

GLOUCESTERSHIRE SAFEGUARDING ADULTS BOARD



Sexual and Financial Abuse within Supported Living Home X

Adult Case Review

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1.0 Introduction

1.1 This Adult Case Review was commissioned by Gloucestershire Safeguarding Adults Board following the imprisonment of Adult A on 20th March 2014 for the rapes of Adults K, J and M. Adults K, J and M are women with a learning disability who were residents at Supported Living Home X. At the time of the offences, Adult A was employed as a care assistant at the same Supported Living Home.

1.2 Adult A was sentenced to 14 years imprisonment and a further 6 years on licence. He was placed on the Sex Offenders Register for life.

1.3 On 25th April 2014, Adult B was imprisoned for 8 months for offences of fraud by abuse of position of trust against Adults L, J and N. Adults L and J are women with a learning disability who were residents at Supported Living Home X. The other victim, Adult N is a man with a learning disability who also resided in Supported Living Home X. The offender Adult B was the manager of Supported Living Home X and is married to the offender Adult A.

1.4 An earlier allegation of a sexual nature was made against Adult A whilst he was working as a care assistant at Supported Living Home X. The allegation was made in 2007 by Adult P who is a woman with a physical disability and a learning disability who was a resident in Supported Living Home X at the time. The allegation was investigated by the police and referred to the Crown Prosecution Service which decided that there was insufficient evidence to authorise the charging of Adult A. Adult A – who had been suspended following the making of the allegation – was reinstated and allowed to continue working as a care assistant at Supported Living Home X. His wife Adult B was the manager of Supported Living Home X at that time also.

1.5 During the course of the Adult Case Review, details emerged of an even earlier allegation of a sexual nature against Adult A. The allegation was made by Adult Z97 in 1997 whilst she was a resident in Supported Lodgings Home S. Adult B was

employed as the housekeeper at the premises. Adult A appears to have fulfilled an undefined support role at the premises. The allegation was investigated by the police who decided that there was insufficient evidence to consider referring the matter to the Crown Prosecution Service.

1.6 Gloucestershire Safeguarding Adults Board wishes to apologise on behalf of the agencies in Gloucestershire for any failings when responding to the allegations in 1997 and 2007. If these allegations had been handled more effectively, the rapes that Adult A went on to commit against residents in Supported Living Home X in 2013 could have been prevented.

1.7 Gloucestershire Safeguarding Adults Board also wishes to apologise on behalf of the agencies in Gloucestershire for any failings when responding to potential indicators of financial abuse in Supported Living Home X. If these indicators had been handled more effectively, the financial abuse that Adult B committed against residents in Supported Living Home X could have been prevented.

2.0 Terms of Reference

Gloucestershire Safeguarding Adults Board approved the following terms of reference for this Adult Case Review:

General (Gloucestershire Safeguarding Adults Board Adult Case Review Protocol 2014):

- 1.1 To establish whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and agencies work together to safeguard adults at risk
- 1.2 To review the effectiveness of procedures (both multi-agency and those of individual organisations)
- 1.3 To inform and improve local inter-agency practice
- 1.4 To improve practice by acting on learning (developing best practice)
- 1.5 To prepare or commission a summary report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action

Specific:

- 1.6 To examine how the allegation made against the perpetrator of sexual abuse in 1997 was handled, and whether the policies and procedures in place at that time were followed.

- 1.7 To examine how the allegation made against the perpetrator of sexual abuse in 2007 was handled, and whether the policies and procedures in place at that time were followed.
- 1.8 To consider whether all opportunities to prevent further offending by the perpetrator were taken as a result of the 2007 allegation.
- 1.9 To review the effectiveness of the commissioning, monitoring and inspection of the services provided at the premises where the victims were sexually assaulted and/or financially abused.
- 1.10 To examine how effectively any other concerns, allegations or alerts in respect of the perpetrators were dealt with, prior to, or after the 2007 allegation.
- 1.11 To examine the quality of the joint investigation which resulted in the conviction of both perpetrators in order to establish areas of improvement and good practice.
- 1.12 To review how the victims and their families were supported following the making of the allegations which resulted in the conviction of the perpetrators.
- 1.13 To consider whether there are any diversity issues arising from this case.

During the course of the review, terms of reference 1.6 was added once details of the 1997 allegation fully emerged.

3.1 Synopsis

The 1997 allegation against Adult A

3.2 During the course of the adult case review a further allegation against Adult A came to light. The allegation was referred to in a statement provided to police by Adult B as part of the 2013 investigation into the rapes committed by Adult A. The 1997 allegation was not used in evidence against Adult A in his trial in 2014 but was referred to by the prosecution barrister during the trial.

3.3 The 1997 allegation was first brought to the attention of the adult case review by the mother of Adult K and the terms of reference for the review were amended to include reference to the 1997 allegation.

3.4 In 1997 the victim Z97 was being supported by Mental Health Recovery Services. She moved to “supported lodgings” at Home S in November 1995, initially on a respite basis which later became permanent. “Supported lodging” was a form of lower intensity support frequently used at that time. It was provided by private landlords who used to contract directly with Gloucestershire County Council. The landlord would provide both accommodation and housing related support to service users. Additionally, it is likely that the landlord would have managed service users’ money for them if they required that type of support. Home S was a 9 bedded shared house in which people would have had individual bedrooms but shared communal areas.

3.5 At some point prior to making the allegation against Adult A, Adult Z97 appears to have become unsettled at Home S as a result of a change of staffing. This change of staffing is believed to relate to the arrival of Adult B as Housekeeper and Adult A in an undefined support role.

3.6 The 2gether NHS Foundation Trust and Learning Disability Individual Management Reports (IMR) reveal that Adult Z97 made an allegation of sexual

assault to her community nurse whilst attending Day Hospital T on Tuesday 1st April 1997. She became very distressed whilst making the allegation in which she said she had been running a bath and “larking about” with Adult A when he exposed himself to her and touched her breasts. She said he told her that she should not tell anyone.

3.7 It is not entirely clear when the alleged incident took place. Health records suggest the weekend immediately before which would be either Saturday 29th or Sunday 30th March 1997. Police records state the incident took place at 6pm on Monday 31st March 1997. However the weekend prior to 1st April 1997 was Easter weekend so it seems possible that Easter Monday could have been interpreted as part of the holiday weekend.

3.8 There was some form of preliminary investigation involving a Social Worker and a Housing Officer followed by a further conversation with Adult Z97 who was adamant that she wished to pursue her allegation. She subsequently made a detailed statement to the police over a period of two hours.

3.9 The allegation was recorded on the Police Marconi legacy crime database (which was subsequently replaced by the force in 1998) as follows: “Injured Party is resident in supported lodgings overseen by social services. She alleges that she was approached by a care worker at the home who indecently assaulted her. He allegedly exposed his flaccid penis to her then grabbed her breasts whilst she was running a bath”.

3.10 No information is recorded about the police investigation other than that the crime was finalised as a “no crime” and the final Police database entry made on 9th April 1997 states: “suspect interviewed – file to file authoriser. Record as no crime. Did not happen”. It is assumed that Adult A denied the allegation.

3.11 The Police IMR states that a finding of ‘no crime – did not happen’ suggests that there was some form of evidence which contradicted the original allegation by Adult Z97. The officers involved in the 1997 allegation - who have all retired – have

been interviewed and cannot recall the incident. Additionally, searches of archived records have revealed nothing further. A member of staff involved in police crime recording policy at the time has advised the Police IMR author that it was not common practice to add comments such as "did not happen" to crime records. However the member of staff expressed the opinion that the officer would not have added the comments had he not had good reason to do so. Additionally it has not been possible to obtain a copy of the crime recording policy to establish what circumstances might justify a "no crime" finding at that time.

3.12 Neither the 2gether NHS Foundation Trust IMR author nor the Learning Disability IMR author have been able to find any further direct information concerning the allegation or the investigation which followed. However records reveal comments attributed to Adult B to the effect that Adult Z97 should not visit Home S for the time being and should make an apology which could be in writing to Adult B. It is apparent from the records that Adult Z97 had told Adult B about the allegation against Adult A at some stage. The IMRs also reveal that Adult Z97 was fearful that Adult A and B would take civil action against her. There is no evidence of any civil action.

3.13 After staying temporarily with her mother in the immediate aftermath of making her allegation, an alternative placement was arranged for Adult Z97. However a core assessment on Adult Z97 completed in 2003 omitted any reference to the allegation when setting out why she had left Home S in 1997, stating that she "became unsettled by a change in the staff employed there and took advantage of the creation of a new supported lodging coming on stream and moved."

3.14 Apart from Adult Z97's departure from Home S, there is no evidence of any other outcomes of the allegation other than mention in correspondence of Adults A and B being offered training "which will be supportive in keeping them and the resident's safe." It is not known whether training was delivered nor what it consisted of. (The fact that Adult A was to be offered training suggests that he may have occupied a formal capacity at Home S).

3.15 Beyond reporting the matter to the police, there is no evidence of any request for the proprietors of Home S to investigate the allegations against Adult A, nor is there any evidence that action to safeguard other individuals living or visiting Home S for respite was considered or initiated by any agency.

3.16 It is unclear precisely what action should have followed the allegation by Adult Z97. In 1991 the Adults at Risk Unit was established within Gloucestershire County Council Social Services Department and the post of Assistant Principal Officer created to lead the unit. In the same year the "Adults at Risk: Procedural Guidance for Professionals" was published. This local multi-agency guidance was in place in 1997 but it has not been possible to find a copy to inform this review nor has it been possible to describe the policy environment by interviewing relevant staff from that period.

The 2007 allegation against Adult A

3.17 In 2007 Home X had been a Supported Living Home since 2004. The Home was owned by the Providers who supported up to eight people with a learning disability. The Provider was the landlord and the service users were tenants. Supported Living is intended to give service users greater independence, choice and control over their own lives. In 'true' supported living, service users have their own tenancies and are able to choose where they live, who they live with and who supports them. People in Supported Living are able to access benefits and therefore have choices about how they live their daily lives which are denied to them in residential care. Local Authorities are measured nationally by performance indicators which capture how many people they have in Supported Living. The placements delivered by the Provider were commissioned by the Learning Disability Commissioning team and by the Physical Disability (Adults) commissioning team at Gloucestershire County Council. (GCC)

3.18 The Provider was a company which consisted of a married couple and their son. To distinguish between them in this report, they will be referred to as Provider (female), Provider (male) and Provider (son).

3.19 in 2007 Adult B was employed by the Providers as the manager of Supported Living Home X and her husband Adult A was employed by them as a care assistant. Adult A and B lived together in Supported Living Home X.

3.20 On Tuesday 17th April 2007 the father of Adult P contacted the police to allege that his daughter had been sexually abused by Adult A on the Thursday of the previous week (12th April 2007) and had disclosed the abuse whilst with him at his house. Adult P had a learning disability and a physical disability but her care was commissioned by GCC Physical Disability services.

3.21 The incident was allocated to Detective Constable 1 to investigate. He established that Adult P alleged that whilst Adult A was alone at Supported Living Home X with her and Adult L, (who was another female service user who resided there) he had called them upstairs to do some cleaning. When Adult P went upstairs he exposed his penis to her and allegedly said "Come on then, touch it, you know you want to." Adult P told him to put it away but Adult A continued to expose his penis. Adult P then went into her room and was followed by Adult A, who still had his penis exposed. At that point Adult A is alleged to have said, "Don't you dare tell Adult B as I was only playing with you."

3.22 Detective Constable 1 later rang the Provider (male) to ensure that Adult A was no longer at work in Supported Living Home X. It would appear that Adult A had already been suspended by this time. The Provider's (male) recollection is that the father of Adult P had also telephoned him to advise him of his daughter's allegation. The Provider (male) says that following the call from Adult P's father, he consulted the then Deputy Manager of the GCC Learning Disabilities Team who advised him to suspend Adult A and contact the police. The then Deputy Manager of the GCC

Learning Disabilities Team has no recollection of receiving this telephone call and there is no record on the GCC "ERIC" database to confirm this call. However it seems reasonable to assume that the Provider sought advice from GCC on this issue. Detective Constable 1's conversation with the Provider (male) also established that Adult A would not be allowed to continue to reside at Supported Living Home X whilst the investigation took place.

3.23 Detective Constable 1 also made a telephone call to Adult P's father and established that she was safe at his address, and a further call to Supported Living Home X to check on the welfare of Adult L and make arrangements to conduct a video interview with her at Supported Living Home X the following day as she had been behind Adult P on the stairs when Adult A initially exposed his penis.

3.24 As he embarked on this investigation, Detective Constable 1 had no knowledge of the 1997 allegation against Adult A. The details of the 1997 allegation were retained on the Police Marconi crime database which had been replaced by the new Unity crime recording database in 1998. The details of the 1997 allegation had not been transferred to the new crime recording database. It has been established that only a limited back record conversion of ongoing crimes from the old system to the new system took place. The bulk back record conversion proposed when the Force adopted the new Unity system in 1998 was never completed due to the Force terminating its agreement to do so with the system supplier, and failing to address the issue subsequently. The Marconi legacy database was retained by the Force and later made available from the Force intranet from where it could be accessed by all staff. However it is understood that in reality it was used by a relatively small number of users. It has not been possible to establish whether the Force expected officers to search the Marconi legacy database when investigating crime. However, it seems reasonable to assume that by 2007, officers may not have been in the habit of searching the Marconi legacy database which by that time had not been operational for nearly a decade. The Police IMR author states that officers who joined the force after Marconi had been replaced were not routinely made aware of its existence.

3.25 The following day – Wednesday 18th April 2007 – Detective Constable 1 carried out a video interview with Adult L at Supported Living Home X in the presence of Adult L's sister and care worker. Adult L was unable to corroborate Adult P's allegation and made no allegations of a similar nature against Adult A.

