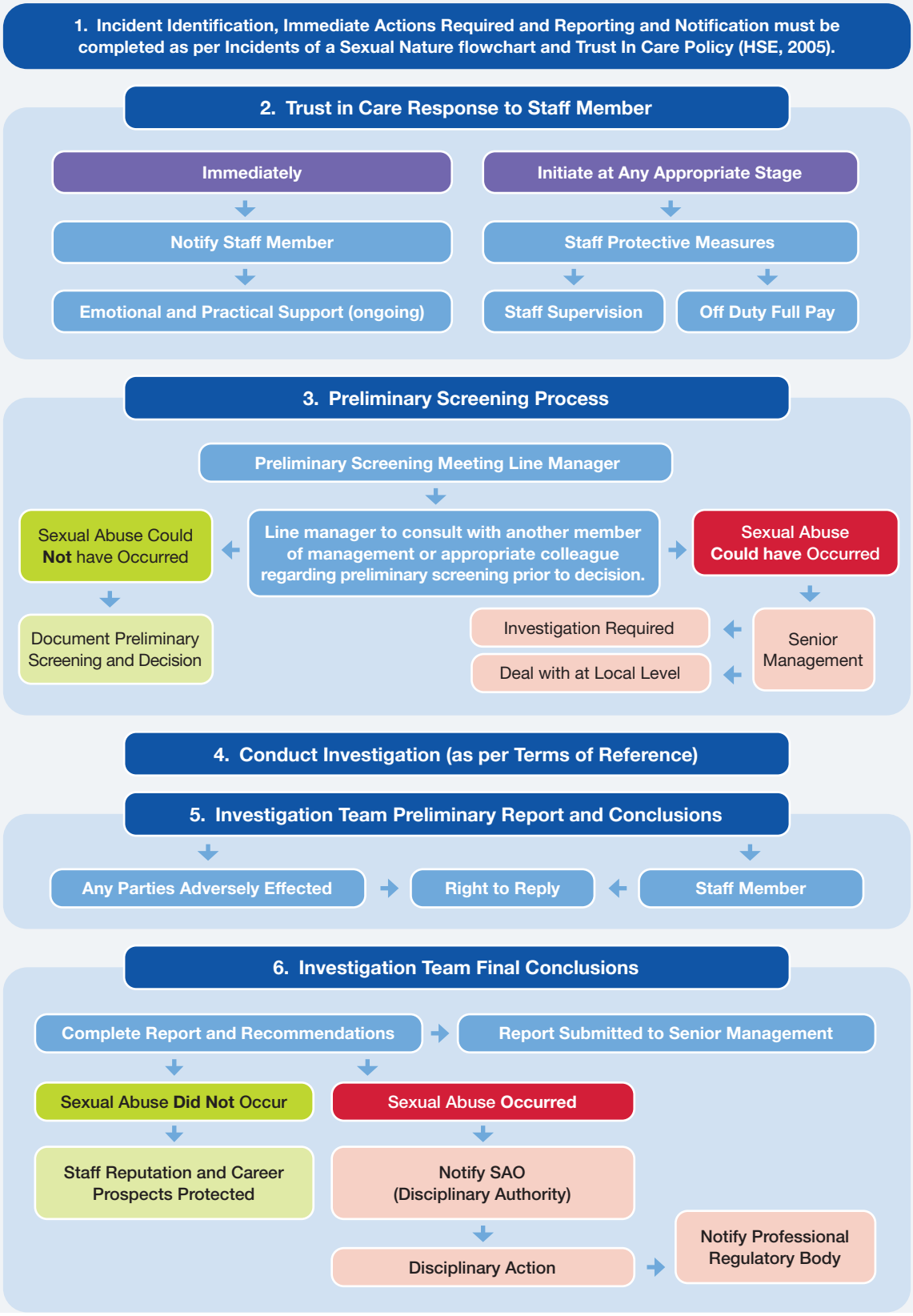
This flowchart is for practice guidance and is not a substitute for the HSE Open Disclosure Policy (2025).



Appendix 1(e) Sexual Safety Policy Navigation Toolkit

Trust in Care

This flowchart is for practice guidance and is not a substitute for the HSE Trust in Care Policy (2005).



Appendix 2 List of Offences which are Considered Sexual Abuse

Schedule 3 of the Children First Act 2015 (as amended by section 55 of the Criminal Law Sexual Offences Act 2017) sets out a list of offences which are considered sexual abuse.

1. Rape.
2. Rape under section 4 of the Criminal Law (Rape) (Amendment) Act 1990.
3. Sexual assault.
4. Aggravated sexual assault within the meaning of section 3 of the Criminal Law (Rape) (Amendment) Act 1990.
5. An offence under section 1 of the Punishment of Incest Act 1908 (incest by males).
6. An offence under section 2 of the Punishment of Incest Act 1908 (incest by females of or over 17 years of age).
7. An offence under section 6(1) of the Criminal Law (Sexual Offences) Act 1993 (soliciting or importuning for purposes of commission of sexual offence).
8. An offence under section 2 of the Criminal Law (Sexual Offences) Act 2006 (defilement of child under 15 years of age).
9. An offence under section 3 of the Criminal Law (Sexual Offences) Act 2006 (defilement of child under 17 years).

9A. An offence under section 3A of the Criminal Law (Sexual Offences) Act 2006 (offence by person in authority).

10. An offence under either of the following provisions of the Child Trafficking and Pornography Act 1998:
    (a) section 3 (child trafficking and taking, etc., child for sexual exploitation);
    (b) section 4 (allowing child to be used for child pornography);
    (c) section 4A (organising etc. child prostitution or production of child pornography);
    (d) section 5A (participation of child in pornographic performance).
11. An offence under section 5 of the Criminal Law (Human Trafficking) Act 2008 in so far as it relates to a child who has been trafficked for the purpose of his or her exploitation (soliciting or importuning for purposes of prostitution of trafficked person).
12. An offence under section 176 of the Criminal Justice Act 2006 (reckless endangerment of children).
13. An offence under section 249 of the Children Act 2001 (causing or encouraging sexual offence upon a child).
14. An offence under any of the following provisions of the Criminal Law (Sexual Offences) Act 2017:
    (a) section 4 (invitation etc. to sexual touching);
    (b) section 5 (sexual activity in presence of a child);
    (c) section 6 (causing child to watch sexual activity);
    (d) section 8 (use of information and communication technology to facilitate sexual exploitation of child).

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