

Safeguarding Adults Review

into the care and risk
management of P; an adult
with learning disabilities who
is believed to have committed
a number of sexual assaults
over a 10-year period.

March 2018

www.enfield.gov.uk/safeguardingadults



Contents

| | | |
|----------|---|-----------|
| 1 | Introduction | 1 |
| 2 | The roles and responsibilities of agencies involved in P's care | 5 |
| 3 | Further information about the placement at Hillgreen Care Ltd. between 2005 and late 2015..... | 10 |
| 4 | Safeguarding Adults Processes relating to P..... | 13 |
| 5 | The Metropolitan Police and Crown Prosecution Service | 16 |
| 6 | Determining responsibility for health-related aspects of P's care | 19 |
| 7 | The Care Quality Commission and other monitoring functions | 22 |
| 8 | Commissioning services for people at risk of sexually offending in future | 23 |
| 9 | Supporting Adults with learning disabilities who have been victims of sexual assault | 26 |
| | Concluding remarks | 28 |
| | Appendix 1. Summary Chronology for P..... | 44 |

1 Introduction

1.1 Preface

- 1.1.1 The Care Act 2014 requires each Local Authority to have a Safeguarding Adults Board that brings together partner agencies to work together in order to implement strategic plans around safeguarding people who are in need of care and support and may be at risk of abuse and/ or neglect in the local area. The Board also has a responsibility to report those plans and actions to the public. The London Borough of Enfield's Safeguarding Adults Board was established in May 2007 (replacing the previous Adult Protection Committee) and includes representation from the Police, the local Clinical Commissioning Group (CCG), the local hospitals, the Barnet, Enfield and Haringey Mental Health Trust (BEHMHT), The London Fire Brigade (LFB), The London Ambulance Service (LAS) and voluntary agencies.
- 1.1.2 Section 44 of The Care Act 2014 places a statutory responsibility upon Safeguarding Adults Boards (SAB's) to conduct Safeguarding Adults Reviews (SAR's) in cases where 'there is reasonable cause for concern about how the Safeguarding Adults Board, members of it or others, worked together to safeguard the adult and death or serious harm arose from actual or suspected abuse'. The referral for this Safeguarding Adults Review came from the London Borough of Enfield who believed that the harm done by P to others could and should have been prevented (particularly in later cases as the evidence of P's behaviour built up).
- 1.1.3 This Safeguarding Adults Review was chaired firstly by Marian Harrington and subsequently by Christabel Shawcross (from November 2016) in their role as Independent Chair of Enfield's Safeguarding Adults Board (SAB). Their guidance ensures that such reports are objective and complete as they are not employees of the London Borough of Enfield or any of the agencies involved in this case.
- 1.1.4 This report has used a number of source documents to inform the learning and recommendations. These included a number of chronologies, an Initial Fact-Finding report by Elspeth Smith, Independent Management Reviews by involved agencies with accompanying evidence and the review and analysis of evidence by Professor Hilary Brown, Emeritus Professor of Social Care, Canterbury Christ Church University.
- 1.1.5 The Enfield Safeguarding Adults Board would like to thank Professor Hilary Brown who brought great experience, consideration and passion for helping people with learning disabilities to her work. She has a long and distinguished career in researching the experiences of adults with learning disabilities who perpetrate sexual abuse and how those people can best be supported and the risk they represent managed. That experience has been invaluable to examining the events relating to P and those he harmed and forming recommendations to try to prevent such events from happening again.
- 1.1.6 The Review Panel would also like to thank the mother of one of the reported victims of P. Without her dedication to her son and to finding out the truth of what happened, information about the reported abuse of another vulnerable person might not have emerged. She provided valuable insight into the culture of the residential home and has been a tireless advocate for her son throughout a long and difficult process.

1.2 About the process of review

1.2.1 This is the Report of a Safeguarding Adults Review that was commissioned by London Borough of Enfield Safeguarding Adults Board (SAB) to examine the way that service providers, Local Authorities and other agencies worked together to provide services to a man P, who was between 18 and 28 years old in the period covered by this report. He is of White British origin and has mild learning disabilities as well difficulties as a result of having experienced a very difficult childhood. P was placed by the London Borough of Hackney in residential services managed by Hillgreen Care Ltd in Haringey and then Enfield. He went on to commit a series of sexual assaults over at least a ten-year period and those victims included other people with learning disabilities as well as members of the public. His victims vary in age, gender and ethnic origin.

1.2.2 The agencies involved with this Safeguarding Adults Review were:

- The London Borough of Hackney – placing authority of P.
- Hillgreen Care Ltd – service provider of residential care.
- The Metropolitan Police.
- Respond – a therapeutic organisations that works with people with learning disabilities affected by sexual abuse (both as possible perpetrators and survivors).
- The Care Quality Commission – the regulator for residential care providers.
- P's GP within the Enfield area.
- Barnet, Enfield and Haringey Mental Health Trust.
- London Colleges (CONEL and City and Islington).
- Enfield Clinical Commissioning Group (previously the Primary Care Trust).
- The London Borough of Enfield – Safeguarding and Integrated Learning Disabilities Service – as the Host authority (the authority where the residential home P was placed in was located) between early 2009 and late 2015.
- The London Borough of Haringey – as the Host authority between early 2005 and 2009.

1.2.3 The Safeguarding Adult Review was guided by a panel which consisted of senior managers within the agencies most involved in the case, including the London Borough of Hackney's Adult Social Care services as P's placing authority, the London Borough of Enfield as the most recent host authority, health commissioning bodies and providers in the three boroughs in which P had resided. Other agencies, including Hillgreen Care Ltd (the residential home provider who provided the majority of P's day-to-day care between 2005 and late 2015) and Respond, a specialist therapeutic agency, were invited to contribute by submitting Internal Management Reports (IMR's). These IMRs answered specific questions put to them and both agencies also were invited to the panel to discuss the issues. Hillgreen Care Ltd submitted an IMR but declined to attend the panel discussion. The London Borough of Hackney Children's Services answered specific questions about P's childhood and his transition to adult services. Subsequently the Review Panel requested that people who had reported harm by P, and P himself, were approached via their current service providers or designated advocates to make them aware that a review had taken place, to consider if they continued to experience a need for support in relation to the incidents and to invite their comments.

- 1.2.4 The Care Quality Commission were invited to take part in the Safeguarding Adults Review as a key stakeholder; they declined to provide a representative but did submit information to the Panel in the initial stages stepping back as the review continued. As the regulator for residential homes (as well as other services), the CQC is responsible for carrying out any further investigations.

1.3 Victims affected by P's behaviour

- 1.3.1 Of course, when looking at any incident of abuse or neglect our focus should be upon the victims. The Review panel have kept the victims in this case, their views and experiences, at the forefront of thinking throughout this process. A detailed summary chronology is attached and source material was analysed by Professor Hilary Brown for the Review Panel to inform this report and to generate recommendations for improved practice. This central focus on victims may not be immediately apparent in this report because the Panel have been concerned to protect their privacy. Individuals and the circumstances of their abuse have only been described as far as necessary to explain the situation and to examine professional practice but their stories were kept at the heart of the Review Panel's thinking.
- 1.3.2 Victims of P's behaviour included other people with learning disabilities attending college with him or living in the same accommodation, an underage teenage girl without learning disabilities within the local community and someone he encountered online. The only common factor linking these victims is that they came into contact with P. The focus of the report is therefore on P and on how he was cared for and supported by various professional bodies throughout his life. This includes aspects of his history and of the assistance provided to P and those living in his household and community from which the Panel were able to identify elements that contributed to harm. This analysis has led to the recommendations set out in this Review.

1.4 About P

- 1.4.1 At the age of 11, P was taken into the care of Hackney Local Authority due to serious concerns about ongoing neglect and sexual abuse of P and his siblings, both by family members and by other adults. It was evident that he had been significantly disadvantaged by his upbringing and also that P had underlying learning disabilities. He was then placed in a series of foster placements. At the age of 16/17 he was placed in two different emergency residential units. He had shown signs of aggression and early signs of sexually abusive behaviour that were encapsulated in his Leaving Care Report – including allegations of his touching another vulnerable child's genitals and trying to coerce other more vulnerable pupils at school into the toilets. His foster mother at the time was sufficiently concerned about incidents at school and at home that she consulted a local paediatrician (via her GP). He had also reportedly assaulted a member of staff at a residential placement for care leavers in a sexualised manner. These concerns and incidents were raised by education providers and his foster carer. These concerns appear not to have been officially investigated (as would have been appropriate under Safeguarding Children protocols) by the agencies concerned or by the police. They were, however, sufficiently serious to warrant him being assessed for admission to a specialist therapeutic placement for adults displaying violent and inappropriate sexual behaviour and to his being risk assessed by Respond who concluded he would benefit from therapeutic input.

- 1.4.2 Notwithstanding these assessments, the decision was made for him to be placed (just before his 18th birthday in 2005) in a residential home run by Hillgreen Care Ltd which claimed to be a specialist service with expertise in managing people with learning disabilities who displayed behaviour that challenges. But, whilst living in Hillgreen Care Ltd's care, he continued to commit sexual offences and it is his care and support throughout this period that this Review is concerned with.
- 1.4.3 During the period between P moving to Hillgreen Care Ltd and his removal (a period of over a decade), the residential home was commissioned by The London Borough of Hackney to provide his care and management. As time went on, and further allegations emerged, additional therapeutic input (from Respond) and a higher level of supervision from Hillgreen Care Ltd, was also commissioned by The London Borough of Hackney.
- 1.4.4 It is now apparent that not all assaults were reported (at the time they took place) to either the Police or local authorities under Safeguarding Adults protocols (or indeed the equivalent protocols for children). By treating each of a succession of assaults as separate "unsubstantiated" incidents, the organisations and professionals did not draw up the kind of comprehensive profile on which professionals working with P could have based more complex risk assessment and management strategies. A complete picture of how dangerous P was could and should have been at the forefront of their work with P.
- 1.4.5 The reported rape of another resident, Victim 7, at P's Hillgreen Care home in Enfield in 2015 triggered a Safeguarding Concern sent to the London Borough of Enfield which led to this Review. Further allegations then emerged that he had assaulted other residents. The Crown Prosecution Service secured one conviction of P in 2016, for a sexual assault in the community against a young member of the public (Victim 5) which took place in 2014. Other reported incidents had involved adults with learning disabilities living alongside P or attending college with him including one very serious assault that was investigated by the police but did not lead to a prosecution. The Crown Prosecution Service could not proceed with these other allegations due to a variety of issues including problems with physical evidence and the difficulty in obtaining statements from witnesses with learning disabilities. Nevertheless, the numerous allegations against P, and his own partial admissions at various points, provide a sufficient basis to believe that these assaults happened as reported.
- 1.4.6 It is difficult to say, in retrospect, how effective any specific long-term therapeutic intervention would have been in preventing these assaults. Any clinical work should have been paired with one-to-one supervision designed to prevent any incidents and both elements should have been reviewed on a regular basis (such supervision was commissioned but there are questions about whether it was consistently applied in the home which will be discussed later). It is also important to note that in the absence of a conviction or compulsory legal restriction, it is difficult to legally restrict a person's movements in order to prevent abusive sexual behaviour which is why formal reporting and investigations are so important. The recent introduction of Sexual Risk Orders has to some extent bridged this gap for the future. However, this review identified a number of opportunities for alternative approaches to mitigate the risk presented by P that were missed. Professionals should have taken action to prevent him from harming others irrespective of the fact that he had not been convicted because the information they held was sufficiently credible to use as the basis for professional decision-making.
- 1.4.7 The individuals reportedly assaulted by P were all vulnerable, whether as a consequence of their learning disability, autism and/or youth, and this meant that all the agencies involved had a clearly

defined responsibility to do all they could to identify and mitigate any risks to them. Given what was known about P's disturbed childhood, his past behaviours, and the nature of the allegations made over time, the Review panel came to a view that at least some of these assaults could have been prevented.

2 The roles and responsibilities of agencies involved in P's care

2.1 Examining each agency's involvement to learn lessons

2.1.1 The following review will go through the responsibilities of each agency concerned in order to understand the learning that can be gleaned from the issues raised and to make clear recommendations.

2.2 About Hackney – The Placing Authority

2.2.1 Local Authorities should always aim to place people in their local area but where this is not possible they may place people out of their area. As the placing authority, they remain responsible for the person's social care. The London Borough of Hackney, as P's placing authority, sought two specialist assessments to inform them in making decisions about a placement for P as he approached 18-years-old. However, they failed to act on the recommendation from these assessments that he should be placed in a secure and therapeutic environment and receive consistent therapeutic input. Their decision may have reflected the lack of clarity about incidents involving P while he was an adolescent; it appears that none of these had been investigated in any meaningful way prior to him turning 18, and (in the absence of any clearly recorded findings and/or convictions) they were too easily set aside. Instead the London Borough of Hackney chose to place him in a residential home run by Hillgreen Care Ltd with a mixed group of residents with severe learning disabilities and/or autistic spectrum disorders. The learning disabilities of those P was placed with were much more severe than his own which added to their vulnerability.