3.26 Following the video interview, Detective Constable 1 had a conversation with a Care Worker 1 at Supported Living Home X who advised the officer that Adult P had previously admitted to lying about incidents involving money at Supported Living Home X. No further details of this conversation are available and it appears that no statement was taken from the care worker.

3.27 Later the same day Detective Constable 1 interviewed Adult P at her father's home and in his presence.

3.28 Following the interview with Adult P, Detective Constable 1 arrested Adult A for an offence of "care worker inciting sexual activity with a mentally disordered person" which is contrary to section 30 of the Sexual Offences Act 2003. When interviewed, Adult A denied the offence and stated that he had been alone with the two women in Supported Living Home X for 20 minutes at most. Following the interview, he was given police bail whilst further enquiries were carried out.

3.29 Detective Constable 1 later took a statement from Adult B in relation to her whereabouts at the time the alleged sexual offence took place. The statement cast doubt on the account and timings provided by Adult P. There appears to have been no doubt that Adult B had been away from Supported Living Home X transporting service users to a day centre at the time the alleged incident took place. However, Adult P had also alleged that Adult B had been away for much of the day which Adult B's statement contradicted. Detective Constable 1 warned Adult B of the consequences of providing a false statement and subsequently sought and obtained corroboration of her account from the Provider (male), suggesting the officer was well aware of the potential conflicts of interest arising from Adult B being the

manager of her husband Adult A. During her interview with Detective Constable 1, Adult B did not disclose her knowledge of the 1997 allegation.

3.30 On 28th April 2007 the evidence collected during the course of the investigation was submitted to the Crown Prosecution Service. The Prosecutor (CPS 1) viewed the evidence on 19th June and concluded that there was insufficient evidence to proceed to charge. CPS1 applied the Code for Crown Prosecutors which set out the "full code test" which must be met in order to justify a charging decision. The test was not met in this case because CPS 1 concluded that there was no realistic prospect of conviction. In reaching this decision CPS 1 took account of information which included the following:

- Adult P did not report the incident straight away to Adult B, saying that Adult B had left the building and was at a meeting all day.
- Police enquiries appeared to establish that Adult B was not at a meeting all day.
- There were issues over the truthfulness of Adult P
- Adult L was said to be present and did not see Adult A "do anything wrong."
- Adult L was described as having "severe learning difficulties" and so leading questions had had to be asked in order to elicit her account.
- Adult L was described by Care Worker 2 as honest.

CPS1 added that if further complaints came to light the investigation should be revisited.

3.31 Adult P's father had made a referral to the Community and Adult Care Directorate of Gloucestershire County Council on Wednesday 18th April 2007 - the day after he first reported the matter to the police. He had moved his daughter out of Supported Living Home X to stay with him following her allegation but this was an unsustainable arrangement in the longer term because his health issues precluded him from being his daughter's primary carer. In the referral he said he needed some support and was unsure what to do about Adult P. At that stage he indicated that she wished to return to Supported Living Home X as she liked it there.

3.32 The referral was promptly followed up by the Adult Services Team Manager in Stroud and Dursley who focused exclusively on accommodation options for Adult P. Eventually an alternative local placement with a different Provider was secured for her.

3.33 There is no record of any safeguarding alert being made by any of the agencies with knowledge of Adult P's allegation. The policy in place at the time was the Procedural Guide for Professionals (Adults at Risk). The definition of abuse in the policy explicitly includes sexual abuse. The policy sets out the criteria for adults to be considered "at risk", which would have encompassed the service users at Supported Living Home X following the allegation against Adult A. The policy anticipates an investigation (in addition to any criminal investigation) would have taken place. From the records available it would appear that the policy was not followed in this case.

3.34 Additionally the policy states that the case should have been put under "regular review" by the local social work team, meaning that all service users at Supported Living Home X would have been reviewed in 2007 with subsequent close monitoring of them. There is no record of this action taking place.

3.35 The Provider was contractually obliged to carry out an investigation which should have examined the actions of Adult A from a broader perspective than the criminal investigation. The Provider should have kept the commissioner of the service (GCC) informed of the progress and outcome of the investigation.

3.36 The Providers say that an investigation was carried out by the Provider (female). However they have been unable to furnish a copy of the investigation report. The Provider (female) says that her investigation involved speaking to Adult P, her father and Adult A. When asked about the outcome of the investigation, she replied that "we didn't change anything." When asked if any advice was given to Adult A, she then said, "we spoke to him but I have no recollection of what we said." The Provider (female) confirmed that the investigation resulted in no recommendations and no actions. The Provider said that the outcome of the investigation was not shared with the commissioner nor did the commissioner ask for it. GCC Learning Disability Commissioning has no record of any investigation carried out by the Provider.

3.37 The Provider was legally required to notify the regulator of the allegation against Adult A within 24 hours of becoming aware of it. The Provider (male) states that a prompt notification to the regulator – at that time the Commission for Social Care Inspectorate (CSCI) - was made by telephone but, as with the investigation report, has been unable to furnish a record of the notification nor can he recall who he spoke to. The regulator has no record of any notification from the Provider of the allegation against Adult A. Nor has the regulator any record of being notified of the allegation from any other agency or person.

3.38 Adult P's new placement took several months to finalise due to Adult P wanting the support of one particular Provider who first had no vacancies and with whom it then took time to sort out financial arrangements. On 27th June 2007 David Drew MP (for Stroud) wrote a letter on behalf of Adult P's father to the then Group Director for Community and Adult Care. His letter highlighted the distress caused to Adult P by the incident in which Adult A allegedly exposed himself to her, and drew attention to the difficulties arising from Adult P now living with her father. The MP went on to request support for Adult P and her father. He questioned the suitability of Adult P living with her father given her needs and her father's health problems. Mr. Drew also noted in the letter that the marital relationships between husband (Adult A) and wife (Adult B) prevented Adult P from returning to Home X, even if the husband was no longer to work there, because of the difficulty of having made an allegation against the husband of the manager. (Whilst Mr. Drew didn't specifically express concern that they are husband and wife – he did draw attention to a repercussion of this).

3.39 It is believed that the letter from Mr. Drew received a reply. A draft of the response likely to have been sent to him has been located. The draft set out the actions taken by GCC to arrange day care for Adult P and to seek an alternative placement for her away from Supported Living Home X. The draft letter confirmed the outcome of the criminal investigation but did not say whether GCC intended to carry out, or had carried out, its own investigation, nor did it address Mr. Drew's concerns about the management arrangements at Supported Living Home X.

3.40 No evidence remains to suggest that the letter from the MP, or the preparation of the draft response prompted any further action.

3.41 Adult P's allegation against Adult A was referred to in detail in the documentation completed during the course of the process of securing a new placement, but by the time a care plan was completed for a trial stay at the home in which she was to be placed in January 2008 there was little reference to the nature of the allegation and no information about the impact of this in terms of support and safeguarding of her, other than that she should not be supported by men. There is no evidence in the documentation that Adult P's experience was discussed with the new Provider in sufficient detail as a result. After October 2007 there is no further reference to Adult P's allegation on the GCC database.

3.42 There is no record of Adult P repeating the allegation against Adult A or of making any further disclosures in respect of herself or other service users in Supported Living Home X, but the author of the Learning Disabilities IMR suggests that there is a chance that had Adult P made further disclosures in a more subtle way, these may not have been picked up because of the staff supporting Adult P not being fully aware of the sexual nature of her previous disclosure.

The allegations made against Adult A in 2013

3.43 On Saturday 13th April 2013, Adult M made a disclosure to Care Worker 3 at Supported Living Home X. After bursting into tears she said, "Adult A keeps coming in to my room at night. He puts his stick up me." She then pointed to her vagina and indicated that this had last happened on the night of 11th April. She repeated her disclosure several times, each time pointing to her vagina. Care Workers 4 and 5 also heard Adult M's disclosure. The Care Workers considered this to be very unusual behaviour by Adult M. Care Worker 3 said she had never heard Adult M refer to anything of a sexual nature or point to her vagina prior to this disclosure.

3.44 The Care Workers contacted the Providers and Provider (son) and Provider (female) visited Supported Living Home X. The Provider (son) telephoned GCC

Emergency Duty Team at 3.59pm that day and spoke to Senior Social Worker 1. He informed her that Adult M alleged that a male member of staff had "poked his willy at her". He added that the member of staff had been suspended and that Adult M appeared "happy" and that only female staff would be with her. It was agreed that the Provider would contact the social worker allocated to Adult M on Monday. At this stage no further action was taken by the EDT and no contact was made with the police.

3.45 Feeling dissatisfied with the response of the Providers to the disclosure made by Adult M, Care Worker 3 reported this matter to the police at 4.30pm the same afternoon. Care Worker 3 has contributed to this review. She had been employed by the Providers for four years and had formed the view that they had not handled previous concerns about the behaviour of Adult A and Adult B professionally. However on this occasion she felt they were certain to deal with such a serious matter appropriately. Care Worker 3 stated she was really upset that they didn't ring the police and felt that Provider (female) was trying to undermine the disclosure. She states she heard her say "what if she is lying." Following the report from Care Worker 3, Police control room staff speedily linked the report to the 2007 allegation and notified the senior officer on duty. At 5.45pm Detective Constables 2 and 3 were sent to Supported Living Home X to engage with Adult M and obtain more information about the allegation.

3.46 The Police also contacted the EDT who advised them that they had already been notified of the allegation by the Provider of Supported Living Home X. The EDT advised that Adult A had been suspended and that only female carers would provide night cover - after further clarifying this with the Provider (son). When Senior Social Worker 1 re-contacted the Provider (son), he confirmed that only female staff would be on duty at Supported Living Home X that night. He added that he was arranging for an independent female worker to take Adult M out for a coffee the next day as he would like an "independent view" of the situation. The EDT did not advise him against this course of action.

3.47 The police decided not to subject Adult M to medical examination that evening and disrupt her care routine. Arrangements were made for her to be medically examined at the Sexual Assault Referral Centre (SARC) the following day when her support worker would also be available.

3.48 At 9pm that evening Adult A was arrested at his home address on suspicion of rape. The police found that both Adult A and Adult B had previously been made aware of the allegation by the Provider (son). The police were critical of this action by the Provider on the grounds that it had the potential to frustrate the criminal investigation.

3.49 When Adult M was seen at the SARC the following day (Sunday 14th April 2013) she made further disclosures which implied that she had been regularly raped by Adult A and that the most recent rape had taken place within the forensic window. As a result Adult M was forensically examined. In her video interview she provided further details, saying that he would come into her room, slam the door, wake her up, shout at her and then keep lying on top of her whilst naked. She said that it had happened lots of times. Although she did not have the words for vagina and penis, she was able to confirm that penetration had taken place. She said that she became upset when Adult A entered her room and told him to go away but he didn't. She became visibly upset during the video interview. Subsequent forensic examination of Adult M's bed sheets and mattress found the presence of Adult A's semen on both sheets and mattress.

3.50 That day Adult A was interviewed whilst in police custody and denied the offences saying that he had a good relationship with Adult M who would always ask when he was on duty at Supported Living Home X because she and Adult L liked to see him. He was later granted police bail.

3.51 The following day (Monday 15th April 2013), Adult K was asked by a social worker who knew her well whether anyone had held or touched her. Adult K is unable to communicate verbally but uses Makaton sign language and an electronic

communication aid. Adult K used the communication aid and pressed a pre-set button which indicated Adult A. When asked to show where she had been touched she opened her legs and pointed to her vagina. She also used her Makaton sign for "bad". She was able to sign to say that it had happened whilst she was sleeping at night.

3.52 Adult K's disclosure was reported to the police the same day and an initial interview took place in which she repeated her disclosure by pointing to her vagina and pressing the "Adult A" button on her communication aid. However the electronic communication aid had insufficient words pre-programmed into it to facilitate a more complete interview and so the police decided to approach an intermediary to assist. A second interview with Adult K took place in August 2013. With the assistance of an intermediary who used Makaton, picture symbols and her updated electronic communications aid, she was able to disclose that she had been raped by Adult A on one occasion. Adult K had to leave the interview to be physically sick on several occasions.

3.53 On Monday 15th April 2013 EDT informed the GCC Learning Disabilities Commissioner of Adult M's disclosure and the response to it. Learning Disability Operations Team took steps to gather relevant information about Adult M and other service users at Supported Living Home X and linked with the police. Learning Disability (LD) Team Manager 1 was assigned to the operational lead role to co-ordinate contact with service users, their families, other GCC staff and other professionals. LD Team Manager 1 contacted the Provider and requested that Adult B also be suspended in order to safeguard the service users. LD Team Manager 1 also became aware of the disclosure made by Adult K, and having established that she wished her parents to be informed, met with Adult K's family.

3.54 On 17th April 2013 the Provider was suspended from oversight of Supported Living Home X by the Learning Disability Commissioner, and all new placements to any of the Provider's other Learning Disability establishments were suspended. An acting manager was installed at Supported Living Home X who was independent of

the Provider. This manager worked for GCC's in-house services and knew the service users well.

3.55 When Adult A answered his police bail in August 2013, he continued to deny raping Adult M and K but was unable to explain why his semen had been found on Adult M's bedding and mattress. Later that day he was charged with offences against Adults M and K.

3.56 In September 2013, Adult J made a disclosure to staff at Supported Living Home X. They heard a loud bang from her room and found her in bed hitting herself. She got out of bed and began hitting herself with her clenched fist in her genital area, whilst repeating "don't touch (Adult J)." This and other similar behaviour prompted staff to raise concerns with the police who decide against interviewing her as she has difficulty in answering questions. However a forensic examination of her room discovered semen which matched Adult A's DNA profile on the carpet close to her bed and at the side of her wash basin.

3.57 Later Adult L was video interviewed after she requested to move from Supported Living Home X. She disclosed sexual offences by Adult A, who had entered her room during the daytime to touch her sexually.

