Safeguarding Adults Review

Sexual safety in Care Settings

Commissioned by Hertfordshire Safeguarding Adult Board

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1. Introduction

1.1 Hertfordshire Safeguarding Adult Board (HSAB) have commissioned a discretionary Safeguarding Adults Review to better understand how well partner agencies, including private providers of residential care understand their duties to prevent abuse and respond effectively if concerns arise in respect of sexual safety.

1.2 “Violet” (a white British woman, aged 98 years) fractured her hip in a fall, and when discharged from Hospital A in June 2024, she was placed in Care Home A (provided by Provider A) in a discharge to assess unit, due to her increased mobility needs. A week later, she called for assistance in the early morning while being sexually assaulted in her bedroom by another resident, “Steven” (a white British man, aged 79 years). Violet was taken to hospital for her safety, where she sadly passed away in August 2024 due to sepsis.

1.3 It transpired that from April 2023; safeguarding referrals had been made about Steven while he was placed in another care home [Care Home X]. Steven had moved into care in November 2022 due to diagnoses of dementia, recurrent depressive disorder and mild cognitive disorder. It was reported that he had become controlling and obsessive in respect of a consensual relationship with another female resident, then to have sexually touched another woman on four occasions, who lacked capacity to consent to sexual activity, or had not consented. There was also an incident when he pushed a female resident and hit the staff member who intervened and in July 2023 he was detained in a mental health unit under s2 of the Mental Health Act 1983, initially on a ‘frail, functional’ mixed gender ward, but he was moved to another ward (also mixed gender) where he remained under s3 MHA. Further incidents of sexually inappropriate behaviour towards female patients and staff were reported as late as 31 December 2023.

1.4 On 5 January 2024, a Care Planning Approach meeting was held to plan for Steven’s discharge, where it was recorded that there had been no sexually disinhibited behaviour for several weeks. He was moved to a specialist mental health step-down unit provided by Provider A, [Care Home Y] in January 2024, then to a mainstream ward in the same home. There were no reports of sexually disinhibited behaviour during this period, although he made some mildly sexually suggestive comments to female staff. He was moved to Care Home A, also provided by Provider A in April 2024 as his sister had asked for him to be placed closer to her. Provider A were not informed of the sexual risk to other resident when Steven moved, so no protective measures were in place as he moved between their units. Following the assault, Steven was placed under 1:1 supervision, then detained in a mental health unit before his health deteriorated and he has subsequently passed away.

2. Scope of Review

Purpose of a Safeguarding Adult Review

2.1. The purpose of having a SAR is not to re-investigate or to apportion blame, to undertake human resources duties or to establish how someone died; its purpose is:

- To establish whether there are lessons to be learned from the circumstances of the case about the way in which local professionals and agencies work together to safeguard adults;
- To review the effectiveness of procedures (both multi-agency and those of individual organisations);
- To inform and improve local interagency practice.
- To improve practice by acting on learning (developing best practice); and
- 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.

2.2. There is a strong focus in this report on understanding the underlying issues that informed agency and professionals' actions and what, if anything, prevented them from being able to help and protect Violet from harm.

2.3. It is to the credit of HSAB that although this case did not meet the statutory criteria for a mandatory SAR, partners took a decision to undertake a discretionary SAR, to secure the learning from this case. In discussions with safeguarding leaders, it was clear that Hertfordshire partner agencies have made it a priority to strengthen safety, including sexual safety, in care homes and this review will contribute to their strategic approach to this issue.

Themes

2.4. The HSAB prioritised the following themes for illumination through the SAR:

- What is the local understanding of the Violence Against Women and Girls agenda and its application to older women, in particular residents of care homes? What is the level of understanding across partner agencies regarding sexual abuse in the context of adults who may lack capacity to consent due to degenerative conditions?
- What is in place to support assessment of sexual risk in respect of individuals with dementia or other cognitive impairments, and how is this used to mitigate risk, both within a placement or at points of discharge or transfer?
- What, if any, barriers prevented information sharing in respect of the person who caused harm, disruption of his behaviours and safeguarding measures that could have been applied to prevent further victimisation?
- What does a safe environment look like in a care home and how do we ensure these standards and risk mitigation models are embedded across the county?

Methodology

2.5. The case has been analysed using a learning together approach, through the lens of evidence-based learning from research and the findings of other published SARs.[1] Learning from good practice and a discussion of the legal framework have also been included. By using that evidence-base, the focus for this review has been on identifying the facilitators and barriers with respect to implementing good practice. The review has adopted a whole system focus, examining the support for the person, direct practice, organisational factors, interagency factors, governance and oversight, as well as the broader legal, financial and policy context.[2]

2.6. The overarching purpose of the review has been to learn lessons about the way in which professionals worked in partnership to support and safeguard adults in care homes. Agencies provided reports setting out a description of their involvement with Violet and Steven, with a chronology of key events. The author used these to draw together an Early Analysis Report, summarising the agency returns to provide a framework for multi-agency discussions at learning events with front-line practitioners who worked directly with Violet and/or Steven and the leaders who oversaw the services involved in supporting them.

2.7. The learning produced through a SAR concerns 'systems findings', which are the underlying issues that helped or hindered in the case and are systemic rather than one-off issues. Systems findings identify social and organisational factors that make it harder or easier for practitioners to proactively safeguard, within and between agencies.

[1] Preston-Shoot, M., Braye, S., Preston, O., Allen, K. and Spreadbury, K. (2020) National SAR Analysis April 2017 – March 2019: Findings for Sector-Led Improvement. London: LGA/ADASS

[2] Braye, S., Orr, D. and Preston-Shoot, M. (2015) 'Learning lessons about self-neglect? An analysis of serious case reviews.' Journal of Adult Protection, 17 (1), 3-18.

Contributing agencies

2.8. The following agencies provided documentation to support the SAR:

- Hertfordshire Adult Care Services [ACS]
- Hertfordshire Constabulary
- Hertfordshire Partnership Foundation NHS Trust [HPFT]
- West Hertfordshire Teaching Hospitals NHS Trust [WHTHT]
- Department for Work and Pensions
- HUC NHS 111
- Provider A
- GP Surgery

2.9. Where relevant, representatives from these agencies attended the practitioner and learning events and a representative from Care Home X also attended the practitioner event to ensure that there was a complete understanding of Steven's history.

2.10. In addition to anonymising Violet and Steven's names, the names of the care homes and hospitals where they stayed have been anonymised, to ensure that Violet and Steven cannot be identified from this information

3. Violet

3.1. Violet was a confident, independent woman who knew her own mind. She took pride in her appearance and placed great importance in maintaining her dignity. Her husband had passed some years ago, but she had a loving family, including her daughter, two sons, grandchildren and great-grandchildren and was an energetic, strong woman "*with an amazing spark".* She had a passion for horse racing and in addition to a weekly flutter on the races, had a share in a racehorse. Despite a fondness for sweets and being pre-diabetic for 30 years, Violet was very healthy and had not required support to live in her own home until she broke her hip in a fall. She had a hip replacement, so required a mobility frame and started having problems with ulcers, receiving district nursing care. Although she would not consider moving to a care home, her family believed she needed additional support and requested a care and support assessment from Hertfordshire Adult Care Services [ACS].

3.2. However, before this took place, Violet fell in the night and sat alone for 12 hours jammed between the bed and the wardrobe. In addition to the distress this caused her, it transpired that she had broken her hip again, but her clinical team assessed that she could not safely undergo an operation and treated her conservatively, allowing her to heal naturally. She remained adamant that she did not want to go into a care home permanently, but agreed to a Discharge to Assess [D2A] placement, both to support her rehabilitation and to enable ACS to determine an appropriate package of care to enable her to return home. In the assessment provided by the Hospital, she was deemed to have capacity to take decisions in respect of her care.