2.2.2 P's assessed needs and mental capacity

2.2.3 P was assessed as having mild to moderate learning disabilities in the assessment by the London Borough of Hackney that was carried out prior to his 18th birthday; he attended both specialised and mainstream educational facilities (though he was unable to continue in mainstream school due to his behavioural issues). He was relatively independent in terms of personal care, communication and a number of functional skills although he required prompting and support. Occupational Therapy assessments completed in 2012 state that, prior to the allegations in 2008, he used to be able to travel independently but highlighted that he had issues with numeracy, literacy and concentration which impacted on his daily life.

2.2.4 P's mental capacity was assessed at different times by different professionals and in relation to

different topics. Decisions about mental capacity are time and decision specific so a person's capacity may vary significantly over time and in relation to different areas of decision-making. The first mental capacity assessment, that the review panel is aware of, was conducted by a psychiatrist at the Haringey Learning Disabilities Partnership for the Police. The psychiatrist stated that he believed P had capacity to understand that he had committed a potentially criminal act but that the Court would have to seek an expert opinion around his fitness to plead. The Court sought expert assessments from two separate forensic psychiatrists (one for the prosecution and one for the defence) who concurred that at that time P did not have capacity to engage with a criminal trial.

2.2.5 An application for a Deprivation of Liberty Safeguard in 2009 was declined, but the doctor did note that he felt that P lacked the capacity to manage intimate relationships. The London Borough of Hackney itself conducted two Capacity Assessments that this review has seen (there were Best Interests Meetings in 2010 around where he should live which implies an assessment of capacity was done at that time but this has not been seen). A social worker conducted an assessment in early 2015 on the question of whether P could understand the potential consequences of his 'sexually inappropriate behaviour' for himself and for others– it found that he did have capacity at that time although he did need prompting on specifics such as the age of consent. A further capacity assessment was done by a different London Borough of Hackney social worker in 2015 (following the reported rape of Victim 7) to assess whether P had capacity to understand 'what constitutes sex and what constitutes consent to sexual activity, in relation to this instance [the reported rape of Victim 7]'. This assessment concluded that, on balance, he did have capacity in this area – although there was some evidence of his merely repeating what others had said to him which led to concern that his understanding needed to be checked.

2.3 The London Borough of Haringey, acting as the first host agency

2.3.1 Hillgreen Care Ltd operated at that time at seven addresses across four London boroughs. P was placed firstly into the neighbouring London Borough of Haringey and subsequently into the Enfield area (also nearby).

2.3.2 P had very little contact with the London Borough of Haringey while he lived in the Haringey area. During this period, from 2005 until 2009, the London Borough of Hackney remained responsible for his placement and social care needs but the London Borough of Haringey were the host authority. The only records that they were able to locate related to the allegations of assault (against Victim 1 in 2006) and rape (against Victim 2 in 2009) which were both reported to the Police and went through their own formal Safeguarding procedures. There is further information about the way all of these allegations were investigated in the sections on Safeguarding Adults and the Metropolitan Police.

2.3.3 In 2009, a psychiatrist from the Haringey Learning Disability Partnership did conduct an assessment for the Police in which he stated that he felt P had capacity to commit a criminal act but that the Court would have to seek an expert opinion around his fitness to plead (which in fact they did and which resulted in him being deemed to lack capacity at that time). He cautioned that it would be essential to establish the truth of the allegations, in order to ensure that P got the interventions that he needed, regardless of his mental capacity. Evidentiary problems meant that a 'Trial of Fact' in relation to the 2009 case could not go forward. The judge was sufficiently concerned to issue a strong statement about the 'very significant risk to young women' posed by P and he recommended that social services and other agencies should address the protection of P and others.

2.4 The provider agency

2.4.1 Hillgreen Care Ltd represented their service as one specialising in challenging behaviour and claimed to have an in-house Consultant Psychologist at the time of placement. There is no evidence that P ever saw any in-house health professionals of any kind. The London Borough of Hackney commissioned, and Hillgreen agreed, a financial package for providing one-to-one supervision of P to manage risks as they became known (the issues with this supervision will be discussed more in the Hillgreen Care Ltd section of this report). There is little or no evidence that the staff team at Hillgreen Care Ltd had the specialist skills and training to manage sex offenders with learning disabilities nor were they in contact with professional networks with expertise in this area of care. At a later stage, when specialist support was available, (working with Respond therapeutically and with Occupational Therapy from the London Borough of Enfield), staff from Hillgreen Care Ltd did not properly engage with sessions run for them or help consistently with the exercises set. In this way P's day-to-day care was not informed by the specialist expertise that was available to the Hillgreen staff team through these organisations.

2.4.2 It is apparent that the London Borough of Hackney were relying on the service provider to provide adequate supervision to prevent P from offending but failed to monitor this or to recognise increasing levels of risk as allegations continued to emerge. Between an allegation that P had assaulted a 14-year-old on a bus in 2014 (Victim 5) and the reported rapes which led to him moving on in late 2015, a care plan review actually reduced funding to Hillgreen Care Ltd and redefined the eventual aim of P's care package to be him moving on into supported accommodation.

2.4.3 When P was charged with rape in 2009 (of Victim 2), his bail conditions meant that he was moved to another Hillgreen care home and this involved crossing local authority boundaries to reside in the Enfield area. At the time, there was a suggestion by the provider that the new home would be a male-only placement. All those that had made allegations about P as an adult (there were allegations that he had assaulted other male children when he was under 18-years-old but these appear to have never been investigated) were female so this was thought to be a safer environment for him to be in. The service did not remain for men only.

2.5 P's Health Care needs

2.5.1 P's health care needs at this point shifted to become the responsibility of the Enfield Primary Care Trust (and later the Enfield Clinical Commissioning Group) who at that point commissioned services for people with learning disabilities through the London Borough of Enfield's Integrated Learning Disabilities Service. It is a health service requirement to transfer care immediately when someone changes their area (signified by them registering with a new GP in their new area) to the appropriate local services.

2.6 The London Borough of Enfield acting as the second "host" authority

2.6.1 The London Borough of Enfield also became the "host" safeguarding authority responsible for investigating allegations of abuse or neglect. However, no formal or informal handover was made to the London Borough of Enfield and they did not become aware of P, or of the allegations

surrounding him, until the Court case resulting from an alleged rape in 2008, was resolved (in 2010, ten months after he had been moved to the area). At that point, the London Borough of Haringey held a meeting to mark the end of their Safeguarding process and invited representatives of the London Borough of Enfield as the current host authority. A number of recommendations from this Review highlight the need for transparency and communication around all placements where the Host and Placing Authorities differ (particularly where there may be risk or other complexity). This case was complicated by the fact that P had been moved across two London Boroughs during the course of his placement with Hillgreen Care Ltd.

2.6.2 At the point when, the London Borough of Enfield became aware of the high-risk behaviour reportedly being exhibited by P, they already had significant concerns about the quality of provision at Hillgreen Care Ltd beginning with a serious Health and Safety breach in the year that the Enfield location opened (2009). This incident had highlighted issues with risk assessments and had led to serious harm to another vulnerable service user. At later points, various members of the Integrated Learning Disabilities Services in Enfield reported back a range of concerns to the London Borough of Hackney about Hillgreen Care's engagement with other services, about their staff's abilities to deal with sexual risk and the quality of their risk assessments (this is occurred on various occasions and is described in more depth later in this Review). However, these concerns appear not to have been taken on board by the London Borough of Hackney and were lost in the general funding discussions.

2.7 Engaging with specialist services

2.7.1 The London Borough of Hackney funded two periods of specialist psychosexual therapy from Respond, a nationally recognised organisation that works in this area. This had been initially recommended prior to P's 18th birthday during the transition planning process (in 2004). However, funding for this input did not start until 2011 (several years after P moved into Hillgreen Care Ltd, by which time a number of sexual assaults had already been reported); this was a year after the court case that had led a Judge to conclude that P was a danger to others (despite the fact he was not convicted in that case). This funding was stopped twice in the two and a half years that followed despite advice from Respond to the contrary. These decisions were taken despite further allegations having been made against P and against clinical recommendations. A later section of the report explores the discussions that occurred between the placing and host local authorities about which agency should have been responsible for commissioning and funding this component of P's care package.

2.8 Holding and sharing information across time

2.8.1 It is important to draw a distinction between what an organisation, such as a placing or host authority, 'knows' in terms of information that it holds and what an individual member of staff might know. One thing that came through clearly in the Independent Management Review written by the London Borough of Hackney was the extent of the difficulties presented by different information systems used over time. In the most obvious example, their report states that they were unaware of the 2006 assault on Victim 1; however, the minutes from the London Borough of Haringey's Safeguarding Adult meeting held afterwards clearly show that a worker from the Hackney Leaving Care team was in attendance (as P was still only 19 at that point). The Hackney Leaving Care team

leave their notes and information on the Children and Families system which is different from that used by Adults' Services. Hillgreen Care Ltd also did not include this assault in their history of P despite attending safeguarding meetings and liaising with the police and other agencies involved. Hence the information appeared to be lost until it was raised again by the Police in 2009; and even as late as 2013 it did not appear in a London Borough of Hackney risk assessment.

- 2.8.2** Information about this assault will have been held on Victim 1's file (as she was also placed by the London Borough of Hackney) but would not have come up in a search on P. There is an imperative to put the adult at risk at the centre of safeguarding activity and this is reflected in the records made at the time of any enquiries or formal investigations. However, the system also needs to generate a clear and identifiable record in cases where the alleged perpetrator is also an adult in need of care and support. Clearly individuals have an obligation to transfer and handle information responsibly and with appropriate caveats, but organisations and systems in place should be designed to assist with this.
- 2.8.3** A twin focus on the reported perpetrator should allow a cumulative record of risk to be curated. It is important that services review how they keep information about risk (particularly where incidents may not be proven as an offence in a criminal court, or where allegations are withdrawn for various reasons, despite there being enough information to allow conclusions to be drawn that assaults took place) so that key elements of a person's history are clear in their record and can assist those responsible to try to protect further victims. This raises challenges around confidentiality and natural justice (false allegations or suspicions should not be allowed to prejudice someone's care and treatment) but this case clearly demonstrates the danger inherent in not evaluating this information appropriately and entering it into an easily accessible cumulative record on which professional decision-making can be based.
- 2.8.4** The London Borough of Hackney relied upon Hillgreen Care Ltd to closely supervise P in the home and in the community. This was their primary method of mitigating any risk that he might pose. Hillgreen Care Ltd had a responsibility primarily to safeguard all their residents and to highlight incidents or behaviours that troubled them. This reliance proved to be misplaced and the monitoring of this provider's diligence flawed.
- 2.8.5** Commissioners of social care have an obligation to review the care of an individual on an annual basis (or more regularly if there is a change in circumstances). The London Borough of Hackney did review the care plan and placement of P at regular intervals throughout his placement with Hillgreen Care Ltd. Given the risks involved in P's placement, the Panel would have expected these regular reviews to be detailed and robust and that they would have tracked and reflected on the pattern of incidents that were becoming evident.
- 2.8.6** The 2013 review, carried out by a London Borough of Hackney social worker, references the 2010 court case and the Judge's concerns; there is, within the review, a discussion about enabling P to access the community more safely but no recognition of the risks he posed in the home. So, while his propensity to offend against members of the public was acknowledged, the risks he posed to vulnerable people who lived alongside him were not represented. It is unclear why the risk to other people with learning disabilities was not seen as equally important.
- 2.8.7** In one review it also states that P's computer use is being monitored due to him having been found accessing 'young' pornography (the review does not state what 'young' means) and because a young woman (unnamed) had told P that she would report him for harassment over Facebook. A

risk assessment was conducted by the social worker but crucially the 'Risk Management' section was left blank and unsigned. The letter that was sent with the review to P highlighted that his therapy with Respond would soon be coming to an end but stated that a referral had been made to the Enfield Integrated Learning Disabilities Service's Psychology team (although the worker should already have received a letter stating that this referral had been declined). There is mention that a more specialised service would be looked into but this was not followed up. In 2015 (following the assault of Victim 5, a 14-year-old girl, that took place on a public bus), the care plan review led to funding for P's one-to-one supervision being reduced when it might have made more sense for it to be enhanced. The fact that Hillgreen Care's own risk assessments were vague and inadequate also does not appear to have been raised in any of the reviews. It is clear that, although P's reviews did discuss risk, they did not address it in any meaningful way.