3.58 Adult L's sister questions whether this 2013 interview was sufficiently sensitive to her sister's needs. She says that unlike the 2007 interview, she was not invited to attend this interview to support her sister.

3.59 Adult A was later interviewed whilst on remand in prison and made limited admissions of guilt. In January 2014 he pleaded guilty to raping Adults M, K and J; however he sought to minimise the learning disability of the women, suggesting they were complicit in the sexual intercourse.

Financial Abuse by Adult B

3.60 Following an initial audit of Supported Living Home X service user financial records, Learning Disabilities requested that GCC Internal Audit carry out a formal audit in June 2013.

3.61 Internal Audit examined the financial records produced by the Provider which gave rise to considerable doubt that service user monies had been properly administered. In particular there were a number of cash withdrawals from the bank accounts of Adults L, N and J which had not been accounted for. The estimated financial value of these transactions during the review period of March 2012 to May 2013 was £9000.

3.62 The sister of Adult N suggests that it could have been useful for the outcome of the GCC Internal Audit to have been shared with the families of service users. She said that the families may have been able to shed light on suspicious transactions or could have answered queries.

3.63 In October 2013 GCC Internal Audit contacted the police to report their concerns over cash withdrawals from service user bank accounts which had not been accounted for - and in some cases followed immediately afterwards by a withdrawal which had been accounted for. Additionally there were many instances of bank card transactions appearing on bank statements but lacking any corresponding record on the personal bank card sheet or being backed up by any receipt. On the basis of what they had discovered, Internal Audit concluded that there was evidence of financial abuse of service users at Supported Living Home X.

3.64 After these irregularities were linked to Adult B, she was interviewed by the police in December 2013. Initially she claimed that inconsistencies between withdrawals recorded on service users' bank statements, their personal bank card sheets and the petty cash records at Supported Living Home X were the result of staff omissions and errors or that withdrawals were made by family members who would have access to service users' bank cards and PINs when they went home at the weekends. However, she eventually admitted that she had been stealing money

from service users to feed her addiction to gambling. She said she would take service user bank cards with her to bingo where she would withdraw up to £100-200 at a time from cash machines which she would then spend on games of bingo or slot machines. She said this took place every two to four weeks. She covered these unauthorised withdrawals by putting a false record on the personal bank card sheets and petty cash records or simply did not record the withdrawal. She admitted stealing from Adults J, L and N. She was unable or unwilling to say how much she had stolen or how long the stealing had been going on.

3.65 Adult B was ultimately charged with three counts of “fraud by abuse of position.” The police investigation, the CPS charging decisions and the Court’s ability to hand down an appropriate sentence were all frustrated by the Provider’s poor book keeping and auditing of the service users’ finances which made it impossible to accurately assess the extent or duration of Adult B’s crimes.

4.1 Analysis

Terms of Reference

To examine how the allegation made against the perpetrator of sexual abuse in 1997 was handled, and whether the policies and procedures in place at that time were followed.

4.2 It has not been possible to obtain a complete picture of what took place in 1997. For example it is known that Adult Z97's allegation led to a police investigation and it is known what the outcome of that police investigation was, but very little is known about the content of that investigation or on what evidence the conclusions of the investigating officer was based.

4.3 The 1997 allegation contains a number of striking similarities to the allegation made against Adult A in 2007:

- The victim was a vulnerable female service user.
- Adult B occupied a position of authority within supported lodging house S.
- It seems that Adult A fulfilled an undefined support role within the supported lodging house, and appears to have taken advantage of his access to a vulnerable woman.
- At a time when he was alone with the victim he exposed his penis to her whilst placing her in fear.
- He warned the victim not to tell anyone what took place.
- He denied the offence when questioned.
- He was supported by Adult B (who in this case appears to have demanded an apology from the victim and may have threatened to sue her)
- The victim does not appear to have been believed in that the investigation was finalised as "no crime" and was marked off as "suspect interviewed – file to file authoriser. Record as no crime. Did not happen". Additionally a memorandum written by Adult Z97's case worker to the day manager at Day

Hospital 1 following the allegation states that "Adult B would appreciate an apology from Adult Z97 if Adult Z97 felt able to communicate this in writing to her." The tone of the memorandum strongly suggests the author perceives the allegation to have been untrue.

4.4 Very regrettably there appear to be a number of similarities in the response of the various agencies to Adult Z97's allegation in 1997 and the response to Adult P's allegation a decade later:

- At the conclusion of the police investigation there appear to have been no further investigations or enquiries by Providers or Commissioners of services. There appears to have been no consideration of the risk that Adult A may pose to other service users within or visiting supported lodging Home S.
- The primary focus of partner agencies was on finding an alternative placement for the victim.
- The allegation made by Adult Z97 gradually faded from organisational memory until it was no longer referred to in assessments of the victim. When her core assessment was completed by a Social Work specialist in 2003, the 1997 allegation was completely omitted. Indeed the assessment suggests that Adult Z97 left supported lodging Home S due to not getting on well with staff and took advantage of a new supported living scheme.
- As a result of this organisational amnesia, the subsequent needs of the victim may not have been fully met.

4.5 A crucial difference to 2007 is that the 1997 allegation was eventually rendered "invisible", in that the police record of the incident was not transferred to a replacement police database some years later so that Detective Constable 1 was unaware of it when he investigated the allegation against Adult A in 2007. This is highly significant. The rapid and purposeful police response to the allegation made against Adult A in 2013 was driven in part by the early linking of the allegation with the similar allegation made in 2007.

4.6 As previously stated the details of the 1997 allegation were not transferred from the Marconi crime database to the Unity crime and intelligence system which replaced it in 1998. The bulk back record conversion necessary to transfer records from the legacy system to the replacement system did not take place. It would appear that the risks associated with not completing an adequate back record conversion were not fully appreciated or managed. This was a very serious failing.

4.7 It has not proved possible to answer the second part of these terms of reference as GCC has been unable to locate a copy of the relevant policy. In 1991 a multi-agency working party developed "Adults at Risk: Procedural Guidance for Professionals", which remained in force in 1997. In the absence of a copy of the guidance it is not possible to say whether the policies and procedures of the time were followed. However it seems reasonable to assume that if any of the agencies involved had raised a concern about Adult Z97 or other service users who lodged in or visited Home S, there would have been a process for convening some kind of multi-agency discussion. There is no evidence that this happened.

To examine how the allegation made against the perpetrator of sexual abuse in 2007 was handled, and whether the policies and procedures in place at that time were followed.

4.8 In her video interview, Adult L gave no evidence of seeing the incident or of hearing the words Adult P alleged Adult A had used. However the CPS advice states that the interview with her was "very difficult" as she had "quite severe learning difficulties". This begs the question of whether additional communication aids or an intermediary might have assisted.

4.9 Adult L's sister, who was present during the video interview in 2007, has informed this review that her sister was asked questions using words that she had difficulty understanding. Adult L's sister said that she didn't raise the issue at the time as "intervening was difficult".

4.10 The CPS IMR author advises that “special measures” such as a “registered intermediary” (RI) were authorised by the Youth Justice and Criminal Evidence Act 1989 and that Adults P and L would almost certainly have qualified as “vulnerable adults” under Section 16 of that Act. However the CPS IMR author observes that in 2007 the use of “registered intermediaries” was a relatively new concept and that although pilot schemes had been running since 2004, national implementation, including Gloucestershire, did not take place until 2008. However, none of this precluded the Court from being asked to use its discretion to allow evidence obtained with the assistance of “registered intermediaries” to be admitted in the interests of justice, although there was no guarantee this would have been allowed.

4.11 The families of some of the victims have participated in this review and their view is that various communication aids had been available for many years in 2007 and should have been used.

4.12 Although there is no evidence that Adult L was inhibited by location of the video interview within Supported Living Home X, it seems possible that interviewing her in the institutional setting in which the wife of the alleged perpetrator was the manager might have been a significant factor in the outcome. It appears that Detective Constable 1 may have been trying to cause as little disruption to the care of the individual as possible but he will have noted that Adult P only made her disclosure when away from Supported Living Home X at her father’s home.

4.13 The conversations Detective Constable 1 had with Care Worker 1 from which the allegation that Adult P had previously been dishonest emerged, and the conversation with Care Worker 2 to the effect that Adult L was an honest person, appear to have had a telling impact on the ultimate decision by CPS. No statement appears to have been taken from Care Worker 1 and it is not known whether a statement was taken from Care Worker 2. Should the apparently untested views of Care Workers have played such a prominent role in the decision over whether or not to authorise the charging of Adult A?

4.14 In her statement to Detective Constable 1, there was an opportunity and an obligation, given her role and responsibilities, for Adult B to disclose details of the 1997 allegation. She chose not to do so. However it should not have been necessary to rely on Adult B's honesty if the details of the 1997 allegation had been transferred to the replacement crime and intelligence database.

4.15 Had the 1997 allegation been visible to Detective Constable 1, he would have noticed the similarities with the allegation he was investigating. There would have been an opportunity to re-visit or even re-investigate the 1997 allegation. Crucially the 1997 allegation would have altered Detective Constable 1's mind-set and prevented him from seeing the 2007 allegation in isolation.

4.16 The author of the CPS IMR takes the view that knowledge of the 1997 allegation would also have altered the mind-set of CPS1. Because the 1997 allegation was so strikingly similar to the 2007 allegation, CPS1 is likely to have requested that the 1997 allegation be re-investigated. If any re-investigation of the 1997 allegation had come to the same conclusion as the original investigation, then the facts from 1997 could have been used as evidence of Adult A's "bad character", although on its own, this may not have strengthened the case against him in 2007.

4.17 The safeguarding policy of the time did not appear to be followed in that there appears to have been no communication between the GCC Adults team and the Learning Disability team which would have enabled the latter team to safeguard other residents of Supported Living Home X. However, the Learning Disability Commissioner of the time was aware of the allegation and she has informed this review that she would have expected all Supported Living Home X service users to be immediately reviewed. The reviews of service users which took place during the period following the 2007 allegation do not appear to have been informed by concerns arising from that allegation. There is also no evidence to suggest that there was any focus on the contract with the Provider or on carrying out any quality checks in the wake of the 2007 allegation either.

4.18 Not for the first time during this period, GCC as commissioners of the service at that time, reinforced the ineffectiveness of the Provider. It is doubtful as to whether the Provider carried out any meaningful investigation after the police investigation came to an end. But there appears to have been no attempt to check that the Provider had fulfilled their contractual obligations.

4.19 It is not clear whether the Providers fulfilled their legal obligations and notified the then regulator of the allegation against Adult A. The successor regulator, the Care Quality Commission (CQC), has no record of any notification being made. The Providers state they made the notification, but as with the investigation referred to in the previous paragraph, can provide no evidence of this.

To consider whether all opportunities to prevent further offending by the perpetrator were taken as a result of the 2007 allegation.

4.20 It seems that opportunities were missed to prevent further offending by Adult A. As soon as the police investigation had concluded he returned to his former role. Whatever investigation the Provider did or did not undertake, no measures whatsoever appear to have been put in place to prevent Adult A having unsupervised access to vulnerable female service users at Supported Living Home X. Indeed once it had been decided that Adult A and Adult B should no longer permanently reside in Supported Living Home X in 2009 – as part of efforts to create an environment in which service users had greater autonomy – it was necessary for two members of staff, and later one member of staff to work night shifts at Supported Living Home X. No restrictions or monitoring of Adult A performance on these initially accompanied and subsequently lone night shifts were put in place by the Providers. When challenged on this point, Provider (male) said Adult A was there simply to sleep. This was one of several examples of the Providers taking an extremely casual approach to safeguarding concerns.

4.21 As the report has demonstrated, numerous opportunities to prevent further offending by Adult A were missed or not even considered:

- No safeguarding alert or referral was raised by any agency with knowledge of the allegation.
- No strategy meeting or other meeting of professionals appears to have taken place to consider the risks posed by Adult A returning to his former role as care assistant at Supported Living Home X
- No strategy meeting or other meeting of professionals appears to have taken place to consider the risks to other service users at Supported Living Home X
- The invitation from CPS1 to revisit the investigation should further complaints come to light did not prompt consideration of whether other residents of Supported Living Home X might have information to offer.
- The safeguarding policy of the time appears to have been almost completely ignored.
- Basic information sharing between colleagues in GCC Adult and Learning Disability disciplines does not appear to have taken place.
- Wider information sharing with staff from other disciplines such as Occupational Therapy, Speech and Language Therapy and many others – including the CQC as regulators - would have given them the opportunity to be much more watchful and aware than they were able to be.
- Not even the intervention of an MP on behalf of Adult P and her father rang any alarm bells despite the fact that he drew attention to the allegation against Adult A and expressed concern about the role of Adult B in supervising her husband.

4.22 Given these failures, the Panel overseeing the completion of this Adult Case Review applied Root Cause Analysis (RCA) to the handling of the 2007 allegation. RCA is a process which aims to go beyond individual failings and uncover the underlying causes of an adverse incident such as this. The following underlying or root causes were highlighted:

- It is incredibly hard for service users in institutional settings to make disclosures.

- There was a lack of advocacy services for people with a learning disability
- Managing disclosure in institutional settings is very challenging.
- There was a lack of proactive oversight and scrutiny of the Providers of care
- There was an over reliance by social care on the outcome of the police investigation determining whether or not additional safeguarding action was required.
- There was a narrow incident-based approach to safeguarding which appeared to inhibit staff in looking holistically at the issue.
- The framework within which safeguarding was managed had many deficiencies.

To review the effectiveness of the commissioning, monitoring and inspection of the services provided at the premises where the victims were sexually assaulted and/or financially abused.