3.3. Violet's family supported her in choosing the care home, and although they were not familiar with Care Home A, when Violet moved in, they noted that she liked the food and got on very well with the main carer on her floor. Staff from the care home noted that due to the trauma caused by her fall at home, Violet was very careful to ensure that her call button was in easy reach, either around her neck or her bed post. She was also clear that she wanted the door to her room to be left open, to ensure that staff could easily check on her and could hear her if she called out. Her daughter commented that Violet was also very sociable and that she still wanted to chat with staff and other residents. Her family visited daily and thought everything was going well, including a visit from a social worker to start the D2A assessment.

3.4. Every day in the week after Violet moved in, she enjoyed the company of lots of visitors. However, on the Sunday morning, her daughter received a call from a member of staff at the care home, saying that there had been "*an incident with your mum*", and that "*a resident had got into her room*", but no further details and no indication of urgency. On arrival, Violet was alone and distressed in her room and said "*It was awful, I haven't been able to sleep. It took three of them to drag him out of the room, he was swearing and carrying on at me, he was absolutely foul.*" With her fractured hip, Violet was trapped in her bed during this terrifying incident. The member of staff who had called Violet's daughter said that she had asked her manager (who was not present at the home) about calling the police but was told to do the drug round first. When challenged why she had not told the daughter about the nature of the incident, she said "*I told you he was masturbating on her when staff came into the room".* The night staff members who had witnessed the assault had gone home after their shift, before the police arrived. When the main carer on Violet's floor arrived, she was not aware that there had been an incident, had not been asked to support her and said that she just thought Violet had "*been a bit off*" that morning.

3.5. Violet's family called the police and report that when an officer arrived, they commented that they had not been provided with the details of the staff members who had witnessed the incident, and that the security door between Violet and Steven's wards was still open when police arrived. When the officer went to check whether the security door was still open, they saw Steven come out into the corridor unsupervised. Violet's daughter said that the officer was so concerned that they recommended that Violet should go to hospital for her safety.

3.6. While it is to the credit of Hospital A (operated by West Hertfordshire Teaching Hospitals NHS Trust [WHTHT]) that they admitted Violet to offer her a place of safety following her trauma, Violet's daughter was highly distressed about the experience her mother had while in hospital, noting that she moved wards several times in her first week, which left her feeling overwhelmed. Unfortunately, this is unavoidable in an NHS pathway, where patients are moved to the part of the hospital where their developing health needs can best be treated. Violet told her family that when she moved, staff would come in and ask her to explain why she was in hospital, resulting in her reliving her trauma. However, the family noted that support by the independent sexual violence advocate [ISVA] was absolutely excellent. The ISVA would sit with Violet, hold her hand and ask her about herself to distract her and prevent her from dwelling on the assault– "*Mum asked for her because she made her feel safe.*" Violet developed a urinary tract infection in hospital and despite appropriate medical treatment for this her condition rapidly deteriorated and she was placed on palliative care. Her family were clear that prior to the assault, Violet was engaged and full of life, but that the incident had a profound psychological impact on her, leading to significant deterioration. They believe that the trauma she experienced was the cause of her decline.

3.7. The author is very grateful to Violet's daughter for meeting to share her fond memories of her mother and her serious concerns about safety in the care home and the organisational response to the assault. Despite her grief, she was thoughtful and measured, raising valuable learning points for this review. The author and SAB partners wish to express our sincere condolences to Violet's family for their loss, and the Board Manager gave her daughter assurance of the Board's commitment to act on the learning from this review.

4. Steven

4.1. Steven had been the lead singer in a rock band when he was younger, which is how he met his wife. Elvis was his hero. He was very sociable and followed his local football team, as he lived near the training ground, and although he also played football for fun, he acknowledged that he had no real talent. Steven first became known to Hertfordshire Adult Care Services in January 2022 shortly after his daughter died of cancer. He had relied on her for care after his

wife died and took her death very hard, and was diagnosed with depression. He struggled with the isolation and expressed a wish to improve his relationship with his son, as they had grown apart over the years, although he still had a good relationship with his sister who would visit him. A practitioner who met him at the time noted that "*he was dedicated to his dog, but not caring for himself or the dog*", Steven would stay in bed during visits and his home became neglected and unhygienic, so practitioners would buy dogfood for his pet. Although efforts were made to support him in the community, including through the community mental health team [CMHT], his memory was starting to decline and he required additional care that could only be provided in a care home, Care Home X was identified. He was "*gutted*" that this meant his dog had to be rehomed.

4.2. Staff in Care Home X described that when Steven moved in in November 2022, he was a lovable character, but they could see him declining very rapidly, in particular in respect of his memory. Although he did not have a formal diagnosis at this stage, in some ways he recognised this, often commenting "*I'm a stupid old fool*", but would then question why he could not go out of the home. He briefly moved home in January 2023 but quickly realised he could not manage alone and returned to Care Home X within days. Steven developed a relationship with another female resident, initially a friendship through meetings in communal areas, before starting a consensual sexual relationship. Mental capacity and risk assessments were undertaken of both residents, to ensure that they each had capacity in respect of sexual relations, and their families were informed. However, over time, she voiced that "*I need some space from him*" as he grew more obsessive and controlling in parallel with his cognitive decline. Measures were put in place to support her, including half hourly staffing checks, but Steven struggled to understand the change in their relationship. In April 2023 Care Home X raised a safeguarding concern with ACS regarding this relationship. The care home was advised to refer Steven to Mental Health for their input, and this was not reported to the police. Another safeguarding referral was made in April 2023 after an incident when he pushed a female resident then hit a staff member who went to intervene resulting in a report to police, but this was finalised on the basis he lacked capacity and the low level of the offence meant that a prosecution would be disproportionate.

4.3. In June 2023, a safeguarding referral made after three incidents in quick succession when he was seen by staff to be sexually touching a female resident, who was assessed to lack capacity in respect of sexual relationships. However, a decision was taken that this did not meet the threshold for a safeguarding enquiry as she told staff this had been consensual and this was not reported to police. The referrals from April and June were recorded on ACS's case recording system on the files of the women involved, however no risk assessments were completed on Steven by ACS and no special factor or banner (flags that can be placed on Adult Care Service's case recording system to easily identify risks) was added.

4.4. In early July 2023, police recorded a sexual assault by Steven against a different female resident who lacked capacity at Care Home X care home. Staff found him asleep next to her in bed, his hand soiled and her incontinence pants pulled down and soiled. The woman initially stated that he was trying to make love to her, but the following day could not recall the incident. Police recorded this as a sexual assault and investigated, but on consultation with the care home manager and ACS, concluded that there was no realistic prospect of a conviction as both residents had dementia. Consequently, neither the evidential, nor the public interest tests would be made out for a prosecution (these tests are explained in section 5 below). Steven was referred to the Mental Health Crisis team, who prescribed medication, but the care home requested a care review as they felt they could not safely manage his behaviour, and ACS agreed to fund 1:1 support for Steven in the interim to manage the risk. A referral made for an assessment under the Mental Health Act 1983, and the detective assisted the Approved Mental Health Professional with information for this process.

4.5. In July 2023 Steven was detained to a mental health unit provided by Hertfordshire Partnership University NHS Trust under section 2 of the Mental Health Act 1983 [MHA] mixed gender wards and he remained detained under s3 MHA for several months. Although discharge planning started soon after he was admitted, there were a number of incidents when Steven displayed sexualised behaviour to staff or other female patients and care homes approached as part of the discharge planning process advised that they would not be able to manage his behaviours. Staff conducted risk assessments and developed a risk mitigation measure of taking steps to distract Steven if he started to engage with female patients, which was successful.