3 Further information about the placement at Hillgreen Care Ltd. between 2005 and late 2015

- 3.1 During the period that P lived under the care of Hillgreen Care Ltd, he is reported to have committed at least 11 sexual assaults. Research demonstrates that sexually abusive behaviour is not a series of unrelated incidents but is better thought of as an ongoing pattern of predatory, opportunistic and/or exploitative behaviour. Recorded incidents represent only those that have been disclosed and/or discovered and informed professionals should have been alert to the fact that there were likely to be other incidents that had not surfaced and/or been reliably recorded.
- 3.2 As can be seen from the above section, as the residential provider, Hillgreen Care Ltd was responsible for managing P's behaviour and if they considered that they could not contain the risks to refer back to the placing authority (the London Borough of Hackney). The provider agency stated that they had not been fully informed about the historic allegations against P at the time of his placement when he was nearly 18-years-old. The London Borough of Hackney disputes that but, even if true, it should be noted that both the London Borough of Hackney and Hillgreen Care Ltd were aware of the assault that took place in 2006 when P was reported to have assaulted Victim 1, also placed by the London Borough of Hackney, also a resident of Hillgreen Care Ltd, living within a Hillgreen home. Hillgreen Care Ltd staff were clearly aware of that allegation and also present at related meetings where previous allegations were referenced. It would be expected that, from this point at least, Hillgreen Care should have recognised the risk to others in the home and specified these on P's risk assessments. They should also have, through other actions such as seeking assessment and consistent clinical input, been raising awareness within their own staff group and sharing concerns across the professional network.
- 3.3 Significantly, the reported assault on Victim 1 was not included in any of the information Hillgreen Care provided about P and it seems that this allegation was largely disregarded – to the extent that Victim 1 continued to live in the same household as P (which would not have been regarded as good practice even if the allegation had been proven to have been false which it was not). She resided in the same household as P for another 3 years.
- 3.4 At one point, in 2009 prior to P's move to the Enfield area, there was a referral made for him to attend a local dating club for adults with learning disabilities which in the context of P's reported behaviour was completely inappropriate – it is unclear who made this referral. At this point, P was

being investigated for the crime of rape, which again demonstrates a complete lack of recognition of the nature and extent of the risks P's reported sexual behaviour posed to others.

- 3.5** Risk assessments and care plans at Hillgreen Care Ltd (the documents which told staff how to support P) mentioned that he posed a risk to women in the community but did not adequately describe the risk he presented to other adults in the home. One risk assessment talked about P being on one-to-one staffing but in other documents they talk about simply 'knowing' where P was within the home at all times. Typically, in a care setting, one-to-one staffing would be understood to mean being physically with the person at all times unless they were alone in a private area such as toilet or bedroom (even then the exit would be monitored). It is unclear how specific the language used by the London Borough of Hackney when commissioning this input from Hillgreen Care Ltd was when the initial funding for this one-to-one care was set up but, given that this care was commissioned in response to reports of assault and the industry wide understanding of the term, there should have been no ambiguity. Instead the people accompanying P seem not to have known what their role was, so for example the assault on the bus (for which P was convicted) took place in the presence of a member of staff who did not appear to have been briefed in advance or subsequently to have even been aware that the assault had taken place.
- 3.6** In routine inspections, the Care Quality Commission highlighted issues with risk assessments in their work with Hillgreen Care Ltd and an experienced Community Nurse from the Enfield Learning Disabilities Service also highlighted concerns towards the end of P's placement there.
- 3.7** When Hillgreen Care Ltd were asked by the CQC, just after the reported rape of Victim 7 (in 2015), to provide risk assessments, they at first were not able to do so. They then claimed that the Community Nurse in question had endorsed the quality of their risk assessments when in fact she had met with the manager and called a social worker at the London Borough of Hackney about her concerns.
- 3.8** There are reports of individual staff at Hillgreen Care Ltd being very caring but, without the framework of formal and consistent risk assessments and training to inform staff about patterns of sexual offending and its impact on victims, they did not have the knowledge or skills to care for and contain someone like P who posed ongoing risks to those around him. Nor were they able to provide the necessary support and validation to those of his reported victims who lived with him in their service.
- 3.9** There were some attempts to provide training for staff at Hillgreen via the organisation Respond, notably the London Borough of Hackney funded a staff training session, but this was poorly attended and not supported by management. An Occupational Therapist also found that they did not engage with 'homework' tasks with P that were set in order to help him understand more appropriate behaviour in the community.
- 3.10** It appears that senior managers and front-line staff at Hillgreen Care Ltd consistently downplayed the seriousness of allegations against P and failed to report concerns/disclosures which later came to light. For example, during an unrelated health assessment, P stated that he had been in court for rape (referring to the court case in 2010) and a member of staff corrected him saying he had been accused of sexual assault, which had not been proven which, while strictly speaking accurate, had the effect of seeming to minimise the seriousness of his behaviour. The same assessment quoted the manager of the home saying that there had never been any inappropriate behaviour in the home but rather the issue was P's behaviour to members of the public (this was 6 years after the assault

of Victim 1 in the Hillgreen residential home that they both lived in). In public, he was said to stare and follow others into public toilets but those responsible for accompanying him were not clear how vigilant to be.

- 3.11** A psychologist from the Integrated Learning Disabilities Service at the London Borough of Enfield did conduct a general psychological assessment of P, at around the time of the assault on the bus in 2014, and made several recommendations. She stated that there was a high level of concern about P's offending behaviour, and she raised queries about the expertise of Hillgreen Care staff, convening a Professionals' meeting to discuss the case. At this meeting the London Borough of Hackney was asked to consider an alternative placement for P and to seek a forensic risk assessment.
- 3.12** P was then referred to the North London Forensic Service (part of the Barnet, Enfield and Haringey Mental Health Trust – BEHMHT) who highlighted that P did not seem to have a mental health condition but also that a member of Hillgreen front-line staff (who had accompanied him to the assessment) had disclosed an allegation about him entering Victim 6's room, at their home, and forcibly removing her clothing. This conversation was in early 2015. This had not been reported and the Doctor recommended that Hillgreen staff report any such future incident – good practice would have been for them to have reported it as soon as it became known and also for her to report this immediately under Safeguarding Adults processes or directly to the Police herself.
- 3.13** Victim 6 lived with P for another 9 months and went on to disclose two incidents of rape and an ongoing situation in which she had been feeling harassed by P. It was only a chance comment by a staff member to a family member after the reported rape of Victim 7 which triggered a Police investigation. The inability of Hillgreen Care Ltd staff to recognise that this was something that needed to be formally reported (although one staff member stated she did complete an internal incident form and handed it in to their management team) is echoed in the events of the final days of P's placement with them.
- 3.14** In late 2015, a front-line member of Hillgreen's staff walked into the bedroom of Victim 7 and reported witnessing what appeared to be P engaged in a sexual act with Victim 7. This was reported to senior management within Hillgreen Care (including some who had been present at various meeting about previous allegations) who instructed the member of staff not to formally report the incident as they felt it may have been consensual. This was clearly not the case as Victim 7 is a young man with profound learning disabilities who does not communicate verbally. He would not have been able to report an assault or understand the concept of consenting to a sexual encounter. The statement that the encounter may have been consensual would have been disingenuous as the severity of Victim 7's disability meant that there could have been no realistic belief that he had capacity to consent. Furthermore, a former staff member stated that they had explicitly discussed the commercial consequences for the company when deciding whether to make a report.
- 3.15** This delay in reporting this incident meant that Victim 7 was not given medical care or examination immediately and that potential forensic evidence was lost. His clothes were washed which is contrary to any publicly available guidance on Safeguarding Adults and the lack of DNA had to be taken into account as part of the Crown Prosecution Services's decision not to prosecute.
- 3.16** Professor Brown's analysis of the academic literature of sexual offenders who have learning disabilities shows that it is common for a perpetrator to abuse other more vulnerable individuals less

able to voice concerns, with no sanctions which results in their behaviour becoming entrenched but that it is only when they abuse a member of the public in a public space that they are held to account at which point they may face more draconian measures than other offenders. Hillgreen Care Ltd knew about multiple allegations about P made by vulnerable adults also in their care, but that they had not reported, recorded or acted upon. It is clear that the senior management of Hillgreen Care Ltd, downplayed or ignored the risk that P posed to others despite a wealth of evidence, including ongoing risk to other vulnerable residents living within their service to whom they had a duty of care.

3.17 It appears that they hid behind the fact that as P had not been proven to have committed these sexual assaults in a criminal court they could justifiably act as if they had no evidence to warrant protecting other vulnerable people in their care and in the community. This not only exposed others to high levels of risk but it also stopped P from receiving the support he needed as his behaviour became more entrenched.

3.18 Even after the assault of Victim 5 in 2014 (on a public bus) the response was not immediate in terms of any tightening of restrictions upon him through Hillgreen Care Ltd or any other agency. Additional assessments were completed and a lot of additional professional discussions were had but funding towards P's supervision was actually reduced in April 2015.

4 Safeguarding Adults Processes relating to P

4.1 When someone has a concern that an adult with care and support needs has been abused or neglected (or is at risk of this) they should raise a concern (previously known as an alert) with the Local Authority where it happened (or is believed to have happened) which begins an enquiry. This is called a Section 42 enquiry after the section of the Care Act (2014) which governs it. Prior to this and since the No Secrets White Paper in 2000, each local authority was required to develop its own process of managing what were then called 'Safeguarding Alerts' and London boroughs have operated a Pan-London process since 2011. This is not a new area of professional practice and has been embedded over the last decade into all adult social care services.

4.2 All guidance emphasises the important point that Safeguarding Adults is everyone's responsibility. The host local authority has a responsibility for running the safeguarding process and ensuring that everything is done appropriately. The placing authority has responsibility for ensuring that the placements they make are safe and meeting needs as well as for ensuring that care plans/ risk assessments and similar documents and provisions are updated properly following any concerns (of course, host and placing authorities are often the same body but, as in this case, there are many situations in which separate local authority departments are involved in these roles). The Care Quality Commission receive information on all safeguarding concerns so that they can judge whether residential homes, domiciliary or health service providers are giving safe and appropriate care. Health partners are often vital in investigating concerns, ensuring safe care within health settings and in other agencies providing care to people in need of care and support. They also have a responsibility to help victims recover from abuse or neglect. Individuals who provide services directly, such as a residential home worker or manager, have an explicit responsibility to provide safe, respectful and ethical care and to take on board the recommendations of experts to ensure it stays that way. All professionals have a responsibility to report concerns to the host local authority (and to the Police if

an incident is potentially criminal) where the reported victim and/or the alleged perpetrator is an adult in need of care and support.

- 4.3 Criminal investigations often take place alongside safeguarding adults processes. A crime committed against an adult with care and support needs will be processed through the Criminal Justice System in the same way as a case involving any other victim but the local authority also works in parallel to put in place a risk management plan to support the victim and implement other preventative, restorative and protective work depending on the person's wishes and views.
- 4.4 Where there are multiple concerns about a provider, as opposed to an individual, over a period of time, an inadequate or critical Care Quality Commission report, that highlights ongoing risks, or any single incidents that are considered to be very serious, the London Borough of Enfield will begin a Provider Concerns process (the framework for which was established in 2011). This allows the adult social care department to engage with all placing authorities (not just those responsible for individuals impacted by specific incidents of abuse or neglect) and uses the expertise of the multi-disciplinary team to address high-level risks and overall quality within an entire provider/ location. This process runs alongside the Safeguarding Adults process which focus on a particular incident of abuse and its impact on a particular person or family – within the enquiry it prioritises the views and wishes of the victim/subject of that specific incident.
- 4.5 Safeguarding Adults procedures operate on the principles set out in 'Making Safeguarding Personal' (which were formalised in this document in 2014 but are broadly in line with guidance that has pertained throughout different iterations of policy since 2000) – Empowerment, Prevention, Proportionality, Protection, Partnership and Accountability. The reported victim of abuse or neglect is the primary focus of the process. These principles seek to ensure that the victims of abuse are given a voice within the safeguarding process and are kept at its centre. However, this means that the process, information and actions follow the reported victim rather than the alleged perpetrator. Where the perpetrator is also an adult with care and support needs, a parallel enquiry into his or her needs is also required as highlighted by this case.
- 4.6 P was the person reported to have caused harm in relation to 5 separate Safeguarding Adults concerns prior to the reported rape of Victim 7. These related to incidents in 3 different boroughs and therefore were processed by 3 different local authorities. One incident was reported to the London Borough of Islington as it took place at the college P attended – this incident was very brief and interrupted (in this case the close supervision by Hillgreen Care staff was successful) and, in the absence of context, looked like, and was treated as, a case of two students with learning disabilities behaving inappropriately rather than as a potential assault. The college were asked to investigate and speak with the students about their behaviour. There is no indication that the person affected by P's behaviour in this situation was assessed to see if they had capacity to consent even though this was central to the way the incident was construed. This highlights the dangers inherent in dealing with incidents in isolation.
- 4.7 Another allegation involving P was dealt with by the London Borough of Enfield and emerged in the context of a number of significant concerns about Victim 4 (who did not live with him and was supported by another agency), who described herself as his girlfriend. She disclosed that he was pressuring her into sex and retrospectively reported another incident that took place on public transport. She requested that it not be taken any further and said that the relationship was over. A Strategy meeting was held to discuss the case and representatives from both Hillgreen Care Ltd and

the London Borough of Hackney were present and asked about P and what level of risk he posed. The answers they gave in that meeting did not give a full picture and downplayed the previous reported incidents (the 2009/10 court case around the reported rape of Victim 2 was described as about a service user he 'allegedly inappropriately touched' and they stated that this had been 'thrown out of court'). The adult at risk in this case was believed to have capacity to make decisions about her relationships and about the safeguarding process so the enquiry was closed. The risk by that time was believed to have passed as they were no longer seeing each other. P was being supervised in the community and it was felt that there was no on-going risk to Victim 4 and that her wishes should be respected. However, it should be noted that, given she didn't know about P's past offending, this was not a fully informed decision.