4.23 The services delivered from Supported Living Home X were not inspected by the CQC or its predecessor organisation for four and a half years. (29th October 2008 to 25th February 2013) The CQC acknowledge that this length of gap is unacceptable and that no service should go this length of time without an inspection visit. Two factors caused this lengthy absence of inspection. Firstly the CQC were required to register 25,000 Providers under new legislation in 2010 which impacted on resources and resulted in inspection visits being made only when serious concerns had been identified. Secondly, the Provider changed their legal entity by registering as a new Provider in December 2011, which meant that under working practices at the time, new Providers were not inspected during their first year.

4.24 Additionally there were no requirements for CQC inspectors to seek the views of commissioners or health professionals. So when a commissioner visit in February 2013 generated concerns they were not shared with the regulator. However the regulator acknowledges that they did not make contact with the commissioners prior to their inspection of the Provider's domiciliary care agency which provided services to Supported Living Home X in March 2013.

4.25 CQC also acknowledges that the inspection methodology they used was not effective at gathering service users' views. For example questionnaires sent out to service users were not appropriate to their needs, people who were unable to communicate verbally were not given the opportunity to express their views and inspections did not regularly or routinely include the use of "experts by experience" – people who have experience of using care services - or specialists. The CQC IMR concludes that the people supported by this Provider were let down by these inspection processes.

4.26 The CQC's predecessor the CSCI inspected Gloucestershire County Council in 2008 and in their report published in January 2009, rated GCC's safeguarding adults performance as poor with uncertain prospects for improvement. A number of major contributory factors were identified including lack of consistency both strategically and operationally and limited development of a strategic partnership.

4.27 The author of the GCC Learning Disability Commissioning and Operations IMR concluded that commissioning, monitoring and inspection arrangements were not sufficient in 1997 and 2007.

4.28 Specifically, monitoring tended to be reactive and frequently individual service user focused. There was an expectation that family members would play an active role in monitoring the quality of care provided by establishments in which their relatives were living.

4.29 The sister of Adult N said that she was unaware of the GCC Commissioner's expectation that family members would play an active role in monitoring the quality of care provided to their relatives. She said it would have been helpful for family members to be informed of this expectation. She also queried whether the GCC expectation was entirely reasonable given the fact that some family members may lack the ability to monitor quality of care if they were elderly or lived some distance away for example.

4.30 The sister of Adult L and the mother and sister of Adult K felt that GCC as commissioner should use families of service users as a resource and should have been more responsive to the concerns they raised.

4.31 Commissioners did not set minimum expectations of services supporting people to manage their own finances, nor was there any routine system in place to check that Providers were discharging their responsibilities to an adequate standard.

4.32 Care Plans for Supported Living Home X service users identified that they were at risk of financial abuse in 2009 but there is no evidence of any preventative measures being put in place.

4.33 The mother and sister of Adult K ask why the concerns they raised with GCC about the management of Adult K's financial affairs by the Providers were not linked to this awareness that Supported Living Home X service users were at risk of financial abuse.

4.34 There was no strategy to support service users to safeguard themselves from sexual abuse, nor to educate Providers in the issue.

4.35 There was and remains no one central repository for recording Provider related concerns which would allow any concerns to accumulate so that any patterns of concern could be readily identified. There are however a number of new mechanisms in place since April 2012 to bring together quality information about providers of disability services and plans underway to create a 'quality portal' to

fulfill the role of such a repository.

To examine how effectively any other concerns, allegations or alerts in respect of the perpetrators were dealt with, prior to, or after the 2007 allegation.

4.36 As stated in Paragraph 4.28, service users were recognised as being at risk of financial abuse in 2009. However concerns about the Provider's management of financial issues did not generate any proactive or preventative measures to safeguard Supported Living Home X service users from financial abuse.

4.37 In July 2012, GCC suspected the Provider of fraud through over charging for two sleep-in nights when records indicated only one sleep-in night had actually been provided. One night was funded by the Independent Living Fund (ILF) and dedicated to meeting Adult K's needs and one funded by GCC for the other service users living at Supported Living Home X. However, after looking at the staff rotas in July 2012, GCC Learning Disabilities Operations staff questioned whether two sleep-in nights were being provided as only one sleep-in person was shown on the rota. In 2012 it was possible to ascertain that the two sleep-ins had not been delivered for several months. It was not possible to verify whether the two sleep-ins had ever been delivered over the past 8 years. Further investigations made by Learning Disabilities Commissioning and Operations at the time suggested that whilst GCC had not been defrauded, it was likely that the ILF had as it was the ILF who funded the extra sleep-in night. The ILF was informed of this but decided not to pursue the matter retrospectively.

4.38 Also in July 2012, GCC looked into the hours funded by GCC and the hours actually delivered by the Provider and identified a potential £1,500 per week discrepancy. In order to prove that the Council had been defrauded, more complex analysis was necessary. GCC Learning Disability Commissioning and Operations stated that a request was made to GCC Internal Audit to carry out the necessary analysis but that Internal Audit lacked the capacity to undertake the work at that time. However, Internal Audit has no record of receiving any such request and

Learning Disability Commissioning and Operations has no record of the request being made. It was however decided by Learning Disabilities Commissioning that the Provider would be placed on an Electronic Call Monitoring (ECM) pilot to gain assurance that they were providing the commissioned hours of care.

4.39 In October 2008 potential financial abuse of a service user by Adults A and B was reported to the CQC by two staff members at one of the Provider's other homes. It was alleged that Adult A and Adult B were using the mobility car of Adult M "as their own car". The staff told the inspector that when Adults A and B were off work they took Adult M's mobility car with them. The staff also alleged that Adults A and B used the mobility car during the working week as well and Adult M would frequently have to get a taxi for transport, which Adult M would have to pay for.

4.40 There is no evidence that the CQC passed this allegation on to GCC to take action and did not mention it in their subsequent inspection report. The same or a very similar allegation appears to have been made in 2010 when Learning Disability Operations handled it by "addressing the matter with the Provider".

4.41 When behaviour change was noted in any of the Supported Living Home X service users it was not explored as a potential indicator of stress or unhappiness within Supported Living Home X. In September 2012, Adult L was "noted to be aggressive in the evenings" whilst on 15th February 2013, Adult M is noted to "irritably hit out at others". Adult M's change in behaviour was assumed to be related to menstruation. (Looking back to 1997, a change of behaviour by Adult Z97 prior to the allegation did not arouse any suspicions.)

4.42 Adult K's family noticed various bruises and pinch marks on her arms stomach and legs during home visits. This was raised with Adult B who attributed the bruises and marks to "falls". On 1st February 2013 a safeguarding alert was made in respect of a bruise to Adult K's arm by a member of staff at a GCC day centre. The matter was investigated but it did not prove possible to obtain an explanation for the injury.

4.43 In 2012 Adult A requested a Criminal Records Bureau (CRB) check as he was applying for a support worker post with the same Provider. The 2007 allegation was discarded and not disclosed as part of the CRB check.

In deciding whether to disclose or “discard” i.e. not disclose, the following three criteria are applied. If the information fails any of these tests it is discarded:

- It is reasonable to believe that the information is relevant to consideration of risk to the vulnerable.
- It is reasonable to believe the information might be true.
- Disclosure is proportionate – primarily is the level of risk greater than the interference with the applicant’s human rights? In 2009 the Supreme Court considered the competing rights of vulnerable groups and the individual (the applicant) and made it clear that neither consideration has precedence over the other.

4.44 It was decided by the Criminal Records Bureau that the information in respect of the 2007 allegation was clearly relevant although the fact that it was apparently a one-off allegation five years earlier diminished its relevance to an extent. The information quality was judged on the basis of information obtained from CPS consideration of the case in 2007. The CPS observations were noted, but it was considered that for the purpose of the CRB consideration the information ‘might be true’. Moving to the third and final test of proportionality, the decision maker concluded that disclosure would have a significant interference with the Adult A’s right to a private life and his ability to pursue the occupation of his choice and set against that was the lack of substantiation and the doubts about the veracity of the allegation, plus the assessment that the risk of harm to a vulnerable person was not high because the offence did not include violence, physical contact, coercion, grooming or significant distress to Adult P. The original decision maker and the person reviewing the decision after the 2013 offences came to light, concluded that

the risk to vulnerable people was not sufficient to justify the interference with the applicant's human rights by disclosing information where there is reasonable doubt about whether it was true.

4.45 On the basis of the information available from the CPS record of 2007 it would not have been possible for the CRB decision maker to determine the level of distress suffered by Adult P.

4.46 The Gloucestershire Police Disclosure and Barring Service (DBS), which succeeded the Criminal Records Bureau, does not routinely access the Marconi legacy database despite the fact that back record conversion to the replacement database had been so limited. This review has been advised that the reason that the DBS does not access the Marconi legacy database was that they believed that all information regarding serious and sexual offending had been transferred from Marconi to the current system. This review has been advised that this belief, though widely held, was completely erroneous. This appears to represent a significant risk to the integrity of the Disclosure and Barring System. This review has also been advised that Gloucestershire Police has initiated a review of all Marconi legacy records. The DBS will be made aware of any information about any other cases which emerges from this review so they can decide whether or not a retrospective disclosure is required. Had the 1997 allegation been available to the CRB decision maker, each allegation would have added weight to the other due to the similarities; the fact that the 1997 allegation was closed as 'no crime' would not have had a bearing on this as this in itself, at that time, did not mean that nothing happened. However the additional advice from the Officer that the incident "did not happen" would have been significant and would have weakened the corroboration provided by the 1997 allegation. Thus the availability of the 1997 allegation would have been insufficient to change the decision made not to disclose the 2007 allegation.

4.47 However, since Adult A was applying for a slightly different role with the same Provider who was well aware of the 2007 allegation, the disclosure decision in 2012 had no practical impact on his employment status with the Provider. However, discovering that the 2007 allegation was not disclosed under the CRB process could

conceivably have contributed to a sense of impunity for Adult A; his wife was the manager of the home and had kept quiet about the 1997 allegation, neither she nor the Provider monitored or restricted his lone access to vulnerable females by day or by night and now there was no danger of the 2007 allegation being brought up again.

To examine the quality of the joint investigation this resulted in the conviction of both perpetrators in order to establish areas of improvement and good practice.

4.48 The Police and CPS IMR authors states that in the intervening six years between the 2007 and 2013 investigations, education, awareness and training in the investigation and prosecution of allegations of abuse of vulnerable adults has evolved nationally. This has been influenced by a number of high profile cases such as Winterbourne View and led to a better understanding of safeguarding vulnerable adults. The introduction of the police Central Referral Unit (CRU) and the Public Protection Bureau (PPB) in Gloucestershire in 2009 made safeguarding pathways far more easily visible and accessible to all staff. The Police IMR author goes on to say that the 2013 investigation represented a joint investigation between police and adult safeguarding with decisions taken in tandem and with clear lines of communication between named individuals in those organisations.

4.49 The families of Adult K and Adult L have praised the police. They said the police were very sensitive to their needs, kept them up to date and did their job efficiently.

4.50 The Police IMR author states that the relationships fostered with adult safeguarding during the 2013 investigation are worthy of note. The officers involved in that investigation when interviewed said that the processes and access to files and information was 'extremely easy' and 'smooth' because of the relationships formed.

4.51 Learning Disability Commissioning and Operations worked closely together to fully support the investigation whilst aiming to ensure the right outcomes for the service users affected. An example of this dual focus was ensuring the delivery of new mattresses to Supported Living Home X so that when the old mattresses were removed for forensic testing there were new mattresses available immediately to minimise disruption for the service users and families. Additionally arrangements were made to ensure that service users would always be out whenever the police visited Supported Living Home X which sometimes entailed the local Training Unit putting on additional events to minimise the stressful impact on the service users.

4.52 The placement of a GCC Registered Manager and external staff into Supported Living Home X following the April 2013 allegations by the Learning Disabilities Commissioner was an example of good practice because it created a safe environment in which service users gradually were able to feel safe enough to make further disclosures as a result of being given time and consistent people to work with.

4.53 Learning Disability Operations also attended team meetings with the staff team at Supported Living Home X to ensure their effective understanding of how to report safeguarding issues as a response to concerns about their competence in this area. When the Provider continued to have difficulty with this, Learning Disability Operations provided more intensive support in this area.

4.54 Additionally bringing in the external GCC registered manager was ultimately crucial in collecting sufficient evidence to eventually lead to a decision to terminate the contract with the Provider.

4.55 There is a clear and auditable trail of adult strategy meeting minutes in which multi-agency information is shared and decisions are reached and updates shared in partnership. The first of these meetings is held on 16th April 2013, three days after

the initial disclosure by Adult M and the meetings are then held monthly until September.

4.56 The criminal investigation into Adult A was commended by the prosecution barrister and the Judge at Crown Court with individual investigating officers singled out for praise for the quality of the interviews with the victims and the high standard of the investigation. The whistle-blower was also singled out by the Courts for her courage.

4.57 The video interviews were undoubtedly enhanced by the use of an intermediary and her report and recommendations for the use of communication aids for some of the video interviews.

4.58 Throughout the 2013 investigation there is clear and obvious management oversight and recorded decision making that is crucial in assisting the review of the investigation and police contact with these adults. This is recorded by the Senior Investigating Officer (SIO) and the officers in the case within policy books used as part of the investigation.

4.59 Part of the SIO's decision making included a detailed forensic strategy which considered the possibility of further offending by Adult A from the outset. This meant that the SIO did not limit the seizure and examination of items to the initial complaint. As a result forensic evidence was available to support the later allegations of Adult K and J. This assisted in securing guilty pleas from Adult A and avoiding the stress and difficulty of a full Crown Court trial for the victims and their families. There was also a suspect interview strategy for Adult A which had been created in conjunction with specialist advice from the College of Policing, this also helped in securing the ultimate guilty pleas from Adult A and the avoidance of a trial.

4.60 Despite the inability to charge the 2007 incident, evidence from that incident was admitted as bad character in the 2013 case. This meant that the Crown Court

Judge was able to sentence Adult A with full knowledge of these previous allegations, giving the court a full picture of Adult A's offending.