4.6. Although there had been incidents of sexualised behaviour as late as the end of December 2023, in early January 2024 Steven was assessed as being ready for discharge. A Care Planning Approach meeting was held to plan for his discharge, where it was recorded that there had been no sexually disinhibited behaviour for several weeks. On ACSIS there were no risk assessments completed around his history of sexualised behaviours and no banners/ risk factors stating that he was a risk to others. No incidents at the mental health unit were referred to the police. He was accepted to a specialist mental health step-down unit in Care Home Y, run by Provider A. Although the purpose of establishing this unit had been to ensure that there was effective information sharing to enable mental health patients to be safely discharged from detention under the MHA, no details were shared with the specialist unit in respect of the risk Steven posed to female residents or patients, only his risk to staff, which the specialist unit believed to be a manageable risk. All subsequent information sharing with ASC referenced that he "*showed inappropriate behaviours towards staff"* which was understood to be in relation to mildly sexually suggestive comments to female staff. However, this behaviour was not observed while he was placed in the specialist unit and practitioners noted that he rarely socialised with other residents, preferring to interact with staff. He moved from the specialist unit to Care Home Y's main ward, then at the request of Steven's sister, he was moved to Care Home A in late April 2024, which was also provided by Provider A. During his stay at Care Home A, there were no observations of sexualised behaviour or allegations made regarding Steven, prior to the assault on Violet in late June 2024. However, that night, staff reported that Steven was quite distressed, walking down the corridor and trying to get into other residents' rooms, without success. A nurse took him to the refreshment room to get a drink to try and calm him down, as they entered Steven had walked out again. He then went into Violet's room, when the incident occurred.

4.7. Following the assault, Care Home A report that they immediately provided 1:1 supervision for Steven by male staff members, to ensure the safety of other residents. A sign was subsequently placed on the door to the Discharge to Assess unit that that the door was to remain closed. Two days later, ACS contacted the care home following safeguarding referrals from Hospital A, police and the care home in respect of the assault and verbally agreed ongoing 1:1 supervision for Steven; the care home manager advised that Violet was in a safe place. They discussed a risk assessment, GP review and referral to mental health. The home's interim manager advised ACS that police were continuing to interview staff members and were waiting for them to revisit Steven, as police felt Steven understood what had happened and had capacity around the assault. Police visited the next day visit to obtain further evidence in relation to the assault. One to one supervision by a male care worker remained in place until Steven left Care Home A.

4.8. Initially the care home did not receive a response to the requests for visits from mental health services or the GP. When HPFT's mental health worker visited, they found Steven was settled and concluded that there was no cause for detention under the MHA. The mental health worker advised that Steven should remain on 1:1 supervision and there should be escalation to the police and Adult Safeguarding if there was any further cause for concern. The home contacted Steven's social worker to request a care review. On discussion with ACS, an escalation was sent from ACS's Deputy Head of Service to HPFT Team Managers and Head of Service to

ensure mental health support was provided to the care home and Steven. ACS's locality Team Manager remained in contact with the interim home manager to keep them updated on the meetings and outcome. Steven was later detained under the MHA in a mental health unit before his health deteriorated and he has subsequently passed away.

4.9. Steven's son was invited to participate in the review process, but his father passed quite recently and given the sensitive nature of the review, it is understandable that he felt unable to contribute. The author and SAB partners wish to express our condolences to Steven's family for their loss and recognise that, in light of Steven's apparent lack of cognitive capacity at the time of the assault, this review aims to address the barriers to protecting him from causing harm to Violet. There is no evidence to suggest that Steven had posed such a risk to others prior to developing dementia.

5. Legal and practice context

5.1. The legal framework to protect children and vulnerable adults[3] against sexual abuse is comprehensive, including a mixture of civil actions and criminal sanctions. However, it is not sufficient for statutory safeguarding partners to only respond effectively to sexual abuse, there is also a myriad of legal powers aimed at empowering private individuals, organisations, professionals and regulators to prevent abuse occurring. The system approach to ensuring that risk is reduced is multi-layered; relevant agencies are expected to actively disrupt perpetrators whilst also ensuring anyone at higher risk (e.g. given what is already known of indicators) are provided with proactive advice and support to ensure sexual safety and recognise abusive relationships.

5.2. Sexual assault is defined in section 3 of the Sexual Offences Act 2003, as the intentional sexual touching of another person who does not consent, and where the perpetrator does not reasonably believe that they consent. Consent is defined in section 74 of the 2003 Act: *"...a person consents if he agrees by choice and has the freedom and capacity to make that choice."* Deciding whether the perpetrator's belief that the person consents is objectively reasonable is determined by having regard to all of the circumstances. Further, the Sexual Offences Act 2003 specifies that it is illegal to engage in sexual relations with a person with a mental disorder who is 'unable to refuse' for a reason related to a mental disorder because he/she lacks 'the capacity to choose'.

5.3. The Mental Capacity Act 2005 [MCA] sets out that a person lacks capacity in relation to a specific issue if at the material time they are unable to make a decision for themself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain, which includes mental health conditions. A person is unable to make a decision for themself if they are unable to understand the information relevant to the decision, to retain that information, to use or weigh that information as part of the decision-making process, or to communicate their decision by any means. The fact that a person is only able to retain the information for a short period does not prevent them from being able to make the decision and capacity may fluctuate over time. For example, as dementia advances, people may have periods of lucidity and confusion and temporarily lack capacity to take specific decisions during periods that they are unwell. There is a presumption of capacity unless otherwise evidenced and a person cannot be treated as lacking capacity, merely because someone else considers their decision to be unwise. The courts have clarified[4] that capacity to consent to sex is issue specific, not person specific. The person must have sufficient knowledge and understanding

[3] We have used the term vulnerable adults in this context because much of the criminal and civil legal frameworks use this term. We are, however, clear that the victim's ability to protect themselves due to care and support needs is only relevant in that it increases risk, because perpetrators may deliberately target adults with care needs and enhances the statutory duties of partner agencies to actively protect.

[4] Sheffield City Council v E [2004] EWHC 2808

of the issue relating to consent to sex (including understanding that they can refuse consent), rather than considering it solely in relation to the person with whom they are going to have the relationship.

5.4. Section 27 of the MCA specifically excludes the making of best interest decisions regarding sexual relationships, so that if a person is found to lack capacity to consent to sexual relations nobody can decide that it is in that person's best interests to engage in sexual relations. The courts can determine whether or not an individual has capacity to consent to sexual relations; and if a person lacks capacity, the courts can decide whether orders are required to safeguard that person.

5.5. When considering offences under the Sexual Offences Act 2003, the mental capacity of the perpetrator will be relevant to any decision the prosecute. It is necessary to establish whether they had the 'mens rea' specified in the Act, which is the mental element of a criminal offence necessary to establish culpability. A person must be capable of forming the intent to touch and understanding the lack of consent. If the perpetrator cannot comprehend these elements due to mental incapacity, they may not be criminally liable. However, statutory agencies will remain responsible for ensuring that appropriate safeguarding plans are in place, both in respect of the perpetrator and victim.

5.6. It is important to note that the fact someone has a cognitive impairment or mental health disorder does not automatically mean that they lack capacity in respect of committing a criminal offence, even if they are detainable under the MHA or MCA – they may fully understand the criminal nature of their behaviour and the consequences. Guidance for police officers from the College of Policing[5] sets out that professional advice from health or social care practitioners should be used to support decision making by officers investigating a potential crime.

5.7. When taking a decision about whether to charge a suspect with a mental health or cognitive impairment of a crime, paragraphs 4.9 to 4.13 of the Code for Crown Prosecutors[6] provide a framework to consider whether prosecution is in the public interest ('the public interest test'). Paragraphs 4.14(a) to (g) of the Code set out factors tending in favour and against prosecution. The Code notes:

"*Prosecutors should also have regard to whether the suspect is, or was at the time of the offence, affected by any significant mental or physical ill health or disability, as in some circumstances this may mean that it is less likely that a prosecution is required. However, prosecutors will also need to consider how serious the offence was, whether the suspect is likely to re-offend and the need to safeguard the public or those providing care to such persons*."

5.8. Police and prosecutors must also consider whether there is sufficient evidence to charge a suspect ('the evidential test'). This can pose difficulties in circumstances when the victim has a cognitive impairment, as they may not be able to give reliable evidence, although this should not pose a barrier in circumstances when there are other witnesses or physical evidence such as CCTV footage. Guidance from the Crown Prosecution Service in respect of prosecuting crimes against older people[7] warns against any presumption that a victim or witness may lack capacity to support a prosecution:

"It is important to recognise that the competence of a witness is a separate issue to that of the mental capacity of a witness. Mental capacity can be affected by numerous factors and a person with Alzheimer's disease may have capacity which fluctuates over time, even during the course of a day… Prosecutors should therefore not make assumptions about the reliability, credibility

[5] Mental capacity | College of Policing

[6] Code for Crown Prosecutors

[7] Older People: Prosecuting Crimes against | The Crown Prosecution Service

or competence of a victim or witness to give evidence based on their age or age-related vulnerability. Instead, prosecutors should at the earliest stage consider what special measures are available and appropriate to enable them to give their best evidence."