- 4.8 The London Borough of Enfield by this point had enough information about P's previously reported behaviour on their systems to be able to see a more complete picture and to realise that the risks were much higher than initially apparent. However, individual staff took the feedback in the meeting concerned with Victim 4 at face value and did not seek to confirm or clarify it. This raises important issues about how a local authority stores information about safeguarding so that it can be available to those dealing with individual cases, both those affected by, and responsible for abuse, as well as to those whose focus is a particular provider. All information is kept on the file of the person believed to have been harmed. Additional notes should be made on the file of the person reported to have caused harm. However, if these concerns are not 'tagged' or highlighted within the record they will not stand out. A social care file will have many hundreds of observations, meeting minutes, assessments and so on and work must be done to ensure that the important information stands out so that professionals are alerted to the need to seek out specific documents within the history when fact checking and when seeking to establish risk. Professionals coming from other local authorities will face the same issues.
- 4.9 As previously mentioned, there are ethical constraints when keeping a record of unproven allegations but these must be addressed, in a properly professional way, so that safeguarding and risk management decisions are robust and fair. Local Authorities and other commissioning bodies should be working together to establish standards for holding and sharing this information in a manner that balances the rights of alleged offenders alongside those of identified victims – particularly where the host and placing authority are different.
- 4.10 As stated above, in terms of safeguarding concerns about Hillgreen Care Ltd, one major Health and Safety violation (unrelated to P) had occurred prior to the inception of the Provider Concerns process and this had been serious enough to ensure that the London Borough of Enfield did not make further placements within Hillgreen Care. However, they did work with the company as the host authority when other safeguarding concerns were raised about residents (and, as the Enfield Learning Disabilities Service is integrated with health, where there were health related needs within the service).
- 4.11 Individual Safeguarding Adults concerns (involving the provider though not P), had raised concerns about the quality of the service's risk assessments (although these were reviewed), about poor recording, staffing levels and training. Some of the incidents outlined within this report were very serious and they were not reported by the provider in a timely fashion; this in itself provided evidence that the service was not taking safeguarding seriously on behalf of their residents and also that they were operating outside agreed protocols and in breach of what is accepted as good practice. One particular incident of note was where it was identified that managers within the home did not always know how staff were meant to be allocated – meaning that they may have had funding to provide

staffing specifically for P to have one-to-one supervision but did not identify a designated staff member to do this. These factors all contributed to P being left in a situation that reportedly allowed him to abuse within the home and also in the community (despite being accompanied by Hillgreen Care staff) and this became apparent in retrospect. However, the reviews show that Hillgreen Care Ltd completed the actions and acted on some of the specific recommendations made through individual safeguarding enquiries. However, these changes were not sustained as similar problems occurred at a later date.

4.12 One of the Safeguarding concerns (received over a year before the reported rape of Victim 7), about the care of a different resident raised such a wide range of issues, that a full Provider Concerns process could have been considered at that point and on the basis of this single enquiry. However, since there had been only one concern raised within that time period (which did not involve a death or serious injury), it would not necessarily have reached the criteria to trigger a referral to the Provider Concerns process in the London Borough of Enfield at that time. The benefits of making such a referral in relation to a provider as opposed to an individual is that the Provider Concerns process would have more directly involved the Care Quality Commission (who are informed of each Safeguarding Concern but not always involved in Enquiries) and could have heightened the awareness of all the placing authorities involved.

4.13 A serious lesson for all professionals arising from this case is to ensure that they are clear and precise in their statements. This might involve:

- Being very precise about court orders and criminal charges.
- Using professional language and terminology when describing clients, their actions and diagnoses/assessed functional capacity
- The use of descriptive or clinical language similar to that used by the Police, especially when describing sexual behaviour; this reduces the chances of misunderstanding or downplaying/exaggerating incidents.

4.14 Professionals should also evaluate and seek to confirm statements about events or behaviour that suggests risk when they are made by other agencies and individuals. They should at least try to reach and record the best possible consensus about the available evidence on which to base their shared decision-making. Vagueness undermined the commitment to risk management in P's case and allowed information from credible sources to be undermined.

5 The Metropolitan Police and Crown Prosecution Service

5.1 Until this Review, there had not been a comprehensive list of the allegations against P and, because of this, the Police were not always given the opportunity to take action. Some of the incidents may have seemed minor or just suggestive, however there were a number of incidents or disclosures that were clearly allegations of assault which should have been reported to the Police (and/or the relevant local authority who would have passed the information on to the Police) so that these incidents

could have been properly considered and investigated. Either or both routes should be effective in that adult social care services share safeguarding information with the police and vice versa, this is sometimes referred to as a “no wrong door” approach.

- 5.2** Opportunities to report incidents were missed throughout P's life. A key example was when the allegation of sexual assault against Victim 6, another resident at P's home, was brought up in an unrelated Mental Health assessment in early 2015 (as having happened two weeks prior to the assessment and also once before that). A Hillgreen member of staff was advised by a Doctor to always report such things to the Police but this did not happen (neither did the Doctor in question report it). The assessment was then written up and the allegation included (though not highlighted as a report of abuse) and that report was sent to professionals at the London Borough of Hackney. No-one highlighted that this was an allegation that should be treated as a crime or acted on at all. Victim 6 therefore continued to live with, and potentially be at risk from, P for another 9 months.
- 5.3** There were five cases in total that were reported to the Police; however, only one of these resulted in a conviction.
- 5.4** In 2006, there was an allegation that P had sexually assaulted another resident at his home, Victim 1, and P did partially admit this. However, there were perceived issues around gaining a victim statement due to Victim 1's learning disabilities, and Victim 1's mother expressed a view that Victim 1 should not give a statement, so this investigation was not progressed. P was briefly removed from the home but returned when Police concluded the case.
- 5.5** Two years after this, P was accused of the rape of Victim 2, who attended an educational course for people with learning disabilities with P. The Crown Prosecution Service decided to progress this case but P was found to lack Mental Capacity to stand trial. Mental Capacity is time and decision specific (and assessments of P across the years have varied accordingly). The two assessments were carried out by forensic psychiatrists, one for the prosecution and another for the defence, who formally assessed his ability to enter a plea, to understand the trial process and also to understand that certain actions are wrong. Both considered that he lacked capacity in this context. In the circumstances that an individual cannot stand trial there is the possibility of a 'Trial of Fact' so that the evidence can be considered and a definite decision made about what had happened. This was considered in this case, however, there were some problems with the evidence so the trial could not go forward. The judge was sufficiently concerned to issue a strong statement about the 'very significant risk to young women' posed by P and he recommended that social services and other agencies should address the protection of P and others.
- 5.6** It should be noted that P was reported to have assaulted both males and females as a teenager but, at the point when the judge was speaking, he would only have had in front of him reports about assaults against women that had been perpetrated by P as an adult. Therefore, despite his warning, there remained an incomplete picture of the risks involved. It does not seem that any of the Court professionals had access to P's childhood reports which would have given them this information. Hillgreen Care Ltd should have had this information from discussions that took place in the context of his original placement. Later, following the reported rape of Victim 7 (a man), a member of Hillgreen Care Ltd front-line staff commented that they had thought that he only needed to be supervised around women.
- 5.7** In two of the cases that took place in Enfield (in late 2015), the delay between the assault and the

report being made, meant that key forensic evidence, if it existed, was destroyed or unavailable. P made partial admissions to staff that could not be admissible in court. The vulnerability of the victims of these assaults meant that they were often unable to give a clear account of their experience (one victim for example, whose first assault may have happened 9 months before it was reported, struggled to identify time periods due to her learning disability). Despite this, the Police used the Intermediary service to give them the best possible quality of evidence.

- 5.8** In any prosecution, the prosecuting authority must prove the case so that those making a guilty finding are sure. However, where victims have disabilities, which may affect how they relate historical events or hinder their ability to communicate, there are considerable challenges in assuring that they have equal access to the Criminal Justice System and the protections that it allows. Prompt reporting is key in such cases so that forensic evidence can be gathered and witness statements collected while the events are fresh in the minds of those affected. It is notable that in this case the only conviction was brought in a case involving a young woman without learning disabilities whereas cases involving people with learning disabilities, as victims, could not be brought to court. This young woman had strong advocacy from her family and there was independent corroborating evidence including CCTV and documentary evidence. In the face of this P plead guilty.
- 5.9** The Criminal Justice System not only applies sanctions but it also acts as a gateway to forensic services and prevention programmes. P would have benefited from access to Forensic services and to monitoring by the Multi-Agency Public Protection Arrangements group (MAPPA) to prevent him from offending again and to offer him specialist support. These mechanisms are only accessible where a conviction has taken place. The lack of conviction also allowed various professionals to disregard, misunderstand or downplay past allegations as 'unproven'. As mentioned earlier, in one notable instance, a report of rape was later described by staff of Hillgreen Care Ltd as an unsubstantiated allegation of 'inappropriate touching'.
- 5.10** One particular Police Officer should be singled out for praise in that she recognised the risk that P posed and continued to raise professional awareness even after the Crown Prosecution Service had closed the case in 2010. This action should have led to other agencies taking clear action on these risks and the report that she made was the clearest account of his behaviours up to that point. It also represents a good example of the clear, objective way in which such incidents and risks should be communicated in contrast to a number of other documents which obscured events by using vague and/or minimising terms such as 'sexually inappropriate' rather than describing the act itself. The cumulative effect of such poor communication in this case led to the down-playing of risk. There was no misunderstanding this officer's report and concerns.
- 5.11** Several incidents involved members of the public rather than people with learning disabilities. One young woman, whose identity is unknown, told P that she would report him to the Police for online harassment; this led to P's internet use being monitored by Hillgreen Care Ltd but other agencies and the local authorities concerned were not informed. It is unclear how Hillgreen Care Ltd became aware of this allegation but they referenced it in later reviews. Documentation from the home stated that P's internet use should be monitored for this reason and because he was accessing inappropriate materials or "young" porn – there is no indication as to whether this material was illegal (if so there should have been a report to the Police) or simply uncomfortable for staff. This provides another instance where vague language may have led to a missed opportunity to assess risk accurately, plan interventions and/or bring appropriate sanctions to bear.

- 5.12 The serious incident in 2014, (that took place on a bus) involved P deliberately sitting next to a 14-year-old in school uniform and molesting her by putting his hands down her trousers (despite P being accompanied by a member of care staff at the time). This incident was reported directly to, and investigated by, different units within the Police. Initially the decision was made not to progress the case as P's learning disabilities made it unlikely that a conviction would be made but this decision was revisited due to feedback from the Enfield Jigsaw unit and the Multi-Agency Public Protection Arrangements meeting panel. P was eventually convicted 18 months later in early 2016 and this remains his only criminal conviction to date. He received a two-year-suspended sentence with the appropriate Probation Service contact and MAPPA supervision.
- 5.13 But until that point, as a man who had no formal convictions, P could not access mainstream Sexual Offender Prevention programs or special programs adapted for people with learning disabilities as these are not commissioned by the CCG's in this particular part of London, nor could he be managed by the Multi-Agency Public Protection Arrangements group (MAPPA) or receive a forensic mental health service. Two further assaults occurred and/or became known in the residential home after the assault on the bus was reported and while the investigation was ongoing. Whilst the Metropolitan Police acknowledged the delay in the bus investigation and stated that the initial decision not to progress the case was wrong; it is clear that multiple professionals missed opportunities to engage with the Criminal Justice System on behalf of P's victims and that this delay seriously hampered the Police response to P's behaviour.
- 5.14 Another factor identified by the Review is that the psychological and psychiatric assessments that took place did so without all the background information being made available which further emphasised the failure to produce a complete and cumulative record. The two psychiatric reports that were conducted in relation to the court case, in 2009, were very thorough although the doctors completing them did not have access to his full history and especially to incidents in his adolescence (which is not to say that this would have changed the outcome). Nevertheless, these were detailed assessments and it would have been helpful at that juncture, and for subsequent assessments, if those reports had been made available within the wider professional group. The Review panel felt that sharing these and other court related reports with the local authority should be regarded as standard practice so that a cumulative picture could be built up from successive assessments.

6 Determining responsibility for health-related aspects of P's care

- 6.1 In 2009, P was moved to another Hillgreen Care Home within Enfield. It appears that this move had been discussed previously but, in the event, it was made as an emergency when the Police charged P with rape and imposed bail restrictions that meant he had to move as Victim 1 (whom he was reported to have assaulted in 2006 but had continued to live with until this date) had been identified as a witness who could give evidence in court and therefore they could not live in the same household.
- 6.2 10 months elapsed before the trial ended at which point the London Borough of Enfield were formally notified via the London Borough of Haringey's Safeguarding Adults process that P had been placed in the Enfield area by the London Borough of Hackney and that he posed a high level of sexual risk. This information should have been shared by the placing authority upon placement in the Enfield area.