4.61 The use of the Victim Impact statements was very effective in the court process and these also gave the families a voice at court. The statements used were; the mother of Adult K, the sister of Adult K, the sister of Adult L, the sister of Adult J and the statement of the whistle-blower detailing the effect that this had upon her.

4.62 The Crown Prosecution Service highlight the provision of early and concurrent investigative advice and communication between themselves and the police brought about an effective prosecution. The CPS also draw attention to mechanisms put in place to ensure the effective early use of intermediaries to assist in gathering the evidence. They also stress the importance of employing a full forensic strategy as the evidence obtained from this approach was instrumental in Adult A pleading guilty to rape offences thus sparing the victims the ordeal of giving evidence in Court.

4.63 An area for improvement in the joint investigation was information sharing with the service users' GPs after the sexual abuse had been disclosed. The author of the GP IMR stated that there was no discussion with any of the GPs or practices to allow them to consider the effect of the abuse on the service users. In her opinion this was a missed opportunity which might have helped to reduce the potential damage caused by the sexual abuse.

4.64 The joint investigation could have been compromised at the outset by the actions and omissions of the GCC Emergency Duty Team (EDT). Paragraphs 3.43 and 3.44 provide details. On receipt of the EDT IMR, the ACR Panel was concerned that the deficiencies identified by this review had not yet been addressed and escalated their concerns to Gloucestershire Safeguarding Adults Board. Paragraph 6.2, Recommendation 1 of this report and a single agency action plan prepared by the EDT are intended to address the concerns about the EDT.

To review how the victims and their families were supported following the making of the allegations which resulted in the conviction of the perpetrators.

4.65 This terms of reference was added to the Adult Case Review after meeting with families of victims. The mother and sister of Adult K and the sister of Adult L have all expressed concerns about what they perceive to be a lack of support. In particular they feel that the full gravity of the case was not shared with them and they only began to fully appreciate this when they read media reports on the case.

4.66 The author of the Police IMR concludes that despite a successful investigation of the sexual offences by Adult A in 2013, there are issues to be learned regarding victim care. The investigation lasted just under a year from initial allegations to the court process and there was no clear policy recorded in relation to on-going victim care throughout this period. The Senior Investigating Officer (SIO) has been interviewed and although he recalls that conversations were regularly held with support workers and adult safeguarding staff at various points in the investigation regarding support to the victims there is a lack of any clear written policy that defined agency responsibility of on-going care and support to the victims. Investigating officers have both provided comprehensive chronologies from their diaries of their contact with the victims and their families at various key points in the investigation which show clear engagement and involvement, but an agreed written policy that was signed up to and understood by all agencies from the outset would have assisted in providing support to the victims and their families. This could also then have been endorsed by the Crown Prosecution Service.

4.67 The SIO has also suggested that the lack of a documented victims and families strategy meant that while those victims' families which were easily identified were involved in the process, the victims' family members that were less obvious were not. This led to the frustration of at least one set of family members feeling not involved in the case.

4.68 As previously stated LD Team Manager 1 was assigned as operational lead to co-ordinate contact with service users, their families, GCC staff and other professionals. This certainly became a huge task and it is clear from the Learning Disability IMR that she made a significant personal contribution over an extended period. The Adult Case Review has been assured that she received an appropriate level of support to discharge her responsibilities.

4.69 The Learning Disability IMR author points out that it is not a social services role to communicate the outcomes of the police investigations to families, nor is it the role of the local authority to offer victim support through the Court process. This is true although the fact that it is necessary to spell out what social services and the local authority do not do so emphatically suggests that the expectations of victims' families could have been managed with greater clarity by all the agencies involved in the 2013 investigation. Whilst the families of the victims were clearly angry that the 2013 offences had not been prevented, they were also unhappy with how their needs were met during the 2013 investigation. The independent author was struck by the disparity between what was unquestionably a highly successful investigation in which all key agencies worked together highly effectively and the families' experience of that investigation.

4.70 In September 2013, Learning Disability Commissioning arranged for some psychological support for the service users. A joint meeting was held between the psychologist from the 2gether NHS Foundation Trust, the police and LD Team Manager 1 to plan how the support could be carried out in a way which did not jeopardise the police investigation.

4.71 Even after concerns about adversely affecting the police investigation had been overcome, providing psychological support has proved a challenging issue to resolve. Initially psychology staff from Stroud Community Learning Disability team attempted to support the care team at Supported Living Home X but there were concerns over whether the latter staff team had the skills and knowledge to provide an emotionally secure and safe setting. Ultimately it was decided that no psychology input was

appropriate or indeed possible. However ongoing support will be made available as the service user's move away from Supported Living Home X to a new home.

4.72 SARC provided support to Adult's M and K and also Adult K's mother. Adult K's mother has said that SARC found it difficult to support her daughter as they didn't have anyone who was able to sign. Through this Adult Case Review process, SARC have become aware of signing resources they can access from other agencies.

4.73 SARC is a one stop location where people who have been raped and sexual assaulted can receive advice and support. Forensic examination carried out by a forensic medical examiner is also available when appropriate. Independent Sexual Violence Advisors (ISVAs) provide individual support to victims and immediate family members "from report to court."

4.74 SARC also employ a team of counsellors to provide short term support. However at the time SARC were supporting Adults M, K and Adult K's mother, there was a twelve week waiting period to access the services. This issue has since been addressed by the appointment of a dedicated pre and post-trial counsellor following a successful funding bid to the Police and Crime Commissioner.

4.75 The Specialist Safeguarding Adults service state that because of the sensitivity of the investigation it was not felt possible to include family members or advocates at strategy meetings and so contact with them happened outside the safeguarding strategy meetings.

4.76 In the two meetings held with the Providers to facilitate their involvement in this Adult Case Review, they provided no information about how they supported the victims and families after the allegations were made in April 2013.

To consider whether there are any diversity issues arising from this case.

4.77 There are some profound diversity issues arising from this case.

4.78 Since the Disability Discrimination Act 1995 people with a Learning Disability have had a legal entitlement to equal access to public services. The Equality Act 2010 places a general equality duty on all public authorities. In the exercise of their functions they are obliged to have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act
- Advance equality of opportunity between people who share a protected characteristic and those who do not
- Foster good relations between people who share a protected characteristic and those who do not

4.79 The second of the three aims listed above involves having due regard to the need to:

- Remove or minimise disadvantages suffered by people due to their protected characteristics
- Take steps to meet the needs of people with certain protected characteristics where these are different from the needs of other people
- Encourage people with certain protected characteristics to participate in public life or in other activities where their participation is disproportionately low.

Disability is a “protected characteristic”.

4.80 The broad purpose of the general equality duty is to integrate consideration of equality and good relations into the day-to-day business of public authorities.

4.81 All public authorities have a legal duty to make “reasonable adjustments” to the way they make their services available to people with a learning disability, to make those services as accessible and effective as possible. Reasonable adjustments may include making whatever alterations necessary to policies, procedures, staff

training and service delivery to ensure they work equally well for people with a learning disability. (1)

4.82 Notwithstanding the advances made in enhancing legal rights, the past quarter of a century has seen the substantial and wide-ranging health inequalities experienced by people with learning disabilities become increasingly well documented. (2) Mencap's 2007 report *Death by Indifference* described the circumstances surrounding the deaths of six people with learning disabilities who died whilst they were in the care of the NHS, exposing "institutional discrimination". (3)

4.83 In 2009 the Equality and Human Rights Commission (EHRC) published a report which concluded that the right to safety and security was a right frequently denied to disabled people. (4) The report quotes the former Director of Public Prosecutions Ken Macdonald who said that "we must overcome a prevailing assumption that it is disabled people's intrinsic vulnerability which explains the risk they face". (5) The report goes on to observe that "it is not disabled people who create their oppression. It is others". The EHRC report contains echoes of the experience of the victims in this Adult Case Review. The report describes institutional settings as "hot spots" for targeted violence, points out that disabled people can be deemed "unreliable witnesses" and refers to a "vacuum of responsibility" arising from a lack of clarity over responsibilities between social care and criminal justice agencies, with the risk that disabled people fall between the cracks. (6)

4.84 The EHRC implicitly makes the point that a failure to extend the same expectation of safety and security to disabled people that everyone else enjoys is a form of discrimination.

4.85 All the victims in this case have a disability. Adult Z97's disability relates to her mental health, Adult P has a physical disability and a learning disability and all the victims of the sexual and financial abuse uncovered at Supported Living Home X in 2013 have a learning disability. All of the victims in this review were vulnerable

because of their disability. But their intrinsic vulnerability was greatly increased by the following acts and omissions:

- In 1997 Adult Z97 appears to have been disbelieved to such an extent that the police officer investigating her allegation concluded that the offence she alleged "did not happen".
- In 2007 Adult P's allegation was questioned partly on the basis that she had not made a "recent disclosure" to Adult B. Although Adult B was not known to be dishonest at that time, there seems to have been little or no consideration of the difficulty Adult P might have faced in disclosing sexual abuse by Adult A to his wife Adult B in an institutional setting in which both of them exercised power over Adult P.
- In 2007, the failure of Gloucestershire County Council and its partners to follow any of their policies which had been written with the express intent of safeguarding vulnerable adults.
- In 2007, the interview of Adult L within the institutional setting in which the abuse took place and which was managed by the wife of the perpetrator, Adult B. The lack of consideration of communication aids given the difficulty in eliciting information from Adult L.
- The failure of the Providers at Supported Living Home X to follow safeguarding policies in 2007 and 2013 and not to be held to account for their failure by Gloucestershire County Council as the commissioners of the services they provided.
- The efforts apparently made by the Providers to obstruct Adult M's courageous attempt to disclose the fact that she had been raped by Adult A in 2013 and the fact that this went unchallenged by GCC EDT.

- Only limited information shared with GPs caring with victims post 2013 allegation. Little account of the fact that the victims might find it difficult to inform their GPs of what had happened

4.86 The Gloucestershire NHS Care Services IMR author questions whether “routine healthy suspicion” on the part of professionals should be heightened to “healthy suspicion” in the case of service users who are vulnerable as a result of their disability.

4.87 Additionally the author of the IMR which describes GP services concludes that more could have been done to support Adults J, K, L, M and N to benefit from screening and preventive treatments. These include cervical cytology, breast screening, bowel cancer screening, screening for and treatment of osteoporosis. Offering more time and support to help people access these services would be a reasonable adjustment under the terms of the Equality Act.

4.88 This observation is consistent with national research. The Confidential Inquiry into premature deaths of people with learning disabilities (CIPOLD), which consists of a Department of Health funded research programme conducted by the University of Bristol, found evidence of some difficulties for women with learning disabilities accessing cervical screening, because of presumptions being made about their sexual histories or current sexual activity. Some women were excluded from the screening even though nothing was known about their past history, and one care home in the study appeared to have a ‘blanket’ policy of not sending women for screening. (7)

4.89 CIPOLD has made the following recommendation which applies to this Adult Case Review: “People with learning disabilities to have access to the same investigations and treatments as anyone else, but acknowledging and accommodating that they may need to be delivered differently to achieve the same outcome.” (8)

4.90 However, the GP IMR observed some good practice including the fact that all the GP practices involved in caring for the victims had a Learning Disability register and a nurse was specifically trained to carry out annual health checks.

4.91 Additionally the CQC accept that they have not made the necessary reasonable adjustment to enable people with a learning disability to provide feedback on their experience of receiving support within Supported Living Home X.

The Victims and their families

4.92 Adult N – who was the victim of financial abuse at Supported Living Home X – has personally contributed to this Adult Case Review as have his sister and mother.

4.93 Adult P and her family were contacted to see if they wished to contribute to the review and they declined.

4.94 The mother and sister of Adult K who was raped by Adult A and the sister of Adult L who was sexually abused by Adult A and financially abused by Adult B have personally contributed to this review. They were asked whether they wished Adults K and L to contribute to the review but took the view that they would rather they forgot about it.

4.95 Adult N described his experiences of living in Supported Living Home X during the period when Adult B was the manager and Adult A was a care worker. He said that Adult B “didn’t want to know” when service users had health problems or needed assistance. He also recounted an occasion when Adult B took his mobility car to go to the bingo when her car broke down. Adult N described how Adult A behaved towards him. On one occasion he pulled him out of the vehicle taking him to the local training centre and assaulted him by giving him a Chinese burn and kicking him on the legs 4 or 5 times. Adult N described other incidents in which Adult A had not treated him with care and respect. He also described an occasion when

Adult A used a garden cane to hit service users on their bottoms in order to make them go up the stairs to bed. Adult N slept on the ground floor so he wasn't assaulted in this way, but he heard one service user crying after being hit.

4.96 The families of the victims raised a number of issues during their meetings with the independent author. Some of those issues were outside the scope of this Adult Case Review and were forwarded to the appropriate agencies to address. Issues raised by the families relevant to this review have been included at points in the narrative. However a summary of their key concerns which relate to this Adult Case Review are as follows:

- Why weren't we told about the 2007 allegation when our daughter moved into Supported Living Home X in 2009? (Mother and Sister of Adult K)
- Why was Adult A repeatedly left alone with vulnerable females on a night shift?
- Why hasn't a fuller investigation of the financial abuse perpetrated by Adult B taken place? The Internal Audit covered just one year which meant that the full extent of Adult B's financial abuse has not been discovered which resulted in her getting a lighter prison sentence than she deserved and means that we don't know the full extent to which our relatives were defrauded. (Internal Audit state that it was not necessary to go back further than one year in order to obtain sufficient evidence of the crime.)
- Why were we not informed about the full gravity of this case earlier and why were we not better supported?

4.97 The families of Adult K and Adult L have described the impact on the victims. The family of Adult K state that she has been very anxious and suffers from panic attacks. She has signed that she is worried. Her sense of security has been affected. The sister of Adult L says that she checks her bedroom to make sure Adult A is not around even though the police have told her he is in prison and cannot hurt her again. She has suffered behaviour outbursts.