5.9. In any event, whether or not a decision is taken to prosecute an offence, this will not negate the responsibilities of all relevant agencies in respect of safeguarding.

6. Analysis of Agencies' Actions

Understanding of Violence Against Women and Girls and sexual abuse in the context of care homes

- *What is the local understanding of the Violence Against Women and Girls agenda and its application to older women, in particular residents of care homes? What is the level of understanding across partner agencies regarding sexual abuse in the context of adults who may lack capacity to consent due to degenerative conditions?*

6.1. The UK Government's Violence Against Women and Girls [VAWG] agenda[8] aims to halve VAWG within a decade through a cross-government, mission-led strategy. It focuses on prevention, victim support, and systemic reform, addressing domestic abuse, sexual violence, stalking, and online harms. Key priorities include improving trust in public institutions, securing sustainable funding for specialist services, and embedding intersectionality to support all survivors. The strategy highlights that older women can be victims of domestic abuse and other forms of violence, but their experiences are often underreported and overlooked. It acknowledges that older women may face additional barriers to accessing support, such as dependency on the abuser for care, mobility issues, or lack of awareness that what they are experiencing constitutes abuse. The strategy includes violence in care homes and institutional settings as part of its broader definition of VAWG. It notes that abuse in these environments can be physical, emotional, sexual, or financial. The Government's action plan places an emphasis on improving safeguarding practices and ensuring that care providers are trained to identify and respond to abuse appropriately.

6.2. Hertfordshire's Domestic Abuse Strategy (2022-2025)[9] goes beyond the national statutory requirements by aiming for a transformative, prevention-based approach. Key features include multi-agency collaboration involving police, healthcare, local government, and voluntary sector partners; early intervention, with a focus on identifying risk and harm before crisis points; whole-system response, including support for victims and accountability for perpetrators; and lived experience integration, establishing a co-production panel of survivors to help shape policy and challenge victim-blaming. While older women are not explicitly referenced in the strategy, the emphasis on inclusive support and safe accommodation implies attention to vulnerable groups, including those in care settings. This strategy is currently being reviewed by Hertfordshire's Domestic Abuse Partnership [HDAP], and HSAB has confirmed that this report will be shared with HDAP to incorporate the learning from this review.

6.3. Hertfordshire's Adult Care Services strategy[10] also provides a framework to support the VAWG agenda by ensuring that care environments are safe, monitored, and responsive to abuse risks. This includes market sustainability plans for the 65+ care home sector, assessing future needs and risks, safeguarding policies for adults at risk, including those in institutional care, and accommodation strategies to support independent living and reduce vulnerability.

[8] Tackling violence against women and girls
[9] Hertfordshire DA VAWG Partnership Strategy 22-25
[10] Adult care service - strategic plans and reports | Hertfordshire County Council

6.4. There is very little data available on the prevalence of sexual abuse perpetrated against older people. In part this is because prior to 2021 the Crime Survey for England and Wales (collated by the Office of National Statistics) restricted data on reported crimes by age.[11] Dr Bows' research in 2018[12] identified that most older (60+) victims of sexual violence were female and that poor physical and/or mental health were associated with higher risk of victimisation. Dementia was reported across several studies as a characteristic of victims (64% in one study) and 48% of victims required assistance with activities of daily living. Conversely most perpetrators were male and much younger (more than 30 years) than their victims. Lee's study[13] in 2019 completed analysis on older clients (n39) presenting for forensic medical examinations at a sexual assault referral centre [SARC] in Manchester between 2007-17. This study identified 95% were female, with an average age of 83 years. The study identified two populations, those less frail who had been assaulted at home by an alleged stranger and a frailer population (77% of which had dementia) who had been assaulted by a caregiver or fellow resident in a place of care.

6.5. Research evidences that sexually disinhibited behaviour is a common presentation of some types of dementia, affecting 2-17% of patients.[14] Consequently, there can be significant challenges within care settings such as care and nursing homes, mental health units and hospitals in ensuring the sexual safety of residents, as they balance the health and care needs, and rights to a private life and freedom from deprivation of liberty (under Articles 5 and 8 of the European Convention on Human Rights), of all residents in their care, many of whom may display sexual disinhibition as a consequence of dementia or other cognitive or mental health disorders.

6.6. Further research into sexual violence perpetrated against older people notes that rates of sexual assaults in care settings may be twice the frequency of those in the community, but that this may be subject of significant underreporting. This could be due to communication of cognitive difficulties, fear or shame, or because "… *ageist stereotypes suggest older people cannot be victims of [sexual violence and abuse] as they are neither sexually active nor attractive, having a detrimental impact on recognition and response to suspected incidents, or disclosures, at both an individual and societal level*."[15]

6.7. One of the key barriers to safeguarding identified through the course of this review was the use of non-specific language to describe sexual concerns relating to Steven. While this may at times have related to practitioners seeking to 'professionalise' their recordings by using jargon and generalisations such as "*sexualised behaviour*" and "*incidents*", it may also indicate an underlying unconscious bias where practitioners are particularly reluctant to explicitly set out sexual activity by older people. Managers discussed that there could be a huge taboo around the use of sexual assault language and that practitioners were at times concerns that if they use specific language, the person will not be offered a placement in a care home, even if this is necessary to keep them and others safe.

6.8. The phrase "sexualised behaviour" can mean many things to many people, from mildly suggestive comments to serious sexual assault or rape. This created a number of difficulties in respect of risk assessment, mitigation and communication, which are discussed in more detail below. It is vital that practitioners have the confidence to use accurate, descriptive language when recording and reporting incidents and behaviours, and that these are not

[11] The ONS initially capped data at age 59, from 2017-21 it was increased to those aged 74 or under.

[12] Bows, H. (2018). Sexual Violence Against Older People: A Review of the Empirical Literature. Trauma, Violence, and Abuse, 19(5), 567-583. https://doi.org/10.1177/1524838016683455

[13] Lee JA, Majeed-Ariss R, Pedersen A, Yusuf F, White C. Sexually assaulted older women attending a U.K. sexual assault referral centre for a forensic medical examination. J Forensic Leg Med. 2019 Nov;68:101859. doi: 10.1016/j.jflm.2019.101859. Epub 2019 Aug 20. PMID: 31476524.

[14] Series, H., & Dégano, P. (2005). Hypersexuality in dementia. *Advances in Psychiatric Treatment*, 11, 424–431. doi:10.1192/apt.11.6.424

[15] Lee M, McKillop N, Moir E. A Scoping Review of Sexual Violence Events Perpetrated Against Older People. Trauma Violence Abuse. 2024 Dec;25(5):3951-3966. doi: 10.1177/15248380241265387. Epub 2024 Jul 31. PMID: 39082684; PMCID: PMC11545133.

diluted in documentation over time. The frequency and severity of behaviours must be clearly captured. When Violet's daughter was contacted by the home, she was told there had been "*an incident*" in relation to her mother because another resident had entered her room. In fact, another resident had entered Violet's room, touched her breast and masturbated over her, grabbing her hand and forcing her to touch his penis and when she called for help, verbally abused and threatened her. While the member of staff who spoke to the daughter may have been respecting her confidentiality (although Violet's consent could and should easily have been sought to enable more detail to be shared), this meant that her daughter initially had not understanding of the seriousness of the incident and had not intended to visit that morning, had she not felt uneasy about the conversation.