- 6.3 As has already been stated, by 2010 when the Court case around the rape of Victim 2 fell through, P had been the subject of several allegations of sexual assault against vulnerable women. Two separate assessment processes took place and made explicit recommendations about limiting the risk that P might pose to others:
- those done as part of P's transition into adult services, for example Respond specifically recommended a period of two years of regular psychotherapy but this was not been funded as part of the placement package and
 - the assessments that were commissioned in relation to the 2010 court process that resulted in the Judge's comments.
- 6.4 A referral for both Psychological and Psychiatric services was then received by the Enfield Integrated Learning Disabilities Service from the London Borough of Hackney (referencing the Judge's comments and specifying that this referral was specifically to address sexual risk). However, a Consultant Psychiatrist for the service responded by saying that the Service would be unable to provide this and asking what measures the London Borough of Hackney had put in place to manage the known risks within the placement that they were responsible for.
- 6.5 A pattern emerged in the correspondence (occurring through 2010 to 2011 and then again in 2013) whereby the London Borough of Hackney requested this service and the London Borough of Enfield declined on the basis that their service was not commissioned to provide psychosexual input. The London Borough of Hackney held that psychosexual therapeutic work was a health care need and (as P now had an Enfield GP) this therefore needed to be provided locally. The London Borough of Enfield, responsible for managing the Enfield Integrated Learning Disabilities Service, provided a response stating that they did not have the specialism within their service to provide this.
- 6.6 The Primary Care Trust were then approached to commission support (specifically psychotherapy). This review did not have access to the response that the Enfield Primary Care Trust sent but there was an agreement to provide a psychiatric assessment by the Integrated Learning Disabilities Service in Enfield. The psychiatrist from the London Borough of Enfield met with P's social worker and could find no evidence of specific mental health issues. He did not meet with P. His report to the London Borough of Hackney states some of his on-going concerns about Hillgreen Care Ltd and recommends Respond as an organisation. Shortly after this, the London Borough of Hackney agreed to fund the therapy with Respond. However, the fundamental issue of who was responsible for this element of P's health related care needs was not formally resolved and re-emerged when the London Borough of Hackney again referred P to the service in 2013.
- 6.7 P did receive Occupational Therapy, a generic psychology assessment (towards the end of his time in Enfield and which has already been described) which further recommended a resumption of Respond sessions, a forensic assessment by the Mental Health Trust, and raised issues about the practice at Hillgreen Care Ltd. A Community Nurse, from the Integrated Learning Disabilities Service in Enfield, also worked with P for the last 6 months he lived in Enfield (and raised issues with Hillgreen Care Ltd and the London Borough of Hackney about the quality of risk assessments). The discussion was solely about this psychosexual therapy, how it should be funded and where it should come from.
- 6.8 In reading the correspondence, it is clear that the discussion reflected a gap in commissioned services not a dispute about the fact that P required specialist support to address behaviour that

posed a risk to others. This led to a delay in Respond's therapy being commissioned in 2011 and it was then ended with the argument that the Enfield Integrated Learning Disabilities Service would provide similar input in 2013 (though it had been stated by them that they would not) which led to another period of dissension during which P received no such assessment or support. It was recommissioned by the London Borough of Hackney in 2015 after P's assault of Victim 5 on the bus in late 2014. Health and social care agencies need to use the mechanisms in place to escalate and resolve any funding issues between them, ensuring that they are resolved promptly and clearly to all concerned. Clearly allowing such dissension around funding responsibilities to continue is dangerous to the vulnerable people whom local authorities and health services are responsible for. The Care Act and prior legislation, that deals with disputes with local authorities, provides the means to resolve these issues and if necessary to support the continuity of services pending a deliberation about services. This did not happen.

- 6.9** P's therapy at Respond took place (funded by the London Borough of Hackney) for two periods – for 18 months (in 2011 to 2013) beginning 2 years after the Court Case and for another 7 months in 2015 following the assault of Victim 5 (2 years after the previous set of sessions). On both occasions, the sessions were stopped by the London Borough of Hackney despite the therapist's clinical recommendation that they continue and apparently for financial reasons. It may well be that no amount of therapy for P would have reduced his offending behaviour but consistent and effective intervention could have been very valuable, especially if the provider had been led by the more intensive insights of the therapeutic team allowing his risk assessment to proceed on the basis of a far more detailed understanding of his reported offending behaviour.
- 6.10** There is a strong argument that the Enfield Primary Care Trust, and subsequent the Clinical Commissioning Group, were responsible for commissioning psychotherapy for P as he was living in that area, registered with an Enfield GP and receiving healthcare in that area. Although the Enfield Integrated Learning Disabilities Service itself was not commissioned to provide those specialist services, both boroughs have worked together to engage with whatever bodies they needed to, in order to try and ensure that P received an appropriately tailored service. The Clinical Commissioning Group did not in fact receive a request for this service (although the Primary Care Trust did and rejected it) and the GP was not engaged in these discussions which made it impossible for the GP to take on the role of maintaining an overview of P's health care needs in relation to his sexual behaviour. P had a right to have his health needs met and for all the appropriate agencies to work together to make this happen.
- 6.11** There are well over 100 CQC registered organisations and a large number of supported tenancy sites within the Enfield area. It is not unusual for other local authorities or health commissioners to place adults into the Enfield area; however, the information shared at the time of these placements varies considerably. It would be expected that another local authority making a placement into the area would contact the host authority in order to get feedback about the provider and/or about other local resources before making the placement and that they would update the host local authority if their assessment of risk changed once the adult had commenced living there.
- 6.12** The Occupational Therapy service within the Enfield Integrated Learning Disabilities Service did extensive work with P. The original referral was for travel training but ultimately the Occupational Therapist concluded, during his 2011 assessment, that the obstacle to P travelling independently were the concerns about his behaviour in public and not about his independence skills. Although Hillgreen Care staff stated that he had never behaved inappropriately within the home, and

downplayed/dismissed the 2010 Court Case (saying it was a charge of sexual assault rather than rape and that it was not proven), they did acknowledge that he stared at young women in public and that there had been incidents where people had been aggressive after seeing him staring. The Occupational Therapist went on to follow a 'sex and relationships' programme with P – aimed at supporting people with learning disabilities with appropriate boundaries and behaviour. The OT also worked in conjunction with Respond to try and encourage P to think about consent and appropriate relationships. He then developed concerns (and passed them on to the London Borough of Hackney) about how engaged Hillgreen Care Ltd staff were with the support both he and Respond were offering.

- 6.13** This work raises real issues around how far adults with a learning disability and a history of reported sexual offences should be encouraged to have positive relationships and further independence. The Occupational Therapist may have made different recommendations if they had had access to the full history of P. What is very clear is that effective interventions cannot take place without clear communication and information about the entire reported offending history between all parties.
- 6.14** The Enfield Integrated Learning Disabilities Services provided feedback to the London Borough of Hackney about their concerns about Hillgreen Care Ltd at several times during P's 7 years living in the area. This included repeating the concerns from Respond about Hillgreen Care Ltd's engagement with P's therapy, feedback from a psychologist working in the Enfield Integrated Learning Disabilities that the staff at Hillgreen Care Ltd did not seem to have the required skills and feedback from a Community Nurse (who was visiting P regularly due to these concerns) specifically about risk assessments. At various points, the London Borough of Hackney was considering different placements and asking for suggestions about what would be appropriate which reassured the London Borough of Enfield. However, this move did not happen and in fact, P's 2015 review shows that the long-term plan for his care was for him to move into supported accommodation rather than into a more specialised and containing environment. Here again the evidence shows that the communication between the agencies involved in P's care was poor.

7 The Care Quality Commission and other monitoring functions

- 7.1** Regulation of services that provide personal care to adults in need of care and support is the responsibility of the Care Quality Commission. It predominately does this through regular inspections of such services but also receives reports of any incidents that happen in the service and will engage with local authorities and any other commissioning bodies around concerns about quality or safety.
- 7.2** The Hillgreen Care home that P most recently lived in was inspected regularly by the Care Quality Commission and issues were identified in a number of these inspections. After each inspection, the home was required to put together an action plan and make improvements. For example, the 2013 inspection highlighted issues with care planning, staff training and medication management. Hillgreen Care Ltd put together a plan and completed it. It should be noted that, at that point, CQC had not been made aware of concerns about P and his behaviour so would have had to take his risk and care plans at face value. Hence, they were not in a position to assess the risk assessments in the light of P's complete history despite their responsibilities as the regulator.

- 7.3 It is not the Care Quality Commission's role to adjudicate between placing and host authorities about whether a placement is adequate. However, they should be informed if professionals suspect a provider is taking on service users that they do not have the skills to work with safely. Local Authorities should consider this if similar cases emerge in future. CQC's role is to ensure that the care offered matches the registration of the provider, the quality of care offered and its safety, it is not to monitor specific placements. However, by inspecting a whole service at regular intervals and in depth, they can provide assurance that risk assessment and care planning is being done to an appropriate standard.
- 7.4 The Care Quality Commission inspected the Enfield care home run by Hillgreen Care in November 2015, January 2016 and March 2016. They found a number of failings (including in risk assessment and medication management) which they took regulatory action upon. They began the process of withdrawing the home's registration in February 2016 which concluded in January 2017. They also re-inspected all other homes run by Hillgreen Care Ltd at the time (across four London Boroughs) and took action where they found issues in these services. The Care Quality Commission, at the time of writing, is carrying out a criminal investigation to consider what further action could or should be taken. This report does not seek to detail the nature of any such investigation and nor to prejudge the outcome of any such investigation. The Care Quality Commission has commissioned an independent investigation report which will identify what happened and what the CQC could have done differently in relation to Hillgreen Care Ltd.
- 7.5 Another monitoring mechanism that local authorities use is Contract Monitoring (this may be titled differently in different local authorities). Hillgreen Care in Enfield were not subject to regular contract monitoring visits as the London Borough of Enfield did not have a contract with them and no Enfield residents were placed there. The process of reviewing individual service users and their care plans did continue (as mentioned above) but these reviews are specific to individuals and their needs rather than looking at the whole provider.

8 Commissioning services for people at risk of sexually offending in future

- 8.1 The Review panel invited members to think more widely about the services that are available to people with learning disabilities whose sexual behaviour is complex and unsafe. This includes forensic services and how these can be accessed and funded on behalf of people like P.

8.2 The role of Clinical Commissioning Groups (CCG's)

- 8.2.1 The Clinical Commissioning Groups commission a range of services for the population within their area and this includes specialist services for those with learning disabilities through integrated teams that work with adult social care. P had a right to access health provision local to where he was living and in the locality within which he was registered with a GP. People with learning disabilities are entitled to receive their health care on the same basis as any other citizen and services should make 'reasonable adjustments' in order to facilitate access under the terms of Equalities Act (2010).

8.2.2 Where someone moves to the area and they have previously had psychological or psychiatric support then a transfer of the case (with information about their needs and difficulties) should take place and it is the responsibility of the existing professional network to make this available. Although Respond had made recommendations when he was 17 in 2004, and despite the fact that P was subsequently assessed by a psychiatrist from the Haringey Learning Disabilities Partnership prior to leaving the borough (in order to establish his capacity for the 2010 Court Case about Victim 2), he did not receive any on-going treatment from either of these services until much later. There was no formal transfer relating to this health-related need and the responsibility for its funding. A previous section of this review has gone into the discussions about his eligibility for these services.

8.3 Accessing Forensic assessment and service provision

8.3.1 Forensic services provide Sex Offender Treatment Programmes (SOTP) to address the needs of convicted perpetrators and can draw on specialists in risk assessment and treatment within their teams. These programmes have been successfully adapted for people with learning disabilities and must be made accessible to them, including consideration of those who have not been convicted but who are thought, on the balance of probabilities after deliberation by expert professionals, to have committed offences. Sexual offender prevention programmes specifically adapted to people with learning disabilities have been delivered and evaluated and a network of expert clinicians support these programmes in the south east. Clinical Commissioning Groups and local services should inform themselves about these options.

8.3.2 However, in the absence of a conviction, P could not access the forensic services provided in this region and there seemed to be no mechanism for bypassing this eligibility criteria. This is another reason why the Review concluded that it is vital to pursue all allegations against a perpetrator with care and support needs, whether or not they are considered to have capacity, because the lack of a formal court process prevents them from receiving appropriately tailored services which have the potential, in turn, to keep others safe. People with learning disabilities are entitled to receive any mental health input they require in mainstream mental health services and, given that it is more difficult to prosecute people with learning disabilities (and especially where their victims also have a learning disability), failure to make provision for this input is discriminatory.

8.3.3 Where a service is not, and cannot, be offered by a specific team or in a designated area, there may be a need for a local Clinical Commissioning Group to commission provision that is specifically for an individual. This may mean creating a programme within existing structures or commissioning it from outside specialists – for example Respond or the Tavistock Clinic. Although there were some early conversations with the Primary Care Trust (which preceded the Clinical Commissioning Group), the Clinical Commissioning Group and P's GP were not approached around this need. It is worth noting that the London Borough of Hackney had this kind of arrangement in place with the Tavistock and Portman NHS Trust but failed to access it on P's behalf.