4.98 There has also been considerable impact upon the families of the victims. Adult K's mother describes feeling numb with shock and physically sick when she was told her daughter had been sexually assaulted by Adult A. She described how distressing it was to see "her little girl" crying and being physically sick every time Adult A's name was mentioned during her police interview. The sister of Adult L stated that she felt guilty about what happened to her sister and that she found it difficult to come to terms with the fact that her sister had been subjected to such abuse from individuals who were supposed to care for her. Adult K's sister has stated that she has felt "sick, angry, upset, drained and so guilty for not protecting Adult K from him."

4.99 The mother and sister of Adult K, the sister of Adult L and the sister of Adult N all read this report in draft form and made a number of comments which have been included within the narrative of the report.

5.1 Findings

5.2 Rape is a very serious crime. However the rapes committed by Adult A were accompanied by a range of aggravating factors:

- the victims were vulnerable because they had a learning disability
- they lacked the capacity to report what was happening to them to the authorities
- they lived in an institutionalised setting from which they lacked the autonomy to escape their abuser
- the rapist was employed as a care assistant in the Supported Living Home in which they were service users, and as such, he was in a position of authority over them
- the obvious person to whom they could have reported the rapes was the manager of the Supported Living Home. However she was married to the rapist, and in any event, she was focussed on stealing thousands of pounds from them.

5.3 There were a number of “defences” which failed to protect the victims in this case. James Reason’s Swiss Cheese model of accident causation (9), originally developed to understand why accidents such as plane crashes occur, illustrates how the layers of “defence” sometimes fail to prevent catastrophic events. (See figure 1 below)

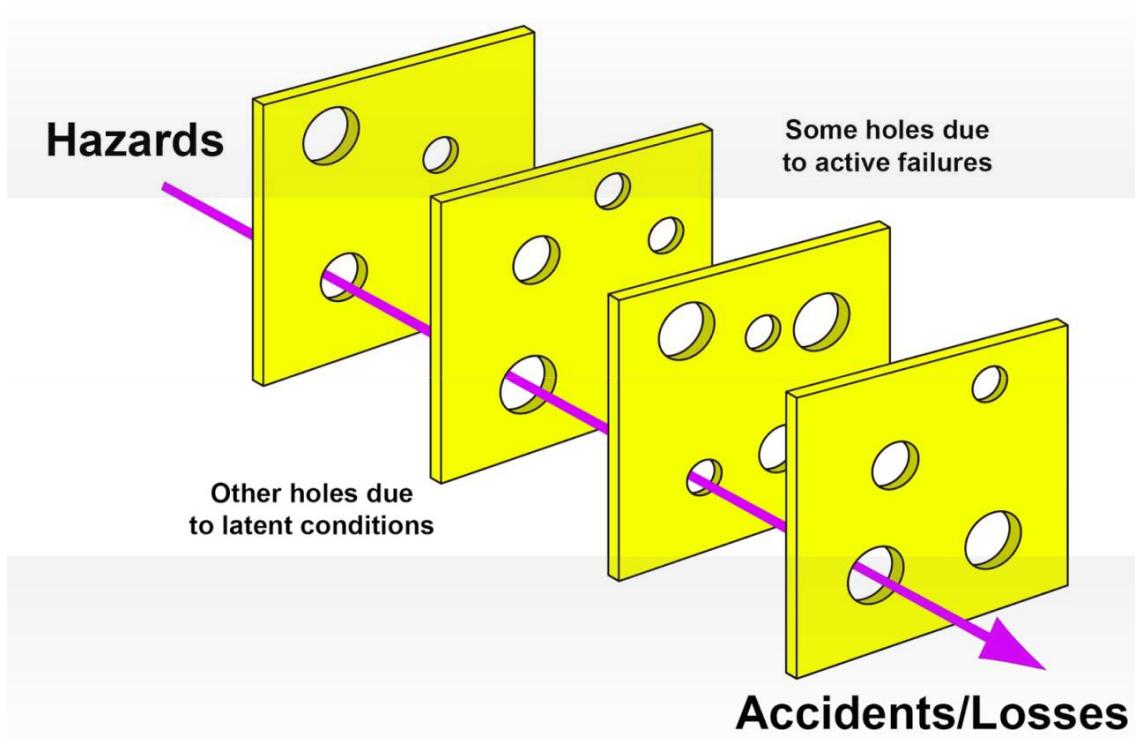


Figure 1: Swiss Cheese model of accident causation

5.4 Looking at the diagram, the “hazard” is Adult A, who was a male sex offender employed in the care system, providing support to vulnerable female adults. The “accident” is the series of rapes of those vulnerable female service users at Supported Living Home X. (It is not suggested that these very serious offences were in any way “accidental.”)

5.5 The slices of Swiss Cheese represent the layers of defence which are intended to prevent the accident. These layers of defence would include the Providers at Supported Living Home X, the status of Supported Living Home X, Gloucestershire County Council as commissioners and care management operational leads, CQC as regulators and the various agencies working together to safeguard vulnerable adults. The holes in the slices represent weaknesses in the defences. So if we take the slice which represents the Provider in this case, weaknesses or holes in would be the low priority they afforded to safeguarding and the unaddressed conflict of interest arising from their employment of Adult B to manage her husband Adult A.

5.6 According to the Swiss Cheese model weaknesses in one layer of defence – such as the Provider failures briefly referred to above, are mitigated by other layers of defence. And when holes or weaknesses in any layer of defence become apparent, action can be taken to rectify the situation. So for example GCC Learning Disability Commissioners recognised that they were operating insufficiently proactively in monitoring the quality of services delivered by Providers and so they took action to address this weakness by creating a dedicated Quality Team. (The role of the Quality Team is described in Paragraph 5.23 below)

5.7 Some of the holes are latent failures in that they are weaknesses which no-one notices which might lie dormant for some considerable time. An example from this case would be the failure of the Police to transfer details of the 1997 allegation onto the replacement police crime and intelligence database. This failure ensured that the 1997 allegation was rendered “invisible” to officers who investigated the 2007 allegation, the prosecutor who decided not to authorise charging of Adult A following the same 2007 allegation and the decision maker in respect of Adult A’s 2012 CRB check.

5.8 According to the Swiss Cheese model an “accident” can happen when a hole in each layer of defence momentarily aligns permitting a “trajectory of accident opportunity” which is demonstrated by the red arrow in figure 1.

5.9 In this case, the layers of defence which should have safeguarded the victims all had holes or weaknesses in them:

- Adult A’s wife and manager Adult B was aware that he presented a risk of sexual abuse to women in his care but appears to have taken no action to restrain him
- the Providers carried out no investigation of any value after the 2007 allegation against Adult A
- GCC as Commissioners never checked whether the Provider had carried

out an investigation into the 2007 allegation

- CQC as regulator did not inspect the services delivered by the Provider at Supported Living Home X for four and a half years.

5.10 These and many other weaknesses in the layers of defence mutually reinforced each other to create an environment in which the victims were exposed to significant risk. However it was an apparently unconnected decision which lined the holes or weaknesses up. Once the decision had been taken to dispense with the ILF funded second sleep-in post in 2012, it became possible for Adult A to operate as the lone night worker at Supported Living Home X, leaving the way clear for him to begin what to Adults M, K, L and J must have seemed like a reign of terror. So the decision to dispense with the ILF funded post was the moment at which the fateful "trajectory of accident opportunity" arose.

5.11 Paragraph 5.8 very briefly describes some of the weaknesses in the layers of defence which should have protected the victims. I will now describe in a little more detail the weaknesses or holes in the layers of defence represented by the Providers of the service delivered to the victims, GCC as the Commissioners of that service and the CQC as the Regulators of the service.

The Provider:

5.12 The Providers were eager to participate in this Adult Case Review and two meetings took place between them and the independent author in which they provided their account of the events which took place in Supported Living Home X and answered questions put to them.

5.13 There is evidence that the Providers were not sensitive or open to disclosures made by service users at Supported Living Home X. In the first interview with the Providers they said that Adult P would "emotionally blackmail" her father to take her back to live with him in the period prior to

making the 2007 allegation. Later in the first interview they said they contacted Adult P's father after Adult P had moved to stay with him after making her 2007 allegation. They said Adult P's father told them that Adult P "had got what she wanted." By the second interview they sought to distance themselves from this characterisation of Adult P as someone who would make an untrue allegation against Adult A in order to leave Supported Living Home X and return to live with her father.

5.14 Their unwillingness to respond in a sensitive and supportive manner to disclosures by service users is strongly evidenced by Provider actions following Adult M's disclosures on Saturday 13th April 2013. The Provider (son) chose to interview Adult M without any other member of staff present and then decided that an appropriate next step was to arrange for another member of staff to take Adult M for a coffee the next day so that they would have an "independent" view on her disclosures. The Provider (son) denied any impropriety, but these actions coupled with his failure to report Adult M's disclosures to the police could easily give the impression that suppressing the disclosures was uppermost in his mind. This impression is reinforced by the letter that the Providers circulated to the staff at Supported Living Home X in the wake of the 2013 allegation. The letter states that "I wish to inform you under no circumstances are you to discuss this issue with any of the following:" This sentence is followed by a list which includes the police.

5.15 The Providers did not seem to grasp the importance of sound safeguarding practices which was surprising given the length of time they had provided services in the "care industry." For example they said that no-one could have predicted that Adult A would commit further sex offences in Supported Living Home X after the 2007 allegation. When considering what action to take on the afternoon of Saturday 13th April 2013 after being made aware of Adult M's disclosures, they said they gave no consideration whatsoever to the 2007 allegation against Adult A. When asked if they had any concerns about deploying Adult A as a lone night worker in Supported Living

Home X after the second sleep-in shift funded by the ILF ceased, they said that all he would do was sleep. It had to be pointed out to them that if any of the predominantly female service user population of Supported Living Home X needed any assistance during the night, then Adult A, as the lone night worker, would be expected to respond.

5.16 When the Providers were asked to comment on the fact that one of their employees – Care Worker 3 – reported Adult M’s disclosures to the police because she was dissatisfied with the way in which the Providers were handling the matter, the Provider claimed that this was evidence of the good safeguarding standards they had put in place in Supported Living Home X, in that they had provided safeguarding training to Care Worker 3. Owing to this latter point being utterly preposterous, the independent author gave the Provider the opportunity to withdraw these particular comments. However he responded by continuing to insist that the fact that a member of his staff felt compelled to go directly to the police because she felt so concerned about the adequacy of the Provider’s response to a safeguarding issue of the utmost seriousness, was evidence of the effectiveness of the overall safeguarding regime the Providers had put in place.

5.17 Poor reporting of safeguarding concerns was one of eleven reasons which were cited by the GCC Learning Disability Commissioner in terminating the Provider’s contract from 20th February 2014. The other ten reasons were:

- Frequent medication errors and inadequate medication management systems
- Frequent financial irregularities, and errors and inadequate financial systems
- Lack of understanding of the Mental Capacity Act (2005)
- Lack of service user records and files
- Gaps in Gloucestershire Disclosure and Barring Service (DBS) checks. (which replaced CRB checks)
- Lack of good supervision process

- Poor fire safety and health and safety procedures
- Poor procedures in place for service users to make a complaint
- Service users are not empowered and supported to achieve their potential
- Service users are not given choice and control about their lives

5.18 The Providers were asked to describe how they attempted to ensure that the finances of service users at Supported Living Home X were properly administered, given the financial abuse of service users Adult B engaged in. The Providers stated that Adult B was entrusted with maintaining spread sheets which recorded monies withdrawn from service user bank accounts which were married up with relevant receipts and petty cash records. At Supported Living Home X, the spread sheets maintained by Adult B were checked on a weekly basis by a member of staff she managed, who would then send an email to the Provider to confirm that Adult B's spread sheet had been checked. The Provider (son), who became the registered manager at Supported Living Home X in 2011, stated that he carried out sporadic checks of Adult B's spread sheet. In the interviews with the Providers they did not appear to appreciate that this method of financial oversight contained serious flaws.

5.19 In their defence, the Providers state that the care services delivered at Supported Living Home X were inspected by the CQC and its predecessor organisation and found to be "good" during 2007 and 2008 and during an inspection visit in 2008. They point out that as recently as February 2013 – two months prior to Adult M's disclosures – the services delivered at Supported Living Home X were inspected by CQC and found to be fully compliant with the outcomes looked at. They expressed criticism of the CQC for inconsistency in carrying out a further inspection two months after Adult M's disclosures which found the service not in compliance with 8 of the 9 outcomes looked at. The Providers also said that they contacted GCC for advice and followed it when the allegation was made against Adult A by Adult P in 2007, and contacted the GCC EDT for advice and followed it when Adult M made her disclosure in 2013.

5.20 The families of the victims say they received no support from the Providers after sexual and financial abuse came to light in 2013. They say that the Providers have offered no apology to them for the damage done to their relatives whilst in their care.

The Commissioner

5.21 The author of the GCC Learning Disability Commissioning and Operations IMR concluded that commissioning, monitoring and inspection arrangements were not sufficient at the time of the 1997 and 2007 allegations.

5.22 The principal means by which the Provider of Supported Living Home X was held to account by the Commissioner was through a contract which set out key obligations such as delivery of quality of service, co-operation with the Commissioner-led inspections, monitoring and evaluation and safeguarding service users. However, monitoring tended to be reactive and frequently individual service user focussed. There was an expectation that family members would play an active role in monitoring the quality of care provided by establishments in which their relatives were living. As previously stated this expectation does not appear to have been communicated to family members.