6.9. However, this minimisation may also indicate an unconscious bias in respect of the serious nature of the assault and impact on the victim. The prevalence of sexually disinhibited behaviour amongst people with cognitive impairments may desensitise staff in care settings, creating an obstacle to prevention of and responses to sexual assaults. Violet's daughter was extremely concerned that if her mother had dementia herself and not remembered the assault, she was not confident that the home would have reported this to the police. This belief was reinforced by the fact police had not been contacted by the time she arrived 6 hours after the assault, there was a lengthy delay in a manager arriving to oversee the situation, the fact that day staff did not appear to have been adequately briefed about the assault either to provide support to Violet (either emotionally or to contact the police or her family herself) or adequately supervise Steven and the comments by staff overheard by a family member as they were leaving "*Maybe they'll do something about it now".*

6.10. Managers in that case explained that their first priority was the safety of their residents and staff and welcomed the work by local partners to develop guidance on such investigations to encourage immediate contact with police. Whilst at times, staff may be uncertain whether a situation amounts to a crime as the couple appears to wish to have sex, but one or other's cognitive capacity is in question, providers and their frontline staff should feel confident to immediately contact police, without awaiting management instruction or first going through other safeguarding procedures (although relevant referrals should still be made). In circumstances when the victim has capacity to take a decision in respect of reporting this should be done with their consent unless the public interest in reporting the incident outweighs the impact of overriding their decision for safeguarding reasons, if they do not have capacity in this regard, a best interest decision should be taken in accordance with the principles of the MCA.

6.11. In 2020 the CQC published findings of their research into promoting sexual safety.[16] They found cultures where sex is treated as a taboo subject enables predatory behaviours. Their report calls for SCIE and providers to update guidance to staff working across health and social care to ensure staff are vigilant to changes in behaviours. It also highlights a need to improve the understanding of when someone has capacity to consent to sexual relations and duties to effectively collaborate with police; safeguarding teams; and support groups to ensure sexual safety incidents are understood, taken seriously and addressed appropriately. This includes ensuring people who have experienced sexual abuse are supported, including offering counselling and that the needs of specific groups are better understood so that their needs are met. Compliance with this guidance now forms part of any CQC inspection.

Systems finding

6.12. There is a lack of national or local guidance on responding to sexual abuse against victims over the age of 18 in care homes when either the victim or perpetrator may lack mental

[16] Available at: https://www.cqc.org.uk/sites/default/files/20200225_sexual_safety_sexuality.pdf. In response to this SCIR published revised guidance which is available at: https://www.skillsforcare.org.uk/resources/documents/Developing-your-workforce/Care-topics/Supporting-personal-relationships/SfC-Supporting-Personal-Relationships-Sept21.pdf

capacity to take decisions in respect of sexuality. Frontline staff in the care home lacked confidence to take decisions in respect of contacting police, ACS or Violet's family without management oversight, resulting in delays in the necessary referrals, and leaving Violet without support following a highly traumatic assault. Further, a lack of confidence by practitioners to use accurate language to describe sexual behaviour of older people and/or unconscious bias in respect of sexuality and the elderly appears to have hindered information sharing, risk management and the response to the assault on Violet.

***Recommendation 1**: All partner agencies should give clear advice to staff on accurate recording and reporting of safeguarding concerns, using specific language to enable risk to be accurately assessed and mitigated.*

***Recommendation 2**: Partners (working with providers, regulators and commissioners) should develop guidance on sexual offences to support providers of regulated care (both residential and domiciliary service), residents and family members understand minimum standards for a safeguarding adult enquiry and criminal investigation into sexual safety. This should ensure that frontline practitioners, including care staff, are clearly advised to contact police (or support the victim to do so) in situations when a sexual assault appears to have taken place, irrespective of their views in respect of the mental capacity of either the victim or perpetrator.*

***Recommendation 3:** ACS and HPFT should prepare a report for HSAB in respect of its safeguarding data on sexual harm in care settings by age and gender, to ensure that partners understand the scale of the issue locally and are better placed to develop a targeted strategic plan to address this.*

Assessment and mitigation of sexual risk for adults with cognitive impairment, and barriers to safeguarding

- *What is in place to support assessment of sexual risk in respect of individuals with dementia or other cognitive impairments, and how is this used to mitigate risk, both within a placement or at points of discharge or transfer? What, if any, barriers prevented information sharing in respect of the person who caused harm, disruption of his behaviours and safeguarding measures that could have been applied to prevent further victimisation?*

6.13. Since 2016 any professionals registered with the GMC, NMC, HCPC or Social Care England are required to take appropriate action to address and report concerns about the safety or wellbeing of service users, follow up any concerns and be open and honest if something has gone wrong. Those in professional roles working with children or 'adults at risk' are also expected to undertake safeguarding training (including during any undergraduate study and induction into a new role) to a requisite level of competency. Local and national policy requires that as a minimum, staff have met the NHS safeguarding assurance framework[17] and HSAB's safeguarding policy applicable at the time.

6.14. During learning events, practitioners and managers discussed the fact that each agency had its own risk assessments, and these were not necessarily saved in a prominent place on the person's file. Importantly, as identified above, these would typically use generic terms such as "sexualised behaviour" to describe incidents without providing specifics. Further, risk assessments were not necessarily shared when the person moved between care settings, or could be buried in a mass of paperwork.

6.15. While the initial concerns in the first care home involved Steven's previously consensual sexual relationship in another resident becoming obsessive and controlling, the second group

[17] NHS England » Safeguarding children, young people and adults at risk in the NHS: Safeguarding accountability and assurance framework

of concerns related to non-consensual sexual touching of other female residents who lacked cognitive capacity to consent. The third set of concerns related to sexualised comments made to female staff members, together with aggression to staff. As those were the most recent incidents, when Steven was discharged from the mental health unit, the recording of "sexualised behaviour" in information provided to the care homes was understood to relate only to that concern.

6.16. Although the incidents at Care Home X were appropriately referred to Hertfordshire's Adult Safeguarding service, these were recorded as safeguarding referrals on the case files of the women he had sexually touched, not Steven's file. This is common practice nationally, as the word of s42 of the Care Act 2014 mandates that local authorities must conduct enquiries if they suspect that an adult with care and support needs is experiencing or is at risk of abuse or neglect and is unable to protect themselves due to their care needs. The local authority is responsible for ensuring that appropriate measures are taken to safeguard the individual at risk. However, there is no reason that the referral cannot also be recorded in the safeguarding section of the person who has caused harm, if they are also understood to have care and support needs. Although there is no criticism of Care Home X's efforts to respond to Steven's behaviour in this case, in other circumstances an ongoing failure to put adequate measures in place to mitigate the person causing harm may be indicative of organisational neglect. Recording incidents of peer-on-peer abuse as safeguarding referrals in respect of both the perpetrator and victim facilitates analysis of patterns of harm and the response to these.

6.17. During the learning event, practitioners also discussed that often, referrals from providers would be made in the name of the person who had been harmed, but the name of the perpetrator and any witnesses (whether staff or other residents) were anonymised. Currently CQC guidance to care providers submitting notifications about alleged abuse requires providers not to include the name of any person on the form other than the person making the referral.[18] It is unclear why providers believe only initials of staff members should be recorded, including when they are witnesses to safeguarding incidents and it is possible that providers have conflated the CQC's guidance with the information to be provided to a local authority to facilitate a safeguarding enquiry. However, these are important records of statutory investigations and there is a clear legal basis under the Data Protection Act 2018 and GDPR for maintaining these records. In the event the adult at risk or their family made a subject access request, any staff members' or other residents' names could be redacted prior to disclosure of the records, and local authority information governance are well equipped to comply with this requirement. Although ACS's existing case management systems may not be set up to facilitate recording and access to allegations and incidents in respect of perpetrators or witnesses, there is no obstacle to this in law, as long as access to that information is restricted to ensure that this can only be access when necessary and proportionate. There is a clear lawful reason and public interest in the Adult Safeguarding and any social worker allocated to assess or support the person who has caused harm being able to access this information. One manager described the different requirements for different safeguarding and regulatory processes as "*feeling like you're in a washing machine.*"

6.18. Because Care Home X had taken appropriate steps to safeguard Steven's former partner, and then funding for 1:1 supervision for Steven to protect the second woman who lacked capacity in respect of sexual relationship, ACS took the view that the referrals did not need to progress to a s42 enquiry. However, the fact that there had been three incidents within a few days in respect of the second woman should have triggered the local authority to consider whether the safeguards that had been put in place for her over this period were adequate. Practitioners commented that they often experienced safeguarding referrals being closed down on the basis

[18] This is expressly stated within the word document for notifications embedded within their notification webpage. Available at: https://www.cqc.org.uk/guidance-regulation/providers/notifications/allegations-abuse-safeguarding-notification-form
https://www.essexsab.org.uk/guidance-policies-and-protocols

that risk had been mitigated, when the number of referrals received indicated that this was not the case. There is a balance to be struck in respect of keeping safeguarding enquiries open in circumstances when mitigation measures have been put in place, however, the serious nature of the risk in this situation warranted closer examination of the effectiveness of those mitigations.