8.4 The role of the GP

8.4.1 When the Enfield Clinical Commissioning Group made enquiries due to this Safeguarding Adults Review, P's GP in Enfield was not aware of his sexual offending, therapy with Respond or of the

on-going conversations about who should commission and provide psychosexual counselling. This gap seems to reflect deficits in communication around this case and signals that the GP had not been well enough informed about the risks posed by P to seek out appropriate secondary care and/or to collate all health assessments on his record. This information should have been sensitively shared by, and with, Hillgreen Care Ltd whose responsibility it was to access health care on P's behalf. GPs are supposed to coordinate secondary care and maintain an up to date overview of a patient's health care needs. In this case the GP had not been provided with sufficient information to take on that role. Both the Integrated Learning Disabilities Services of Enfield and Hackney could and should have engaged with the GP and Clinical Commissioning Group when it became clear that they had reached an impasse in relation to the therapeutic and forensic aspects of P's health care¹. This information should have come from a formal handover but it should also be noted that it would usually be the care provider's responsibility to liaise proactively with the GP and to keep them informed of their client's needs.

8.5 Psychological assessment and treatment

8.5.1 A person with a learning disability will not always need on-going psychiatric or psychological support or assessment. There need to be symptoms or cause for an assessment to take place. There exists a disagreement between professionals about whether the presence of sexual offending with combination with a learning disability can itself be termed evidence of a mental health condition. The lack of empathy displayed may indicate some issues.

8.5.2 The Mental Health Act (2007) also states that a person with a learning disability (a mental impairment) who also demonstrates 'seriously aggressive and/or seriously irresponsible behaviour' even in the absence of a specified mental illness, can be assessed under the Act. Psychiatrists who assessed P at various points reiterated that he did not have a mental illness.

8.5.3 Sexual offending in someone with learning disabilities and other potentially criminal behaviour, therefore, raises complications when it comes to deciding who should fund, and who should trigger or provide interventions. It is likely that the only way to resolve these complications is on a case-by-case basis and commissioners should put in place processes that allow local professional networks to discuss and resolve these issues. Ambiguity should not allow complex cases to drift without a concrete agreement about the way forward.

8.5.4 In this respect it seems that P faced inadvertent discrimination as a result of his learning disabilities because there was no route for him to access services that someone without a learning disability could have accessed. As a man with learning disabilities it proved more difficult to bring a conviction against him than it would have been for another offender and given that entry to these services relies on conviction he was not able to access professionals with specific expertise in sexual offending through the NHS but only through RESPOND whose input was funded by the London Borough of Hackney Adult Social Care for two periods of intervention.

8.5.5 Given the lack of a formal conviction, he was unable to access either a generic sex offender prevention programme or one that had been tailored to the needs of men with learning disabilities. He therefore needed specialist services to be commissioned for him from specialist agencies and

¹ It proved impossible to find correspondence from the old Primary Care Trust but from the recollections of people involved in the service network at that time, it seems that there was very little in the way of dialogue about these issues.

the fact that this was not commissioned placed him at a disadvantage. This is a further example of inequality and possible discrimination against P. There is some evidence that programmes aimed at adolescent sexual offenders can lead to long term changes and it might have been possible to provide more support throughout adolescence given the knowledge that was already held about P's disorganised and abusive childhood. It cannot be known what would have happened if P had received this support before he reached 18 years old but this was a missed opportunity. P learned that his reported offending behaviour would not bring him within the purview of the Criminal Justice System and was therefore without consequence. This view was reinforced by staff at Hillgreen Care Ltd who minimised reports and history in his presence. This may have contributed to his behaviour becoming more and more entrenched.

9 Supporting Adults with learning disabilities who have been victims of sexual assault

- 9.1 Section 8 sets out how perpetrators with learning disabilities face barriers in accessing services that other potential offenders might engage with, but in this section the report explores the extent to which victims with learning disabilities also fail to attract the same levels of support and concern as victims who do not have learning disabilities. Again, this is arbitrary and unfair. If you are a victim you should receive services that are proportionate to the harm you have suffered, and this should be the case whether or not you have been harmed by an offender with a learning disability.
- 9.2 The majority of P's victims, that we are aware of, are men and women with learning disabilities. The Review decided that in this case the reported victims had not all been helped to access sources of support that other adults would have been put in touch with and therefore that the way adults with learning disabilities were supported after allegations of sexual assaults needed to be addressed. The first recommendations made relate to this aspect of the case. Safeguarding is designed to keep victims at the centre of deliberations and interventions. Neither the fact that a person has a learning disability, nor the fact that the alleged perpetrator was a person with a learning disability, should have led them to receive a lesser service when victimised than would be have been offered to any other citizen.
- 9.3 It is notable, and of concern, that the only case in which a conviction has been secured against P was in the one case where the victim has no known disabilities. It is significant that in that case, her family took on a powerful advocacy role in pressing for a prosecution and supported her by engaging with the Police on her behalf. Other families were not kept informed and therefore did not have the opportunity to support their relative in this way and/or they made different decisions. Paid advocacy is also something that should be considered in any safeguarding case whether there is family involvement or not and the 2014 Care Act makes provision for this. An advocate can be helpful in engaging with organisations and ensuring that the victims' voices are heard throughout any safeguarding, care planning or criminal justice proceedings and their role should include seeking support from services offering counselling for survivors and approaching agencies with a remit to seek compensation or redress.
- 9.4 Several of P's reported victims disclosed an abusive incident but continued to have to live or study alongside him. In some cases, this occurred because the provider did not disclose the allegation

to the Police or social services. This Review has emphasised the importance of ensuring that all professionals, in all areas and at all levels, raise formal reports even if they think others have done so. Lack of support for victims is an important consequence of not doing so. Prompt reporting and a basic attempt to preserve forensic evidence is also essential to ensure that victims receive legal justice wherever this is possible.

9.5 However, the case of Victim 1 is particularly concerning as this assault was reported to the Police but, as the Police investigation did not progress, she was expected to continue living with P for another 3 years. It is hard to imagine an adult without disabilities being asked to do the same after a similar allegation whether it was proven or not. Even if the allegation against P had been proven to not be true, these two adults should have been separated for the protection of both. Other women or men who had been the victims of sexual assault or domestic abuse would not expect their personal safety to be disregarded in this way. It represents a discriminatory response to the needs of people with learning disabilities who may be less able to advocate for themselves.

9.6 Assessing whether a sexual act is consensual

9.6.1 In some cases, assumptions were made about incidents being 'consensual' where the adults concerned were unable to communicate their views and wishes. The Mental Capacity Act (2005) makes it clear that professionals should assume mental capacity unless they have reasons to doubt it or to explore further. Mental capacity is specific to the time and situation involved and to the specific decisions that have to be made. Making decisions in the context of abuse is likely to be the most stressful of all decisions and even people with learning disabilities who have capacity in other areas of their lives might struggle in the face of having been assaulted. Moreover, in many of these cases, it is clear that the victims would have demonstrated very obvious causes to doubt their capacity.

9.6.2 Given what was known about P's reported behaviour on an ongoing basis and given that the provider also knew many of the victims in depth as a result of them receiving a service from them, a more proactive approach should have been taken. The review noted that there are complex ethical issues that should be addressed about whether a person is entitled to information about a potential perpetrator's history of sexual offending in the context of capacity assessment. This is an area of work that requires specific knowledge and expertise and some professionals would not feel able to make an assessment of capacity in this context. In that case they should refer on to other more senior colleagues if they have any doubt whether an encounter is consensual or not.

9.6.3 Whether P had mental capacity to recognise his crimes as such or not, his victims' experiences and trauma were, and are, the same as they would have been for any other victim of sexual assault. The Review panel would expect to see the victim of a sexual assault supported in a variety of ways including to access therapeutic support (both specialised and generic victim support) and to gain redress through the courts if possible. Where that is not possible there might sometimes be the potential for bringing a civil case and/or for seeking compensation from the Criminal Injuries Compensation Board and/or anybody deemed to be at fault.

Concluding remarks

It is often said in training that ‘Safeguarding is Everyone’s Business’. Throughout P’s adult life, it is clear that various individuals did not recognise or acknowledge that safeguarding was their responsibility. Allegations went unreported and therefore were not investigated. Investigations were compromised. Risk assessments were not completed and information about risk was not shared. At times these acts were deliberate and at others the result of ignorance or poor systems; however the resulting harm to those who are vulnerable, remains the same. Professional networks must work together to ensure that people are safe as their first priority.

It is clear that there were points throughout that time where professionals did know that P posed a risk to others and where different actions could have prevented further assaults. Even when P was a teenager, there were incidents that could have been investigated further and/or recorded in a clearer way so that a cumulative evidence base could be built up to act as the basis of risk assessment. Even without convictions and proven allegations, specialists were advising that P should receive expert support around his sexual behaviour. The awareness of these risks increased over time and should have triggered increased intervention rather than continuing prevarication.

There are several key points where P’s behaviour could have been recognised and potentially prevented.

- In 2003, whilst P was still only 16, a Community Paediatrician wrote an assessment suggesting that P had committed sexual offences but giving no details. This assessment could have been more clearly worded, but the London Borough of Hackney’s subsequent re-evaluation of it could also have recognised and preserved his high level of concern given that they had credible reports from their own services to support this.
- The London Borough of Hackney could have been led by Glebe House, a specialist provider, and RESPOND’s assessments and prioritised safety and containment in their initial placement decisions as P became an adult.
- The Metropolitan Police could have continued with an investigation in 2006 despite Victim 1’s mother expressing a view that Victim 1 should not give a statement.
- All incidents should have been properly recorded and regarded as warning signs, so for example when Victim 2 alleged that P had removed her clothing without her consent, in the year before P was reported to have raped her, this should have been taken more seriously and seen as an intended sexual assault (as it would no doubt have been treated in the case of an adult without additional needs).
- In 2009, psychiatrists acting for the Criminal Prosecution Service and defence solicitors could, and should, have been briefed about P’s reported past offending, so that they could have come to a more accurate assessment of his fitness to plead and of his need for a safer placement.
- At the conclusion of the court proceedings in 2009, the psychiatric assessments could and should have been shared with Adult Social Care and used by the London Borough of Hackney to trigger and inform a review to examine whether P’s current placement could keep him and others safe.
- Throughout this time, senior staff of Hillgreen Care Ltd should not have downplayed P’s offences by referring to them as “unsubstantiated”; this had the effect that some of his reported assaults were not taken seriously or kept in the forefront of their minds, which seriously hampered planning and vigilance around P. This placed other vulnerable adults at risk.

- Hillgreen Care Ltd had put themselves forward as a service that specialised in challenging behaviour but none of their staff held qualifications in relation to this area of work. During the entire period of their working relationship with P, the company did not fund any staff to train in difficult sexual behaviour. When, in 2015, specialist input and training was offered by RESPOND, funded by the London Borough Hackney, they failed to make staff and management available.
- Staff of Hillgreen Care Ltd who were chaperoning P when he went out should have been properly briefed and trained. They could, and should, have prevented the assault of Victim 5 in the bus in 2014.
- A proper record should have been curated to inform all the agencies acting on P's behalf. To do this Pan-London protocols should state clearly how concerns about a perpetrator in need of care and support are to be flagged up, clarifying the responsibility of a provider agency to document all incidents of abusive behaviour alongside an evaluation as to the accuracy and veracity of the account noting with whom information has been shared. Evidence "beyond reasonable doubt" is not an appropriate threshold on which to base professional decision-making.
- Placing authorities should have a proper system that flags up concerns about a service user who presents risks to others and a screen on their recording systems that flags up an annotated but condensed history of any offending behaviour, whether or not it has led to a conviction.
- CQC should take note of risks from one service user to another and when carrying out inspections they should examine risk assessment and risk management strategies especially in relation to any service user who has a history of offending whether or not this has led to a conviction.
- Throughout this period, Hillgreen Care Ltd should have been very clear that P was a potential threat to other residents. They should have been clear about which of their residents may have lacked capacity to engage in sexual acts and they should have provided sufficient supervision within their houses, as well as in the community, to ensure that service users were safe: the reported assaults on Victim 5 (in the community) and Victims 6 and 7 (within a Hillgreen Care property) could have been prevented.
- When Hillgreen Care Ltd staff failed to act according to written guidelines and instructions they should have been held to account.
- In 2015, Hillgreen Care Ltd was grossly negligent in not reporting the reported assault on Victim 7 to the Police immediately so that forensic evidence could be gathered. This was in breach of their obligations under Safeguarding Adults.
- At least three people knew about the reported assaults on Victim 6 and did not pass on their concerns to the Police or through local Safeguarding Adults arrangements. The incidents were eventually reported by a member of Hillgreen Care Ltd's staff to a Consultant Forensic Psychiatrist in the context of an assessment interview in February 2015. She went on to write about the allegations in her assessment letter which was sent to P's social worker at the London Borough of Hackney. None of these individuals made a formal report through the Police or Safeguarding Adults system: all of them should have done so.

Safeguarding Adults Boards should inform all provider agencies that they must report incidents of sexual abuse, without any delay, to the police in order that forensic evidence can be gathered. The incidents should subsequently be reported to the relevant adult social care team and CQC. Failure to do so is a breach of safeguarding protocols and could be considered negligent to the extent that in certain circumstances this would constitute a criminal offence. Providers should be reminded of their obligations to train their staff in basic

safeguarding awareness and local reporting mechanisms; staff must be empowered to report incidents without discussing their concerns with management if to do so would cause a delay. Provider Forums are one conduit that should be used to ensure that providers are reminded of their responsibility in this regard.