5.23 Prior to the establishment of the Learning Disability Quality Team in 2012, there is no record or recollection of any commissioning-led inspections of Supported Living Home X. However a programme of "Supporting People Reviews" commenced in 2003 and such reviews were carried out in respect of Supported Living Home X in 2005 and 2008. In 2005 Supported Living Home X was considered to be operating at Level D ("underperforming") and 15 actions were identified. In 2008 Supported Living Home X was considered to be operating at Level C ("average") in three areas and at Level 2 ("good") in three areas with 9 actions identified for attention.

5.24 In April 2012 the Learning Disability Quality Team was established in an effort to adopt a more proactive approach to determining the quality of service delivered by Providers. Prior to that four members of staff had been responsible for managing £40 million of external contracts. Initially this team of Quality Checkers were employed on a part time contractual basis although they became permanent posts from October 2013. Their role was to visit the service, talk to service users and staff and assess the service against quality measures the Providers were expected to achieve. Any areas for development would then feature in an action plan with timescales. Supported Living Home X was visited by Quality Checkers in early 2013. During the visits the Provider came across as "disorganised and uncooperative", but the action plan letter was in the process of being approved when the April 2013 allegations were made, and was ultimately never sent.

The Regulator

5.25 The Regulator in respect of Supported Living Home X was the CQC and its predecessor CSCI. Supported Living Homes such as Supported Living Home X present certain challenges to the CQC which have yet to be fully resolved. The CQC is empowered to inspect only the personal care element of the services delivered by the Provider at Supported Living Home X. They do not have the power to inspect the Supported Living Home itself which is a private premises owned by the landlord who is also the Provider in this case. The service users are tenants. (This also raises the question of how much choice the service users are actually able to exercise over how they are supported and who delivers the support they need, when their landlord is also the Provider of their support.)

5.26 As Supported Living Home X is a private residence and not a care home, this led to the unintended consequence that service users were not protected by legislation specifically drafted to protect "persons with a mental disorder" from "sexual activity by a care worker" which is an offence under Section 38 of

the Sexual Offences Act 2003. The police charged Adult A with this offence in addition to the rape charges but were unable to proceed because Supported Living Home X was not legally a “care home” and therefore Adult A was not legally a “care worker.”

5.27 The sister of Adult N expressed surprise that Supported Living Home X was not a care home. She said she was aware that her brother was a tenant but assumed that the establishment remained a care home.

5.28 Another unintended consequence arising from the status of Supported Living Homes is that when the Provider registers with CQC, they inform CQC of the location where the regulated activities were managed from but were under no obligation to state where the regulated activities were being delivered. This potentially presents the risk that information of concern about the Supported Living Home – where the regulated activities are being delivered – might not be linked to the Provider.

5.29 The CQC accept that the methodologies they have employed have not led to these services delivered at Supported Living Homes being inspected effectively. The guidance for inspectors is not effective and doesn’t provide inspectors with the tools to carry out thorough inspections of supported living services. This has been recognised and while improvements have been made further work is currently under development.

5.30 As stated earlier in this report, the services delivered from Supported Living Home X were not inspected by the CQC or its predecessor organisation for four and a half years. (29th October 2008 to 25th February 2013) The reasons given by CQC for this unacceptable gap between inspections were firstly that the requirement placed upon CQC to register 25,000 Providers under new legislation in 2010 impacted on resources and resulted in inspection visits being made only when serious concerns had been identified. Secondly, the Provider changed their legal entity by registering as a new Provider in

December 2011, which meant that under working practices at the time, new Providers were not inspected during their first year.

5.31 As also stated earlier, there were no requirements for CQC inspectors to seek the views of commissioners or health professionals. Nor was the inspection methodology used effective at gathering service users' views.

5.32 Finally, the timing of the inspection of Supported Living Home X on 25th February 2013 was significant. The CQC had made a commitment to inspect all adult care services during the inspection year from 1 April 2012 to the 31 March 2013. At this time CQC was struggling to meet this target and this resulted in what was considered to be less stringent inspections of some low risk services. The inspection of Supported Living Home X was one of these and may not have been inspected as thoroughly as services that CQC had concerns about.

5.33 The CQC add that since the service delivered from Supported Living Home X was registered in 2004 they had received information of concern about the service on three occasions up to March 2013. They say that this is a very low number for a service of this type over this period of time.

5.34 Returning to the Swiss Cheese Model, it is reasonable to conclude that for most of the time since Supported Living Home X opened for business in 2004, the layers of defences which should have protected the service users from sexual and financial abuse were weak. In particular the Providers did not create an environment in which service users could feel confident and supported in making disclosures and there is evidence to suggest that they attempted to suppress the April 2013 allegations. They did not appear to grasp the importance of sound safeguarding practices which was one of eleven reasons why their contract was later terminated by the Commissioner. The Commissioners monitored Provider contract compliance largely reactively until 2012 when the introduction of Quality Checkers gave them greater proactive

capability which was beginning to reveal concerns about the Providers just prior to the April 2013 allegations. The Regulator was empowered only to inspect the personal care element of the services delivered by the Provider, neglected to inspect Supported Living Home X at all for four and a half years and the positive inspection they carried out just prior to the April 2013 allegations was likely to have been less than effective.

5.35 The layers of defence which should have protected service users in Supported Living Home X from sexual and financial abuse have been exposed by this review as extremely flimsy. The multiple deficiencies of the Providers were allowed to go unexposed for so long because the Commissioner lacked the capacity to proactively monitor contract compliance before April 2012 and the Regulator lacked the powers, methodology, processes and resources to adequately inspect Supported Living Home X. As a result there was little to prevent Adult A and Adult B sexually and financially exploiting the service users in Supported Living Home X.

Were the rapes committed by Adult A predictable?

5.36 Adult A used his access to vulnerable females in institutional settings to sexually abuse them. As far as we know his sex offending “career” began in 1997 when he occupied an unspecified support role in Home S. It seems likely that he would have had further opportunities to commit sex offences during the approximately two year period he and Adult B are believed to have worked at Home S.

5.37 A decade elapsed before the second offence at Supported Living Home X which was strikingly similar to his first known offence. He would have had further opportunities to sexually abuse female service users at Supported Living Home X from the time he began working there in 2004. He was a non-driver so would often be left unaccompanied at Supported Living Home X whilst Adult B was transporting service users to the local Training Centre.

5.38 It is not known when he began raping female service users at Supported Living Home X but it is known that he operated as the lone night worker from the point at which the ILF funded second sleep-in night worker was discontinued. This was officially stopped in early 2012 but it is suspected that the Provider may have stopped the second night worker on an earlier date without authority.

5.39 The risk that Adult A may have sexually abused more vulnerable female service users during the period when his employment gave him access to them has been escalated to the GSAB. This risk is heightened by the fact that any additional victims may have lacked the capacity or support to disclose abuse and may well be unaware of media publicity surrounding this case.

5.40 Had the 1997 allegation been visible to those who investigated or made decisions in response to the 2007 allegation, it would have been reasonable to conclude in 2007 that Adult A presented a threat to vulnerable female service users in his care or to whom he had access. He had cynically exploited his position as their carer and having abused them, warned them against telling anyone what had taken place. Given the priority he had given to his own sexual gratification at the expense of the safety of vulnerable females in his care, in 2007 it would have been reasonable to assume that he would continue to pose a threat to any vulnerable female service users in his care or to whom he had access. Therefore I conclude that it was predictable that Adult A would go on to sexually abuse vulnerable female service users in Supported Living Home X.

Were the rapes committed by Adult A preventable?

5.41 Application of Reason's Swiss Cheese model to this case has revealed that there were serious deficiencies in the layers of defence which should have afforded protection to the victims and prevented their abuse. Many of the

weaknesses in those layers of defence were not visible, which increased the risks faced by the victims because weaknesses which are unseen do not result in mitigating actions by the authorities.

5.42 One of the unseen or latent weaknesses was the 1997 allegation, which by 2007 had disappeared from view. Details of the allegation had not been transferred by the police from their previous to their replacement database. Much earlier than 2007, the 1997 allegation had also disappeared from assessments completed in respect of the victim Z97. If the 1997 allegation had been visible to the officer who investigated the 2007 allegation and visible to the CPS who were called upon to decide whether to authorise charging of Adult A it seems likely that it would have been possible to place the allegation made by Adult P before the Courts. However, whether or not this would have resulted in Adult A being convicted of any criminal offence in 2007 is uncertain. Assuming Adult A pleaded not guilty, his defence would have challenged Adult P's motivation and honesty.

5.43 Had he been convicted, one assumes Adult A would have been dismissed from his job as a care assistant at Supported Living Home X and the subsequent rapes prevented.

5.44 Had he not been convicted it is unclear whether multi-agency responses to the risks posed by Adult A would have been any different or more effective than they actually were in 2007. In both 1997 and 2007 the commissioners of services placed undue emphasis on the outcome of the criminal investigation. When the criminal investigations reached a conclusion in 2007 (and 1997), no effective action was taken by Providers, commissioners and operational leads. If the intervention of the local MP, which was passed down and then back up the senior management chain, did not prompt any questioning of the adequacy of action taken in 2007, then it seems unlikely that a trial which ended in a not guilty verdict would have triggered more effective action than that which took place.

5.45 However if the policies in force in 2007 had been followed, decisive action to safeguard the service users in Supported Living Home X should have resulted irrespective of the outcome of criminal proceedings against Adult A.

5.46 I therefore conclude that the rapes of vulnerable female service users resident in Supported Living Home X by Adult A could have been prevented but that there were so many weaknesses in the system in 2007, many of which reinforced each other, that it is likely that only a successful prosecution of Adult A and his consequent dismissal could have prevented the later rapes.

Was the financial abuse committed by Adult B predictable or preventable?

5.47 In 2009 Care Plans for Supported Living Home X service users identified that they were at risk of financial abuse but there is no evidence of any preventative measures being put in place.

5.48 In 2008 CQC became aware of an allegation that Adults A and B were using a service user's mobility vehicle as their own. A similar allegation was reported to GCC two years later.

5.49 In July 2012 GCC as Commissioner suspected the Provider of fraud through over charging for two sleep-in nights when records indicated that only one sleep-in night had been provided for an unknown period of time.

5.50 Also in July 2012 GCC as Commissioner became aware of a £1,500 discrepancy between the weekly hours provided by the Provider and the hours funded by the Commissioner. To establish whether fraud had been committed by the Provider it would have been necessary for the Commissioner to request GCC Internal Audit to carry out more detailed analysis. There is no record of any request for Internal Audit to carry out such analysis being initiated or

received.

5.51 The “system” described by the Provider for ensuring the financial affairs of service users were managed properly by Adult B was inept. “Frequent financial irregularities and inadequate financial systems” was one of the eleven reasons why GCC ultimately terminated the contract of the Providers.

5.52 When the Commissioner suspected the Providers of two separate frauds in July 2012 they should have considered whether the Providers could be trusted to manage the financial affairs of the service users of Supported Living Home X given the fact that their care plans had earlier identified that they were at risk of financial abuse. If it was not possible to take action in respect of the two frauds of which the Providers were suspected, it was surely both possible and desirable to check that their financial systems were robust enough to prevent the financial abuse of service users. I therefore conclude that there was a clear opportunity to uncover the financial abuse of service users in July 2012 which did not appear to have been considered.

6.1 Recommendations:

Emergency Duty Team:

6.2 The successful 2013 investigation provides Gloucestershire Safeguarding Adults Board (GSAB) with a good deal of assurance that many of the failings apparent in the handling of the 1997 and 2007 allegations have been addressed. Additionally most agencies which have contributed to this Adult Case Review have drawn up single agency action plans to address deficiencies identified as a result of the review.

6.3 However the Adult Case Review revealed cause for concern about the effectiveness of the Emergency Duty Team (EDT). The EDT has a very challenging role but it appears that working practices have developed which are not consistent with sound safeguarding practice. For GSAB to have confidence that arrangements for safeguarding adults in Gloucestershire are effective, they need to obtain assurance that the EDT is capably fulfilling its vital responsibilities.

Recommendation 1:

That GSAB obtains assurance that the deficiencies in the effectiveness of the Emergency Duty Team exposed by this Adult Case Review are comprehensively addressed.

Historic Allegations:

6.4 It is of concern that in both 1997 and 2007, the conclusion of the police investigation and CPS deliberations was regarded as the end of the matter. Despite the fact that a criminal investigation is conducted to a higher standard of proof i.e. "beyond reasonable doubt" than any investigation by the Provider which would be to the lower civil standard of proof i.e. "a balance of

probabilities", no further investigation followed on either occasion, nor were wider safeguarding concerns in respect of other service users who resided at, or visited, Home S or Supported Living Home X considered.

6.5 It is not known whether there have been other allegations of abuse by staff who care for vulnerable adults where the outcome of police investigations has determined whether or not additional safeguarding action was required. If such allegations have been made during the period 1997 to date, or to take a later cut-off date, from 2007 to date, then there is the risk that there are other people employed in the care system in Gloucestershire who pose a risk to vulnerable service users. However, the question of proportionality arises in deciding what efforts are justified to address a hypothetical risk. Therefore the following recommendation is one where GSAB is asked to consider the feasibility of attempting to quantify and mitigate any risks.

Recommendation 2

That GSAB consider the feasibility of assessing and mitigating the risk that there may have been other allegations of abuse by staff in institutional care settings where the outcome of a police investigation has determined whether or not any additional safeguarding action was required.

Visibility of Information to Staff:

6.6 The failure to back record conversion of cases from one police database to the replacement database and in particular transfer details of the 1997 allegation against Adult A, appears to have rendered it invisible to the investigating officer in 2007, the Crown Prosecutor in 2007 and the CRB decision maker in 2012. The issue of ensuring that legacy information is available to view when systems change was also a problem for the CQC when the Provider changed the registration of their service in 2011. Thereafter only information about the current Provider registration would have been visible to the CQC inspector on their databases. Had the CQC's predecessor regulator

been informed of, or recorded the 2007 allegation against Adult A, it would have been rendered invisible to CQC inspectors by the Provider's change in registration in 2011.