6.19. Although the safeguarding concerns raised about Steven were recorded in the body of his ACS case notes, risk assessments were not completed or recorded on Steven's ACS case records and no 'banner' was added. This created a barrier to the practitioners subsequently allocated to his case being able to easily identify the history of concerns raised in respect of his behaviour, or the nature or frequency of those concerns. This also meant that the ACS practitioner tasked with ensuring that a suitable placement was available for Steven's discharge was not in a position to challenge the information discussed during the Care Planning Approach meeting, which did not include information in respect of the risk he posed to other residents. They were aware that he had a history of "sexualised behaviour", but none of the details. It is very much to the credit of this practitioner that they reflected thoughtfully on this during the learning event, acknowledging that they could have asked for further information.

6.20. Despite this, Care Home X showed persistence in attempting to obtain a reassessment of Steven's care needs, resulting in his assessment and subsequent detention under the MHA. The care plan prepared by Care Home X contained clear detail of all of the incidents Steven was involved in, however, because he transferred to a mental health unit for assessment and treatment, rather than to another care home, it does not appear that the mental health unit received this and it did not form part of the documentation shared with the specialist unit when he was discharged. HPFT staff commented that it was common that the only document they would received when someone transferred from a care home would be their medication chart. There was an onus on ward staff to make contact with the care home to obtain a history of risk, but often this would only occur after there had been an incident on the ward.

6.21. Five risk assessments were completed while Steven was detained in the mental health unit, and HPFT practitioners explained that these would automatically parse the background from previous risk assessments, so that details could be added to but not lost. However, these were only available on HPFT's case recording system and were not provided to ACS or the specialist unit. The mental health unit staff used a Positive Behaviour Support (PBS) approach to manage Steven's behaviour to other patients on the mixed ward, by gently intervening and distracting him when he started to approach female patients.

6.22. PBS is a person-centred framework for supporting people with cognitive needs or neurodiversity that takes a person-centred approach to create a positive physical and social environment and develop constructive interventions that eliminate the need for aversive and restrictive practices or overuse of medication.[19] By developing a sophisticated understanding of the individual's triggers and approaches that work for them to diffuse situations before they escalate, there is evidence that the approach significantly decreases challenging behaviour and promotes positive skills. However, because neither the previous risks nor the risk management plan were shared with subsequent care providers, this created the impression that Steven's sexualised behaviour related to staff members.

6.23. The purpose of establishing the specialist unit was to provide a safe environment for mental health patients to be discharged from hospital, and avoid the delays in discharge that can be very common for this cohort as many care homes are reluctant to offer beds as they do not feel confident that staff will be able to manage risks. This was evident from the first round of discharge planning for Steven in October 2023, when all of the care homes approached by

[19] About Positive Behaviour Support – Positive Behaviour Support

Brokerage advised that they could not manage the risk he posed – even though the risks to female residents was not included in the anonymised profiles circulated at that point either. As part of the agreed discharge process with HPFT and ACS was to hold in-person meetings to discuss the patient's needs and risks in detail, to ensure effective information sharing and facilitate risk management. Although these meetings took place for Steven, Provider A expressed their frustration that the information in respect of sexual risk to other residents was not shared by his clinical team, even though further concerns in respect a sexualise comment made to staff had been recorded by the mental health unit the week before the decision was taken to discharge him in January 2024.

6.24. Because the specialist unit was a new pilot, Steven was one of the first residents to move in, and this initial cohort were all male. During his time at the specialist unit, no concerns were recorded in respect of his behaviour towards other residents, but the fact there were no female residents may have masked the ongoing sexual risk. When he was ready to step-down to a mainstream care home, he moved into Care Home Y's main unit where there were a number of female residents, but he preferred to interact with staff. At Steven's sister's request, he then moved to Care Home A to be closer to her. This was a transfer between two care homes provided by Provider A, so Care Home A quite reasonably believed that they had been provided with all relevant information and assessments. The fact that partial information in respect of risk had been shared gave a false sense of security. There was some discussion by managers about whether Steven had been 'grooming' professionals when he initially arrived in new placements, to lower their defences so that safeguarding measures were reduced, but other attendees believed that this related more to common masking behaviours that many dementia patients will use to hide the deterioration in their cognition to others. This may also have explained differing views between different professionals who were involved in Steven's care or the investigation during different period in respect of whether he had capacity in relation to the criminal offence.

6.25. Practice by the police officer who attended the care home on the day of the assault was also outstanding in some ways, as they used professional curiosity not only to investigate the offence, but to ensure that safeguarding measures that the home reported to be in place were effective for Violet. However, having observed Steven moving freely around the unit unsupervised when he was supposed to be on one-to-one supervision, the officer's concerns about the inadequacy of these measures should have been shared urgently with Hertfordshire Adult Safeguarding to enable an alternative safeguarding plan to be put in place that day and ensure that other residents were kept safe. Although the officer's crime report noted that "[*Violet] is very clearly traumatised by this incident, and [Care Home A] haven't really provided much support at all*" and that "*In speaking to the members of staff, they hadn't put much in place to safeguard [Steven], [Violet] or other residents/staff*", this information was not clearly explained in the safeguarding referral that was subsequently sent to ACS. This only noted in the context of Steven's diagnosis of dementia/Alzheimers "*I am concerned that he is not receiving the appropriate support from the Care home and have not had sufficient safeguarding put in place for him.*" This needed to explicitly explain that this concern related to the home's safeguarding measures subsequent to the assault. At the leadership event, police commented that frontline officers were expected to be a 'Jack-of-all-trades', and that MCA training was not mandatory for officers. The specialist safeguarding team received training in respect of sexual and elder abuse, but there was a need to upskill frontline officers to support them to understand how to respond to issues across the community.

6.26. While there is no criticism of the officer's proactive, person centred approach for Violet, if it appears that both residents cannot safely remain in the same accommodation following an incident of peer-on-peer abuse, it is preferable for the victim to remain in the home (subject to their wishes) so that they can be supported in a familiar setting, and for the perpetrator to be moved. It is acknowledged that this can pose significant difficulties, as alternative providers may be reluctant to offer a placement to a resident who poses a risk to others. However,

moving the person who has been harmed effectively 'punishes' them for being the victim of an offence. Other options, such as a move to another care home rather than hospital, could also have been explored with Violet and her family by ACS, to ensure they were taking an informed decision based on all reasonable care options. A multi-agency strategy discussion at an early stage would have enabled these options to be explored.

6.27. It is to the credit of Hospital A that they offered Violet a place of safety after she was taken to the emergency department for assessment, but Trust leaders noted that hospital admissions should only take place when this is medically necessary, as acute hospitals are designed to manage physical illness and urgent medical need and will struggle to provide therapeutic environments for survivors of severe trauma as a first line response. The concerns reported by Violet's daughter that her mother moved wards at Hospital A repeatedly in her first week were driven by clinical acuity, bed pressures, and the need to access appropriate specialist input. A community-based setting would have been far better suited to meet her psychological, emotional, and therapeutic needs. Trust leaders acknowledged that the ward moves and lack of continuity in surroundings, while often unavoidable in acute care, could have been detrimental to her wellbeing.