Those entrusted with the care of adults at risk of abuse and neglect should be aware of the need to preserve evidence such as the clothes worn at the time of an alleged assault or sheets and towels. In doing this, they would maximise the potential for investigating Police to gain valuable corroborative evidence from these sources. Commissioning authorities should monitor providers' compliance with local safeguarding protocols and CQC should insist on prompt reporting of safeguarding issues as a measure of quality in all its inspections. If either commissioning bodies, local authorities or CQC become aware of any reluctance or failure to report serious incidents, to the police and/or through proper safeguarding routes, then they should inform other bodies concerned (such as host or placing authorities and the CQC) so that increased monitoring and/or enforcement action (in the case of CQC) can be put in place.

These measures are already considered best practice and are implemented in the majority of cases but this series of events demonstrates the possible consequences of failing to do so.

For a considerable period of time, P was being monitored in the home under one-to-one supervision seemingly with his consent. However, there was no legal basis for this or mandate to enforce it if he had protested. If a person lacks capacity to enter a plea, which is a complex decision made against a specific set of criteria, this should be read as a signal that the person may lack capacity to make other complex decisions including those related to their offending or other high-risk behaviours: assessments in relation to other significant decisions under the Mental Capacity Act (2005) should proceed accordingly.

It may be necessary to impose constraints on individuals whose behaviour poses a risk to others as a result of a reported propensity to sexually offend, even when they have not been convicted. Where possible the professional network should use formal processes and instruments so that any infringement of the person's rights are appropriately scrutinised.

Recommendation 9 lists a number of formal safeguards that could be considered in circumstances where behaviour is constrained but not every mechanism will be applicable in every case. These are ethically sensitive issues and professionals with appropriate seniority should be involved in deliberating about the way forward.

A key theme throughout this review has been the importance of correct information being available to all involved so that patterns of behaviour can be discerned and so that the seriousness of a person's offending can be properly assessed.

Professionals should communicate openly and clearly with other agencies but also fact check what they are told by those agencies if there is risk involved. The information held by provider agencies should be reviewed regularly to ensure an appropriate awareness of risk is kept 'live' and not forgotten. Professionals use of language should be objective and leave as little open to interpretation as possible.

While individuals have a right to influence the way services respond to an allegation that they have been abused, Safeguarding enquiries should not be entirely dependent on the agreement of an adult with care and support needs. Public interest and the protection of the wider community should always be a key concern. It should also be considered if a person has been influenced or coerced into refusing such an intervention and/or if they may lack capacity to make such a decision.

Another important lesson to take away from this Review is the importance of listening to those with learning

disabilities and their experiences, when recognising the impact of abuse and taking the consequences seriously in the immediate aftermath of the abuse but also over time; this includes attending to their psychological and sexual health needs as well as to their safety and future protection.

Even in the absence of conviction, comprehensive and robust protective measures should be put in place for individuals who have been harmed and proactive risk management implemented that addresses the safety of potential victims in services and in the wider population. The experiences of the vulnerable adults who disclosed and/or had their abuse witnessed but were then not protected or listened to, are nothing short of shocking in this case. All agencies concerned need to review their practices in the light of the recommendations made in this Review in order to ensure that a case like this is never repeated. Given the time covered in this Review, there have already been significant changes within some agencies but it is vital that all look critically and robustly at their current practices in light of these findings.

The Review panel concluded that there were a number of actions that should now be implemented and delegated these tasks to the agencies responsible. Specific recommendations, need to be considered in more depth by various groups and bodies, and these are also designated. Each agency will complete their own action plan and oversight of the implementation process will stay with the Safeguarding Adults Board until they are confident that changes have been embedded in practice. Some recommendations will be escalated to a national level.

| Topic | Recommendations | Agencies responsible |
|--|---|---|
| <p>1. Supporting people with who have been abused</p> | <p>People who have been sexually abused by a perpetrator who has learning disabilities should be supported on the same basis as any other victim independently of the needs of the person who perpetrated the abuse.</p> <p>This might include being:</p> <ul style="list-style-type: none"> • Moved to a place of safety and assured that the person who harmed them will be removed from their household and any other settings that they use, and that the alleged perpetrator will be kept away from them in future. They should not be expected to live with their abuser. • Referred to appropriate mainstream services, including mental health services within the NHS, for the treatment of any post-traumatic symptoms or recovery programmes specifically designed for survivors of sexual abuse. • Referred to an independent sexual violence advocate and/or to a specialist counselling service where mainstream services are not available or adapted to their needs. • Helped to access compensation from the Criminal Injuries Compensation Fund. • Provided with legal advocacy to assess whether they have a case to bring against any individual or organization that had not taken appropriate actions to mitigate known risk and, in the event that they lack capacity to instruct their own legal counsel, they should be referred to the Official Solicitor who may act for them. <p>A checklist will be developed by Enfield and Hackney Safeguarding Teams to be shared with the Pan London Safeguarding Adults Network, and through ADASS with other regional bodies, to encapsulate these and other aspects of good practice that emerged during this review.</p> | <ul style="list-style-type: none"> • All agencies at a local and national level – this would include local authorities, NHS services and commissioners and criminal justice system agencies such as probation and the Home Office. • Safeguarding Adults Board’s should canvas the services in their area and ensure that there are appropriate resources for people with learning disabilities who have been sexually abused and that these are properly signposted and coordinated. |

| Topic | Recommendations | Agencies responsible |
|--|--|---|
| <p>2. Compiling an accurate record</p> | <p>When a person with learning disabilities or mental health problems is also at risk of offending (especially if they are not taken to court), records should be made, kept and shared on the basis of a proper evaluation of the evidence and a detailed cumulative record should be curated by his or her placing authority. Where there is ambiguity about the veracity of an allegation this should be carefully noted.</p> <p>This is important in order to ensure that any variation or escalation of their behaviour is acted upon in a timely manner. Sexual acts should be described explicitly (in a manner similar to that which the Police use) so that their seriousness is appropriately conveyed and so that there is no chance of misunderstanding or minimising of those acts. Seriousness should not be downplayed in cases where it has not been possible to bring a case to court.</p> <p>Systems to capture this information should be developed so that a complete record of offending behaviour can be easily generated and appropriately shared, (with links to key documents and assessments). A high-level summary and an appropriate risk assessment should be placed at the front of the perpetrator's file (as held by the placing authority and by the provider agency) and referred to explicitly in subsequent documentation. Adult Social Care teams should audit these high-risk cases from their systems on a regular basis.</p> <p>Each agency will review their own information management systems.</p> | <ul style="list-style-type: none"> • Local Authorities – including all care management teams dealing with adults or children. • NHS agencies where they may be the commissioning service and where they are providing a service to an individual. |
| <p>3. Sharing Court Reports</p> | <p>At the conclusion of legal proceedings, reports and assessments commissioned for court proceedings should be formally shared with social care agencies so that placement and other disposal decisions can be appropriately informed. The Funding or Placing Authority would need to request this.</p> <p>Funding Authorities to consider their processes to ensure that this happens.</p> | <ul style="list-style-type: none"> • Local Authorities and other commissioning agencies. • The Crown Prosecution Service. |

| Topic | Recommendations | Agencies responsible |
|---|--|---|
| <p>4. Enhanced care planning and case coordination</p> | <p>NICE guidelines should be followed when placing and when working with a person who challenges, including people who present risk in their sexual lives. These guidelines require responsible agencies to have a detailed behaviour support plan. A designated coordinator should be in place for as long as the person is in receipt of a service.</p> <p>Sexual risk may not be seen as “challenging” behaviour in this context, because it is more sporadic and more easily concealed, but this should not be allowed to lessen vigilance either on behalf of potential victims or in relation to the person’s own wellbeing.</p> <p>Senior managers within Adult Social Care or health commissioning bodies should ensure there is consistent and systematic oversight of all service users known to present a high risk to others. This should be effected through rigorous and assertive quality assurance reviews, risk assessments and care planning and, where appropriate, liaison with probation and other statutory bodies.</p> | <ul style="list-style-type: none"> • Local Authorities. • Clinical Commissioning Groups. |
| <p>5. Anticipating additional needs at point of transition in to Adult Services</p> | <p>A person with learning disabilities, who presents with complex needs in relation to either their physical or mental health, should be the focus of enhanced transition planning when moving from Children and Families’ services to Adult Social Care and Health services – especially when:</p> <ul style="list-style-type: none"> • they have a history of childhood neglect or trauma, • they are leaving the formal care system and/or • they are at risk of sexually offending. <p>Special attention should be paid to ensuring that key information is accessible to those who will work with the individual post-18 – Adult Services workers often do not have access to Children and Families information systems.</p> <p>Governance arrangements should be put in place to ensure that records are kept appropriately and remain traceable when organisations change their functions or cease operating.</p> | <ul style="list-style-type: none"> • Local Authorities including both Adult and Children and Families Social Care teams. • Clinical Commissioning Groups. • Agencies which provide care and support to those with learning disabilities (both those under and over 18-years-old) – particularly but not exclusively in residential settings. |

| Topic | Recommendations | Agencies responsible |
|--|--|--|
| <p>6. Using expert input</p> | <p>Specialist assessments commissioned on behalf of a service user, whether from the NHS (for example psychological or psychiatric evaluation) or from experts in the private and voluntary sector, should be accurately reflected in their subsequent placements and behavioural support and/or care plans. These specialist inputs are paid for from public money and it is expected that providers will adhere to the advice of experts and that this should be explicit in the contract that exists between a placing authority and an independent provider: this contract and the accompanying behavioural support/care plans should then be appropriately monitored on a regular basis.</p> <p>Commissioners should ensure that such advice is clear in the provider agency's documentation and acted upon consistently. If there is any disagreement in the recommended plans as to how to manage specific behaviours and/or risks, these should be raised with the placing authority and any compromise agreed and formally recorded. Failure to adhere to expert guidance outside of such an agreement should be raised as a safeguarding concern.</p> <p>If a local authority has concerns about a provider which is not following specialist recommendations then it has a responsibility to inform the commissioning body (which may mean triggering another process within their own authority, another local authority or a CCG) and also the Care Quality Commission.</p> | <ul style="list-style-type: none"> • Local Authorities. • Clinical Commissioning Groups. • The Care Quality Commission. • All agencies that provide care and support to adults (not only those with learning disabilities – particularly but not exclusively in residential settings). |

| Topic | Recommendations | Agencies responsible |
|--|---|---|
| <p>7. Making safe placements</p> | <p>Placement decisions should be influenced by a person’s history and by recent assessment. Any decision to set aside the recommendations of professionals or expert assessors, for example regarding the safety of others or the nature of a person’s therapeutic needs, should be rigorously scrutinised and the reasoning for choosing one service over another should be formally recorded.</p> <p>Regulators should also take note of the compatibility of service users when inspecting providers to offer assurance that groupings are appropriate and that high-risk individuals are not housed alongside particularly vulnerable individuals without adequate safeguards.</p> <p>Where risk of sexual offending is a factor, placing authorities must satisfy themselves that they are providing the least restrictive environment <i>that is compatible with the safety of others</i>. They must conduct their own risk assessment and monitor the risk assessments completed by the provider to ensure that key professionals have the right information and are working as safely as possible.</p> <p>Where a placing authority and host authority disagree about the safety of a placement, there is currently no formal mechanism by which the host authority can make representations other than the writing of letters. Monitoring individual placements is not within the remit of CQC but issues relating to them may emerge during, or inform routine inspections and regulatory activity. This Review asks that NHS England consider these issues and what may be done to address them.</p> | <ul style="list-style-type: none"> • Local Authorities. • Health services – particularly those specifically dealing with adults with learning disabilities. • The Care Quality Commission. • Clinical Commissioning Groups. • NHS England. |

| Topic | Recommendations | Agencies responsible |
|---|--|--|
| <p>8. Acknowledging risk to others in all assessments</p> | <p>Assessments in complex cases should acknowledge the twin goals of keeping others safe while maintaining the quality of service provided to a person who is at risk of offending.</p> <p>Assessments completed in line with the Care Act (2014) (as well as others) should include a section on whether the person poses a risk to others in the safety section of the review; dates of assessments should be clearly visible on the front page of each assessment and information/documents consulted or included as part of the referral should be listed. Partner agencies should amend their pro formas appropriately.</p> <p>Where risk is highlighted, annual care plan or care program approach meetings should look at risk assessment and risk management within the provider setting to ensure it is adequate.</p> | <ul style="list-style-type: none"> • Local Authorities. • The Care Quality Commission. • Clinical Commissioning Groups. |