6.7 It follows that GSAB needs to gain assurance that partner agencies put measures in place to ensure that all information which has a bearing on the risks faced by vulnerable adults is transferred to any new systems introduced by partner agencies so that the information is fully visible to relevant staff thereafter. In particular the GSAB will need to gain assurance that both the Police and the CQC have taken steps to ensure that all relevant information on the legacy Marconi database (police) and all relevant information rendered invisible by changes in Provider registration (CQC) is visible to all the staff who might need to use the information to do their jobs effectively.

Recommendation 3

That GSAB seeks assurance from all partner agencies that information which is required by staff to assess and manage risks to vulnerable adults is fully visible to those staff when any changes are introduced which could restrict or remove the visibility of that information. In particular the GSAB should seek assurance from the Police and CQC that they have taken the necessary steps to ensure that critical information that this Adult Case Review has shown to have been denied to staff who needed that information, will in future be available to those staff.

Allegations Management:

6.8 The allegations against Adult A in 1997 and 2007 were not recorded in any centralised database by GCC. If they are not recorded anywhere then vital information in the management of risks to vulnerable adults is not available to staff who require it. The provisions of the Care Act 2014 provide GSAB with a potential opportunity to address this issue. Sections 14.175 to 14.186 of the statutory guidance which accompanies the Act sets out the role and responsibilities of the "Designated Adult Safeguarding Manager". Section

14.175 states that “each Safeguarding Adult Board (SAB) should establish and agree a framework and process for any organisation under the umbrella of the SAB to respond to allegations and issues of concern that are raised about a person who may have harmed or pose a risk to adults.” It is recommended that in implementing this Care Act guidance, the GSAB ensures that the framework put in place would have enabled the allegations raised in respect of Adult A to be recorded and shared with relevant partner agencies.

Recommendation 4

When implementing the "Designated Adult Safeguarding Manager" provisions of the Care Act 2014 guidance, GSAB ensures that the framework put in place to respond to allegations about a person who may have harmed or who may pose a risk to adults would have been sufficient to ensure that the 1997 and 2007 allegations against Adult A were recorded and shared with relevant partner agencies.

Disclosure and Barring Service Checks:

6.8 This Adult Case Review reveals that decision makers in respect of DBS (formerly CRB) checks apply the legislation and case law with considerable care. The decision to discard the 2007 allegation when Adult A applied for a CRB check in 2012 appears sound and is confirmed by the review of that decision.

6.9 However the reliance on the CPS record of cases is an issue which could benefit from further consideration. CPS decision making is concerned with whether there is a reasonable prospect of conviction. In making decisions, the CPS applying the criminal standard of proof i.e. “beyond reasonable doubt” whereas the DBS decision makers apply the lesser civil standard of proof i.e. “a balance of probabilities.” There are risks in using information gathered and presented for one purpose for a quite different purpose.

6.10 The second problem with the DBS process revealed by this Adult Case

Review is the view taken on whether awareness of the 1997 allegation would have altered the decision not to disclose the 2007 allegation when Adult A applied for the 2012 CRB check. The conclusion that knowledge of the 1997 allegation would not have altered the decision to discard i.e. not disclose the 2007 allegation is troubling. Both the police and the CPS have said that knowledge of the 1997 allegation would have altered their mind-set when considering the 2007 allegation and that this could have led to a different outcome. This does not appear to be the case with the DBS process which appears to have given more weight to the conclusion of the 1997 investigating officer that "it did not happen", rather than the striking similarities between the 1997 and 2007 allegations.

6.11 It is also extremely troubling that the DBS decision makers do not appear to access information contained on the police Marconi legacy database despite the fact that only limited back record conversion of cases from this database to the new database appears to have taken place. One wonders whether this has resulted in decisions in respect of other CRB and DBS checks which may need to be reconsidered.

Recommendation 5

GSAB should consider whether it is satisfied with what this Adult Case Review has revealed about the way in which Gloucestershire Police Disclosure and Barring Service checks are dealt with.

Diversity:

6.12 This Adult Case Review raises profound diversity issues which are set out above in Paragraphs 4.67 to 4.81. The learning from this Adult Case Review provides GSAB with an opportunity to review both the single and multi-agency approach to ensuring the general duty of equality is met for adults with a learning disability. This work could usefully focus on what action is needed to

ensure the safety and security needs of adults with a learning disability are met, whether adults with a learning disability are able to fully access screening and preventative treatments, and whether professionals are clear about what action to take when an adult with a learning disability exhibits a behavioural change.

Recommendation 6

That GSAB uses the learning from this Adult Case Review to gain assurance that partner agencies are individually and collectively ensuring that the general duty of equality is met for adults with a learning disability.

Victim Care:

6.13 The author of the Police IMR concluded that despite a successful investigation of the rapes committed by adult A in 2013, there are lessons to be learned regarding victim care. The investigation lasted just under a year from initial allegations to the court process but there was a lack of a victim care policy which clearly defined each agencies responsibility of on-going care and support to the victims and their families. The policy would also have clarified what could be shared with the families and when. Despite extensive contact with the families of victims, a policy – endorsed by the Crown Prosecution Service - would have assisted in providing support to the victims and their families.

6.14 The Ministry of Justice statutory Codes of Practice for Victims of Crime came into effect in December 2013. They should be read in conjunction with the 2013 Witness Charter. The Codes sets out what a vulnerable witness or victim can expect from the police, CPS and the courts during their “journey” through the criminal justice system. In particular the Codes state what information they can expect to receive, the timing of that information and any support available to them. GSAB may wish to consider adopting the principles

of this statutory guidance to ensure a framework of information sharing exists to support vulnerable victims and witnesses.

6.15 Additionally victim care could be specifically included within the contractual requirements for Providers.

Recommendation 7

GSAB should oversee the development of multi-agency guidance which addresses victim and family care where allegations of abuse of vulnerable adults are being investigated.

CQC methodology for inspecting Supported Living Homes:

6.16 The CQC recognises the need to develop an effective methodology and specific guidance for inspectors on how to regulate supported living services. The CQC introduced a comprehensive new methodology on 1 October 2014 and is currently reviewing how this needs to be adapted to regulate these supported living services and the issues raised in this Adult Case Review will be integrated into this review.

6.17 It is recommended that Gloucestershire Safeguarding Adults Board fulfill a “challenge” role in respect of this important piece of work. The Board would be well placed to make use of the learning from this Adult Case Review to constructively challenge CQC’s proposals.

Recommendation 8

Using the learning from this Adult Case Review, GSAB should adopt a “challenge” role in respect of CQC plans to improve methodology for inspecting Supported Living Homes

CQC plans for improving how they obtain service user views:

6.18 Although the CQC has some staff who are very skilled in communicating with people with disabilities, including signing and the use of Makaton cards, they accept the need to improve their inspection methodology and guidance to ensure that people who use services are at the centre of their inspections. The recent changes in CQC methodology have addressed this with a focus on gaining the views of people who use the services, gathering professional and family views, extending use of experts by experience and increasing use of observation techniques. However, the CQC accept that they need to improve how they gather information about services where people have communication difficulties. They acknowledge that they have not been able to listen to the concerns and experiences of this group of people. A new approach is due to be fully implemented shortly.

6.19 It is recommended that Gloucestershire Safeguarding Adults Board fulfill a “challenge” role in respect of this important piece of work. The Board would be well placed to make use of the learning from this Adult Case Review to constructively challenge CQC’s new approach.

6.20 The sister of Adult N said she would like to see the CQC plans for improving the way in which they gather information from people who have communication difficulties. She said her brother tended to say what he thought people expected him to say in order not to “rock the boat.”

Recommendation 9

Using the learning from this Adult Case Review, GSAB should adopt a “challenge” role in respect of CQC plans to improve the way in which they obtain the views of service users who have communication difficulties.

Regulatory Gap:

6.21 Despite originally charging Adult A with offences under the Sexual Offences Act 2003 it was not possible to proceed with these charges because of the legal status of Supported Living Home X. Section 38 of the Sexual Offences Act 2003 creates the offence of “sexual activity by a care worker with a person with a mental disorder” and was charged in addition to the charges of rape. However Supported Living Home X is not a “care home” as defined in the Care Standards Act 2000, therefore Adult A is not a “care worker” for the purposes of Section 38 of the Sexual Offences Act. As Adult A pleaded guilty to the rapes, the inability to proceed with Section 38 had no impact in this case. But rape charges are usually contested by the accused and not having the ability to charge Section 38 – which would have been less challenging to prosecute than rape in the event of “not guilty” pleas – could have been significant. It is therefore recommended that GSAB draw the attention of the Department of Health and the Ministry of Justice to this regulatory gap which leaves service users in Supported Living Homes less well protected than legislators who framed the Sexual Offences Act 2003 probably intended.

6.22 Additionally the CPS IMR author points out that as the victims had been deemed competent to enter into individual tenancy agreements with the Provider as landlord of Supported Living Home X, it may have been difficult for the CPS to show that they were incapable of giving informed consent to sexual activity with Adult A. Again this issue did not arise in this case as Adult A pleaded guilty but it is an issue that GCC Learning Disability Commissioning and Operations may wish to consider as part of their single agency action plan.

Recommendation 10

GSAB should write to the Department of Health and the Ministry of Justice to advise them of the regulatory gap which prevents offences under the Sexual Offences Act 2003 being charged in respect of service users resident in

Supported Living Homes.

Dissemination of Learning:

6.23 Much learning has been identified from this Adult Case Review. It is vital that GSAB ensures that the learning is disseminated as effectively and widely as possible so that professionals in a range of disciplines are challenged to review their practice, including the point that staff must take an holistic approach to safeguarding responsibilities.

Recommendation 11

GSAB should ensure that the learning from this case is widely disseminated.

Further Research:

6.24 Most published Adult Case Reviews which have examined abuse of adults in institutional settings appear to have focused on physical, emotional or financial abuse. Adult Case Reviews which have examined sexual abuse of adults in institutional settings appear to be rarer.

6.25 GSAB may wish to consider whether the learning from this Adult Case Review could be used to inform research into sexual abuse of vulnerable adults in institutional settings.

Recommendation 12

GSAB should consider whether this Adult Case Review could contribute to research on how to prevent Sex Offenders gaining access to, and detecting their offending if they gain access to, the "Adult Care system."

References

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Appendices

A - Process by which the Adult Case Review was completed

Gloucestershire Safeguarding Adults Board (GSAB) appointed an independent author to write this Adult Case Review (ACR) in May 2014. The independent author also fulfilled the role of independent chair of an Adult Case Review Panel established to oversee the review process and approve the final report which would be submitted to GSAB.

The independent author was required to draft terms of reference for the ACR which were subsequently approved by the independent chair of GSAB.

All of the partner agencies involved in the case were required to appoint a manager with no prior involvement in the case to write an Individual Management Report (IMR) which detailed all relevant contacts with the victims and perpetrators and comprehensively addressed the terms of reference. Twelve IMRs were completed to a generally high standard by the following agencies:

GCC Learning Disabilities Commissioning and Operations

GCC Specialist Safeguarding

GCC Emergency Duty Team

GCC Internal Audit

Gloucestershire Police

Crown Prosecution Service

NHS England (General Practitioner services)

2gether NHS Foundation Trust

Gloucestershire Care Services NHS Trust

Gloucester Hospitals NHS Foundation Trust

SARC

CQC

The IMRs were scrutinised at a full day meeting of the ACR Panel when the IMR authors were required to present their findings and respond to questions.

At a subsequent meeting of the ACR Panel, Root Cause Analysis (RCA) was applied to failings in the handling of the 2007 allegation in an effort to understand the underlying causes of those failings.

One victim of financial abuse and his family engaged with this review as did two of the families of victims of sexual abuse. The care worker who reported the April 2013 allegation to the police also contributed her observations.

The Providers engaged in the review through two meetings with the independent author.

The ACR Panel decided to approach the perpetrators to see if they wished to contribute to the review. However, at the time of finalising this report it had not been possible to make contact with Adult A or Adult B.

During the course of the review the ACR Panel escalated four safeguarding concerns to GSAB. The safeguarding concerns related to the current effectiveness of the GCC Emergency Duty Team, the finding that women with a learning disability were not being routinely offered cervical screening and other preventative treatments, the possibility that Adult A may have sexually abused other vulnerable women whilst he was employed in the "care system" in Gloucestershire who may have lacked the capacity or support to come forward and finally the risk that incomplete back record conversion of cases from the police Marconi legacy database to the replacement database could have adversely affected cases other than the sexual and financial abuse in Supported Living Home X and other Disclosure and Barring decisions than the one in respect of Adult A in 2012.

B - Membership of Adult Case Review Panel

Independent Chair of Gloucestershire Safeguarding Adults Board
Joint Commissioner, GCC Learning Disabilities
Head of Safeguarding, Safeguarding Adults, GCC
Service Manager, Gloucestershire Rape and Sexual Abuse Centre
Named Nurse Safeguarding Adults, Gloucestershire Care Services NHS Trust
(GCSNHST)
Consultant, 2gether NHS Foundation Trust
Co-Chair, Gloucestershire Learning Disability Partnership Board (LDPB)
Detective Chief Inspector, Gloucestershire Police
Operations and Development Manager, GCC Learning Disabilities
Deputy Chief Crown Prosecutor, Crown Prosecution Service
Deputy Director of Nursing, Gloucestershire Clinical Commissioning Group
(CCG)
Director of Nursing and Quality, Gloucestershire Care Services
County Community Projects (CCP)
Senior Officer, Gloucestershire Probation Service
Manager, Sexual Assault Referral Centre (SARC)
Head of Inspection, Care Quality Commission (CQC)
David Mellor, Independent Author and Panel Chair

The Panel was supported by the Safeguarding Adults Board Project and
Business Officer