6.28. Violet's daughter's concerns that she was repeatedly asked to tell her story by different services indicates that the way care was delivered caused Violet to feel compelled to revisit her trauma. Daily reviews and involvement of multiple specialty teams are standard in acute hospital practice, but without a system for recording and sharing a single trauma narrative, patients can be unintentionally re-traumatised. A psychologist who assessed Violet advised the family that it was likely that the 'ghosts' she reported seeing while on the ward related to her psychological distress. At the managers event, hospital leaders commented that they had tried to minimise the number of agencies involved in Violet's care to prevent her having to repeat herself, but acknowledged that her rapidly changing health needs meant she was moved to prioritise those medical needs, and that consequently, staff were constantly revisiting events with her. Consideration should be given to how Violet could have been supported to feel safer during necessary moves within the hospital. Further, the exemplary support and psychological safety provided by the ISVA could have been used more effectively to obviate the need for Violet to repeat her story to new teams when moves could not be avoided. While this support was available to Violet in hospital, managers noted that the current waiting list for support from community ISVAs was 6 months.

6.29. Despite these challenges, there is evidence of good practice. The hospital ISVA worked closely with clinical teams and provided trauma-informed guidance that was acknowledged in care records. The safeguarding service and multidisciplinary teams, including occupational therapy, physiotherapy, dietetics, integrated discharge, and later palliative care, engaged actively with Violet's care. Family meetings and updates were documented, and staff made efforts to coordinate across professional boundaries. Violet's rapidly deteriorating physical health, including a severe infection, required involvement from multiple specialists, adding to the complexity of her care.

6.30. While the contribution of the ISVA in this case was exemplary, the disparity between hospital-based support and long waits for community ISVA services highlights a systemic gap in care continuity. The Trust recognises the need to continue developing trauma-informed pathways within the acute setting, to strengthen sharing of single trauma narratives across teams. Leaders are committed to the continued growth and development of the current in house ISVA service to support great results for trauma informed approaches to victims and survivors. The Trust has prepared an overview in respect of its recent developments and achievements in respect of trauma informed care to give assurance to partners which reflects a real commitment to meeting the needs of its patients, and this should be replicated by other Health partners providing acute in-patient services, to enable HSAB to analyse the consistency of the local approach and any gaps in current provision.

6.31. Hourglass' report into sexual violence and assault against older people in care settings over 2016-21[20] concluded that inconsistency in recording concerns, misperceptions that the status of the victim (e.g. impaired cognitive function due to dementia), or their ability to identify the perpetrator, frustrated expected safeguarding practice that abuse against adults with care and support needs would be reported as a potential crime, as a safeguarding concern and via (where appropriate) internal disciplinary processes. This report made several recommendations, including that older adults alleging sexual assault should be signposted for specialist support to the nearest Sexual Assault Referral Centre [SARC].

6.32. This further reinforces the vital importance of care providers being fully involved in multi-agency strategy meetings to plan how investigations will be undertaken and provide their invaluable insight into the perpetrator's mental capacity in respect of the offence, the victim's abilities, presentations and needs. An independent sexual violence advocate should be invited to the meetings, to advocate for their rights. Consideration should also be given to obtaining input from an advocate under s67 of the Care Act, to facilitate the victim's contribution to the s42 enquiry.

Systems finding

6.33. There is a serious gap in how to ensure that evidence in respect of residents in care homes who pose a risk of physical or sexual harm to other residents is consistently collated and recorded in a way that is accessible to Adult Care Services, care providers and other relevant partners. This issue applies not only to Hertfordshire but is a national issue which presents a very serious risk in cases when the person who is the source of risk moves between care and health providers or local authority areas. Although police will record allegations against the alleged perpetrator, is unclear whether are police consistently involved in cases where practitioners are of the view that the source of harm lacks mental capacity in respect of these behaviours. This gap needs to be urgently addressed locally and nationally.

6.34. Further, gaps in information sharing hindered risk assessment and acted as a barrier to safeguarding in this case. Incidents of peer-on-peer abuse should be recorded as safeguarding referrals in respect of both the perpetrator and victim to facilitate analysis of patterns of harm and the response to these. Although some agencies completed risk assessments and implemented risk management strategies, these were not shared between agencies, and the vague language used to describe incidents minimised risk and undermined opportunities to safeguard. The pilot scheme to establish Care Home Y's specialist unit to provide specialist accommodation to facilitate safe discharge from mental health units was innovative and commendable, however, this relies on strict adherence to the agreed handover process to support risk management and information sharing.

6.35. The professional response on the day of the incident lacked coordination and was not person-centred. The absence of a multi-agency strategy meeting at an early stage of the investigation meant that the victim was not provided with all available care options to take an informed decision, resulting in her being moved to hospital inappropriately. Specialist independent advocacy around sexual violence should be routinely involved in strategy discussions and SARCs utilised to support the individual where appropriate, in particular to ensure that unconscious bias in respect of the ability of the victim to remember events or give evidence does not undermine a potential prosecution.

Recommendation 4: *HSAB need to consider how partners will assess, manage and record the risk posed by perpetrators in care homes, who may or may not be open to ACS. In addition to*

[20] Available at: https://www.wearehourglass.org/sites/default/files/inline-files/Sexual%20Violence%20and%20Assault%20against%20older%20people%20in%20hospitals%20in%20England%202021.pdf

developing a local procedure, HSAB should raise this regionally with a view to escalation to the National SAB Chairs Network to develop a consistent national approach.

***Recommendation 5:** Adult Care Services and HPFT should set up a working group to amend the multi-disciplinary adult safeguarding procedures to include:*

- ***a)** While recommendation 4 is actioned, further instruction should be provided to all staff, including locums, to ensure that banners in respect of safeguarding referrals are applied and specific risks highlighted consistently on perpetrators' files.*
- ***b)** When multiple safeguarding referrals are received in respect of the same person either being subjected to, or causing harm, a multi-disciplinary strategy meeting should be convened by ACS or HPFT (dependent on who holds responsibility for conduct of the safeguarding enquiry under local arrangements) before a decision is taken to close a safeguarding enquiry, to understand the reasons for those concerns and facilitate exploration of whether measures to mitigate risk have been effective.*
- ***c)** When undertaking enquiries in respect of sexual assaults against older people involving peer-on-peer abuse, there should be a presumption that a multi-disciplinary strategy meetings (including urgent strategy discussions to ensure the risk posed by the perpetrator have been mitigated) will be convened to explore the incident, and the needs, risks and capacity in relation to both the victim and perpetrator and ensure that the safeguarding plan is approached holistically.*
- ***d)** All agencies should be empowered to trigger multi-disciplinary meetings when concerns arise in respect of an individual's safety or care.*
- ***e)** Agencies should routinely utilise specialist independent sexual violence advocates and SARC forensic units where appropriate to protect against unconscious bias. ISVAs should be invited to multi-agency strategy meetings to promote the voice of the person who has been harmed. Care providers should be invited to strategy meetings, including when the individual has moved to a new placement within a recent period, to support information sharing and inform assessments of mental capacity.*
- ***f)** Risk assessments and risk management plans prepared by individual agencies should be shared with the new provider whenever the individual moves placement and as part of the safeguarding process. These should be collated to ensure that all relevant risks are well understood and a cohesive risk management strategy can be developed and shared as the individual moves between care settings.*
- ***g)** There should be a presumption against use of hospitals as a place of safety following an incident of harm in a care home, unless there is a clear health need for admission. If it is not possible to avoid moving the victim's placement, alternative care provision should be urgently procured, in consultation with the victim and/or their family.*

***Recommendation 6:** NHS partners responsible for in-patient settings should each provide an assurance report to HSAB in respect of their approach to trauma-informed care for in-patients admitted following a sexual assault.*

Embedding best practice

- *What does a safe environment look like in a care home and how do we ensure these standards and risk mitigation models are embedded across the county?*

6.36. A 2018 report by the Care Quality Commission[21] on sexual safety in mental health wards (which Hertfordshire Partnership Foundation NHS Trust contributed to) highlighted widespread issues of sexual safety in mental health inpatient settings across England. Between April and June 2017, 1,120 sexual incidents were reported, including harassment, assault, and inappropriate sexual behaviour—mostly in communal areas and often involving

[21] 20180911c_sexualsafetymh_report.pdf

vulnerable patients. Many incidents were under-reported or poorly documented, and staff lacked training and guidance to respond effectively. Key findings include patients often feeling unsafe and unsupported, that staff and clinical leaders lacked clarity on best practices, that mixed-sex wards and inadequate environments increased risks, and that joint working with police and safeguarding teams was inconsistent. Recommendations included national guidance, trauma-informed care training, improved ward environments, stronger reporting systems, and collaborative safeguarding efforts.