| Topic | Recommendations | Agencies responsible |
|---|---|--|
| <p>9. Using formal safeguards</p> | <p>Where a person may need to be constrained for their own protection or that of others:</p> <ul style="list-style-type: none"> • Consideration should be given to whether he or she qualifies for detention under the 1983 Mental Health Act as this affords a careful balance of public protection alongside safeguards for the rights and freedoms of the individual concerned. It is not sufficiently understood that under the 2007 Mental Health Act, a person with a learning disability may be sectioned if it is deemed that they are behaving “abnormally aggressively or seriously irresponsibly”, even when they present without any signs of mental illness. • If the person does not have capacity, a formal application for DoL’s should be made where a person is being chaperoned or supervised in relation to their sexual behaviour. The Court of Protection may also be approached. • Advice should be sought from the police about whether the person can be made the subject of a Sexual Risk Order or to advise on the use of injunctions and other legal instruments to impose limited but necessary restrictions. Wherever practicable, the use of the new Sexual Risk Order, should be considered as a mechanism for supervising a person with learning disabilities who, while not convicted, remains a threat to other vulnerable people or to members of the public; if convicted a Sexual Harm Prevention Order can be imposed. • Other mainstream mechanisms for assessing and managing risk including the MARAC (Multi-agency Risk Assessment Conference) and MAPPA (Multi-agency Public Protection Arrangements) should be accessed where these are appropriate. | <ul style="list-style-type: none"> • Local Authorities. • Mental Health Trusts. • Independent Mental Capacity Advocates and Independent Mental Health Advocates – who may be commissioned from a variety of organisations. • Domestic Abuse organisations. |

| Topic | Recommendations | Agencies responsible |
|---|--|--|
| <p>10. Sharing and receiving information</p> | <p>When forensic assessments and/or when psychological or psychiatric reviews are commissioned, either through a solicitor or through NHS routes, it is important that clinicians and others are given a complete record of the person's previous offending/challenging behaviour.</p> <p>Care managers working with individuals who have a propensity to sexually offend, should ensure that they have a complete and cumulative record of all assessments that can be shared.</p> <p>The Clinical Commissioning Groups (perhaps through the GP) should also hold an up to date summary of NHS referrals and assessments, including psychological or psychiatric evaluations, and to ensure appropriate information is shared with clinicians who are being asked to provide further assessment or treatment.</p> | <ul style="list-style-type: none"> • NHS England. • Clinical Commissioning Groups. • GPs. • Local Authorities. |
| <p>11. Creating a positive sexual culture in services</p> | <p>Resources should be identified locally that support service providers to assist people with learning disabilities to develop a strong and positive sense of their own sexuality. This could be through appropriate sex education, counselling, facilitated access to mainstream sexual health services and advocacy.</p> <p>Where an adult with care and support needs is known to have a history of sexual offences then all providers working with them (including education and day services) should be aware of this and have risk assessments in place. When an adult with this history is believed to be engaging in sexual behaviour or a relationship with another adult who may be vulnerable then this needs to be considered in light of the history and with consideration of the capacity of all concerned.</p> <p>All providers should have a robust policy and guidelines for staff regarding sexuality and relationships that set out the rights of service users but also the limits to their sexual expression and the importance of assessing capacity to consent. Their practice should reflect positive values while maintaining the safety of anyone at risk.</p> | <ul style="list-style-type: none"> • Local Authorities. • Leaving Care and Disabled Children's teams. • Integrated Learning Disabilities Services. • The Care Quality Commission. • Clinical Commissioning Groups. • All service providers (including education and day services). |

| Topic | Recommendations | Agencies responsible |
|---|--|--|
| <p>12. Making risk management plans specific</p> | <p>Risk management plans for people with learning disabilities who are at risk of offending should be specific about 1:1 supervision and clarify that this requires a staff person to “have eyes” on an individual known to present a risk to themselves or others, at all times. Any exceptions should be spelt out and properly justified.</p> <p>Staff should be properly briefed about the exact nature of the risks and about what they should be doing to prevent harm. Where these arrangements represent a Deprivation of Liberties to which the person cannot voluntarily consent, appropriate authorisation should be sought.</p> <p>Where an additional premium (for example for 1:1 supervision at all times) has been attached to the fee paid to a residential home, supported living or domiciliary care package to mitigate risk, placing authorities should hold regular reviews to ensure that these arrangements remain in place and that any additional services that are being paid for are being consistently delivered. Regulators should have oversight of care plans and risk management strategies and specifically enquire into the management of any individuals who pose a risk of sexual or violent offending.</p> | <ul style="list-style-type: none"> • Local Authorities. • The Care Quality Commission. • Clinical Commissioning Groups. |
| <p>13. Accessing health care including routine and crisis led psychological and psychiatric evaluations</p> | <p>Residential home providers are responsible for accessing primary health care for those in receipt of their services.</p> <p>Secondary and specialist health providers should be identified through the primary care team including how to access routine, or crisis led psychological and psychiatric assessment. Placing Authorities should therefore be assuring that they are communicating with primary health care as part of their care co-ordination role.</p> <p>Organisations serving people with learning disabilities should have an accurate and up-to-date view of the nature and extent of a person’s cognitive impairments and, in the event of their being at risk of offending, of their offending profile.</p> | <ul style="list-style-type: none"> • Residential, secondary and specialist health provider agencies. • GP’s. • Local Authorities. • Clinical Commissioning Groups. |
| <p>14. Including sexual offending in NHS records</p> | <p>NHS England should remind all GP’s that they are responsible for commissioning detailed psycho-sexual evaluations to inform them about the type of victims who are at risk and the types of offences likely to be committed.</p> | <ul style="list-style-type: none"> • Clinical Commissioning Groups. • NHS services. |

| Topic | Recommendations | Agencies responsible |
|--|--|--|
| <p>15. Handing over care when a person with learning disabilities moves into another NHS or Local Authority area</p> | <p>When placing in another area, it is good practice to transfer key information about service users to the host authority. This very rarely takes place at present. This is particularly important where the person poses a risk to others. A standard of what information should be passed on and in what format should be agreed nationally through the Association of Directors of Adult Social Services and NHS England.</p> <p>GPs must be kept informed and involved in discussions around health needs and risk where they are responsible for the patient, including in cases that have forensic implications.</p> | <ul style="list-style-type: none"> • Local Authorities. • Clinical Commissioning Groups. • Provider agencies. • NHS England. |
| <p>16. Addressing risk if court proceedings are halted</p> | <p>Where a person with learning disabilities is charged with a sexual offence which does not result in a conviction but it is considered by a panel of professionals that “on the balance of probabilities” they did commit the offence as alleged, their acquittal should trigger a risk assessment meeting convened by their placing local authority and this meeting should produce a revised and robust risk management plan (with a schedule to review and update this).</p> <p>In terms of current Safeguarding Adults practice, this would fit within the closing meetings within that process.</p> | <ul style="list-style-type: none"> • Local Authorities. • Police. • Provider agencies. |
| <p>17. Safeguarding records in cases where both victim and perpetrator are persons with care and support needs</p> | <p>Safeguarding Adults Boards should review their guidance for safeguarding professionals on how to make enquiries, support victims and record information in those cases where abuse has been perpetrated by another person with care and support need.</p> <p>Two sets of records should be kept and updated, one for the person who has been harmed (where they are an adult in need of care and support) and another for the person who is alleged to be responsible for the harm. An accurate record of the reported perpetrator’s actions should become part of the formal cumulative record (held by the designated coordinator working within the placing authority in every case) and this information should be managed to enable a summary record to be generated.</p> <p>This should set out how risks have been managed, monitored and reviewed and identify what worked and what safeguards need to be strengthened.</p> | <ul style="list-style-type: none"> • Safeguarding Adults Boards. • Local Authorities. |

| Topic | Recommendations | Agencies responsible |
|--|--|---|
| <p>18. Carefully evaluating provider's claims to special expertise</p> | <p>Where a provider asserts that they are able to provide placements to persons who pose a risk to others and/or who have complex needs, the placing authority should satisfy themselves that the provider has a suitably skilled staff team in place and mechanisms to support and maintain their staff through steady recruitment and continuous professional development. Where gaps open up in the staff team or in their expertise, the provider should buy in skilled clinical supervision and advice to ensure that they can continue to deliver on their contracts. Placing authorities are often paying a premium for these services and must be sure that the person is getting the service they are paying for. CQC will monitor this as part of their regulatory function.</p> <p>Where commissioners have to place outside of their own local area, they should seek out the views that local services have of a provider especially in terms of the way this provider has handled safeguarding concerns.</p> | <ul style="list-style-type: none"> • The Care Quality Commission. • Local Authorities. • Clinical Commissioning Groups. • Voluntary organisations and private providers as well as local authority and health run services. |
| <p>19. Evaluating different settings managed by the same provider</p> | <p>Where there are concerns about management oversight of particular services, the Care Quality Commission should be proactive in making connections with other settings managed by the same provider in order to satisfy themselves that these failings are specific to one setting and not occurring across the whole organisation.</p> | <ul style="list-style-type: none"> • The Care Quality Commission. |

| Topic | Recommendations | Agencies responsible |
|--|--|--|
| <p>20. Identifying gaps in health care provision</p> | <p>NHS England and Clinical Commissioning Groups should work with Adult Social Care teams to identify areas of specialist health care provision that are currently difficult to commission or provide. This may include counselling for people at risk of sexually offending, or who are experiencing difficulties because they have been the victim of sexual assault or are survivors of childhood sexual abuse.</p> <p>A number of agencies should be involved in shaping these services taking the primary role in relation to tasks that match their expertise and remit. They should recognise that people with learning disabilities, including those who commit offences, are entitled to receive a forensic mental health assessment in the same way as any other NHS patient, and to attend an appropriately focused offender program in the same way as any other citizen at risk of committing a sexual offence.</p> <p>If a key responsibility cannot be clearly assigned either across commissioning agencies or across geographical boundaries, the matter should be escalated to a Pan London body and/ or to NHS England so that a decision can be made without undue delay.</p> <p>Where there is a high degree of risk these matters must be expedited.</p> | <ul style="list-style-type: none"> • Clinical Commissioning Groups. • Local Authorities. • NHS England. |

Appendix 1. Summary Chronology for P

| Year | |
|------|--|
| 1998 | P was taken into the care of Hackney Local Authority due to concerns about neglect and sexual abuse within the family and from other adults. It is identified that he has a learning disability. |
| 2004 | In preparation for his transition into Adult Services, P is assessed by Respond (who specialise in therapy for adults with learning disabilities who have been victims of, or may perpetrate, sexual abuse) and has an assessment stay at a specialist provider. |
| 2005 | P is moved to live in a residential home for adults with learning disabilities run by Hillgreen Care Ltd. The home is within the Haringey area but he is funded by Hackney Local Authority. |
| 2006 | P is alleged to have digitally penetrated a fellow resident at the residential home (Victim 1). He is temporarily moved out but moves back in when Police are unable to progress the investigation. |
| 2008 | P is alleged to have raped another student (Victim 2) at his college. Investigations by the Police show there had been an unreported incident the previous year where he removed items of her clothing but was stopped. |
| 2009 | P is charged with the rape of Victim 2. His bail conditions mean he can no longer live with X so he is moved in an emergency to another Hillgreen Care Ltd home in the Enfield area (but still funded by the Hackney Local Authority). |
| 2010 | <p>The Prosecution in the case of the rape of Victim 2 do not present any evidence. The Judge states that P is a danger to young women and that he needs careful management.</p> <p>The London Borough of Haringey hold a final Safeguarding Adults meeting in order to end their involvement (as P no longer lives in their area). They invite a representative from the Enfield Integrated Learning Disabilities Service as P lives in that area now – thus informing them of P's placement.</p> |
| 2011 | P begins therapy with Respond. |
| 2013 | <p>Whilst studying in Islington, P is found with another student in the process of taking their clothes off – this was treated as an isolated incident and reported to Islington Local authority. This person is referred to as Victim 3.</p> <p>A Safeguarding Concern was looked into (by Enfield Local Authority) where another vulnerable adult (who described P as her boyfriend) alleged that P was pressuring her into sex and to give her money. She then stated that the relationship was over and that she did not want an investigation to progress – however, the context of P's previous behaviours was not taken into account. This woman is referred to as Victim 4.</p> <p>Therapy with Respond ended.</p> |
| 2014 | <p>Late in 2014, P assaulted a 14-year-old girl in school uniform (Victim 5) on a bus whilst supervised by a Hillgreen Care Ltd member of staff. He was convicted of this crime in 2016.</p> <p>During this period he is having a psychological assessment by the Enfield Integrated Learning Disabilities Service and the psychologist raises concerns about the attitude and training of Hillgreen Care Ltd staff and recommends specialist input from Respond again and a Forensic risk assessment.</p> |

| Year | |
|-------------|---|
| 2015 | <p>Assessment of P by the North London Forensic Service – the resulting report includes information about him assaulting Victim 6 but this is not reported either to the Police or Host Authority.</p> <p>P began another period of therapy with Respond between May 2015 and November 2015.</p> <p>A member of Hillgreen Care Ltd staff reports walking in on what appears to be P and Victim 7 engaged in a sexual act. Victim 7 would not have capacity to consent to any such act and so it is reported to the Police, as a rape, after a delay of some days.</p> <p>P moves from the Enfield area to a more specialist provider in the Hackney area.</p> |

This report is designed by Enfield Council Design & Print Service. Please call 020 8379 5283 for information on how they can help you with your design and print requirements.

**Strategic Safeguarding Adults Service
Health, Housing and Adult Social Care**

March 2018