6.37. Improving staff training in care settings to enhance sexual safety requires a multi-layered approach. Care providers should run mandatory induction and refresher training for staff on sexual safety, consent, and capacity. Trauma-Informed care training should equip staff with skills to recognise and respond to trauma-related behaviours, emphasise empathy, safety, and empowerment in patient interactions and include modules on gender-based violence and its psychological impact. This should be supported through scenario-based learning for practitioners, using real-life case studies and role-playing to simulate incidents and training staff on de-escalation techniques and appropriate intervention. Fundamental to this is respect for diversity in accordance with the principles of the Equality Act 2010, including age, gender and sexual orientation. Ideally training should include specialist workshops for relevant practitioners, inviting experts in the intersectionality between sexual violence, safeguarding, and elder abuse, incorporating sessions on supporting vulnerable groups, including older women and LGBTQ+ patients. Training must be continuous, not one-off, updating content based on new research, policy changes, and incident reviews.

6.38. Clear protocols and reporting procedures must be in place to ensure staff understand how to document and report sexual incidents, providing training on safeguarding policies and legal responsibilities. This should establish clear professional boundaries and consistent enforcement of behavioural expectations and accountability, with a zero-tolerance culture for sexual harassment or abuse, including open communication where residents feel safe to report incidents without feeling shamed and staff feel safe to report concerns without fear of retaliation. This should include a framework to support staff wellbeing, including psychological support, supervision and reflective practice to help staff manage stress, and encourage reflective practice and peer learning.

6.39. A safe physical environment in a care home includes single-sex accommodation where possible, or clear separation of sleeping and bathroom areas by gender. Secure wards should have a layout with no blind spots, functioning door locks, and controlled access to private areas. Communal areas should be well-supervised and designed to reduce risk of inappropriate interactions. Practitioners commented that some care homes had separate male and female floors and communal lounges, with locked doors restricting residents' movements.

6.40. During the learning event, practitioners and managers noted that there was a shortage both nationally and locally in respect of single gender care homes and that as a consequence, no options had been available for Steven to be placed in a male-only care home. Consequently, after the assault on Violet, Steven remained on 1:1 supervision for a lengthy period, which he found restrictive, frustrating and increased his sense of depression, particularly as it was not always clear whether he recalled the incident that had led to these restrictions being imposed. The care home sought a Deprivation of Liberty Safeguards (DoLS) authorisation from the local authority, however, the DoLS assessor considered the restrictions to be disproportionate and only authorised these for a limited period. Steven was detained again under the MHA and moved to a mental health unit before the DoLS expired. One manager commented "*there are a lot of confused people in care homes and not enough is done to keep them safe. I felt terrible when the referral came through about the sexual assault because we should have kept [Steven] safe from that too.*"

6.41. Managers explained that far more women entered care homes than men (with a relative proportion locally of 7 women to 3 men), in part due to the current difference in life expectancy of men and women, but that as this gap narrowed, more men were entering the care system. They also discussed that as people with physical care needs were increasingly supported to live independently in their own homes, the proportion of residents in care homes with dementia was sharply increasing, now accounting for approximately 7/10 care packages across Hertfordshire. They acknowledged that current resources were generally insufficient for care homes to recruit sufficient ratios of suitably qualified staff with the necessary skills to meet the more complex needs of this cohort.

6.42. This has enormous implications in respect of sexual safety. As noted above, sexually disinhibited behaviour affects 2-17% of patients with some types of dementia, and although there may be significant underreporting in respect of female perpetrators, men account for 98–99% of sexual offence convictions across all age groups.[22] Further, managers discussed that in addition to the national challenges in recruiting skilled and experienced care staff, all-male units could face even greater recruitment challenges, as the higher risk of aggression required higher staffing levels, but candidates often perceived these to be less desirable workplaces. As more men with dementia move into care homes the sexual safety risk is likely to sharply increase, so there is an urgent need for partners with responsibility for commissioning mental health, nursing and care home provision locally to develop a strategic plan to meet their resulting safeguarding and sufficiency duties.

6.43. In the interim, commissioners and care providers need to consider how to improve physical safety in care settings. Currently residents with capacity to make decisions on this issue have a key to their room to enable them to lock this if they chose. There was some debate during the learning events about whether the door to Violet's room should have been kept closed and only accessible from the outside by staff using swipe card (without restricting her own ability to leave or enter). However, both staff from Care Home A and Violet's daughter were clear that she wanted her door left open due to the trauma she had experienced waiting alone for hours after falling and breaking her hip. As a capacitous adult, she was entitled to exercise her Article 8 right to a private life and Article 5 right to freedom from deprivation of her liberty in this way. One practitioner commented "*We want the care home to feel like her home, if she wants to leave the door open, that's her right*". A manager commented that this risked victim blaming for leaving a door unlocked. The fundamental issue here is that the individual needs to be informed of the risk that other residents may pose, including those whose behaviour could be disinhibited due to cognitive decline, so that their decision making around shutting or locking their door is based on informed choice.

6.44. Technology may be utilised to improve sexual safety in some circumstances. It is to the credit of Care Home A that at the time of the assault, they already utilised personal safety tools like call buttons or wearable alarms for residents, and the fact Violet had been provided with this and that it was kept within her reach, enabled staff to respond immediately when Steven assaulted her. Care Home X discussed that in addition to increasing their standard two-hourly checks for all residents to half-hourly checks for residents who were assessed as being at risk of falls, they had pressure sensor pads in the rooms to identify when residents got out of bed. Although this had been in place for Steven as he had fallen on several occasions, he would kick the sensor pad under his bed to avoid staff coming to check when he was with the woman he was in a relationship with at the time. However, recently Care Home X introduced motion and acoustic sensors for residents at risk of falls, which were much more effective and had the additional benefit of enabling two-way conversations between staff and residents to facilitate checks in a non-intrusive way. They noted that care had to be taken when using this for dementia patients, as they could be confused by hearing the staff, so physical checks were undertaken. Managers agreed that the motion and acoustic sensors would be very useful in

[22] England and Wales sexual offences 2025| Statista

managing sexual risk, as this could be used to ensure that residents with sexually disinhibited behaviour did not exit their rooms without staff noticing.

Systems finding

6.45. Although national guidance is available to support understanding how to create safe care home environments, local guidance needs to be developed to support care providers across the partnership, taking into account local pressures. To ensure accountability across the partnership, front line care setting staff, residents and their families should be involved in co-designing safety initiatives and feedback mechanisms on the impact of these. However, there is an increasing need for specialist beds for individuals (and in particular men) with dementia, cognitive impairments or mental disorders whose sexual disinhibition poses a risk to others. Consequently, there is an urgent need for partners with responsibility for commissioning mental health, nursing and care home provision locally to develop a strategic plan to meet their resulting safeguarding and sufficiency duties.

Recommendation 7: *Each partner agency with responsibilities for commissioning care/nursing home beds should develop a strategic plan to commission provision to meet the needs of older people with dementia, cognitive impairments or mental disorders whose sexual disinhibition poses a risk to others, to avoid them becoming detained or remaining in hospital for lengthy periods as formal or informal patients.*

Recommendation 8: *HSAB partners should establish a working group to develop local guidance for care providers to support safeguarding and risk mitigation in respect of sexual risk in care settings, including through assistive technologies. Care home policies in respect of doors being closed or locked should address informed consent, including an explanation to residents that other residents may pose a risk to them. This should be co-produced with providers and residents.*