Safeguarding Adults Review

Executive Summary

'Dorothy'

LIVERPOOL SAFEGUARDING ADULTS BOARD

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Publication Date: 4th June 2026

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1.0 Introduction

1.1 To protect the privacy of the individuals involved in this Safeguarding Adults Review (SAR) and their families, pseudonyms have been used. The female resident of the local care home where a serious safeguarding incident (an alleged Rape[1]) occurred is referred to as 'Dorothy', and the male resident, the perpetrator is referred to as 'Kenneth'.

1.2 Dorothy, diagnosed with dementia, and Kenneth diagnosed with an alcohol-related brain injury, were assessed under the Mental Capacity Act[2] (2005) as unable to decide their place of residence for care. They were both placed in a local residential nursing care home based on best interest decisions[3]. The staff at the care home where both resided are trained to support people with dementia.

1.3 Dorothy who is a white British woman in her seventies has been living in the care home designated as a permanent residence since 2022. Kenneth also white British and aged in his sixties was discharged to the same care home in July 2022, this was arranged on a temporary 28-day basis following the Discharge to Assess (D2A) pathway[4] used when discharging someone from hospital.

1.4 Six days after Kenneth had been transferred to the care home on the morning of August 2nd 2022, a carer entered Dorothy's bedroom at the care home, the door of which was open and found Kenneth lying in bed on top of her. Both were found to be naked from the waist down and it appeared that Kenneth was trying to have sexual intercourse with Dorothy.

1.5 The staff member requested assistance. Dorothy and Kenneth were promptly assigned a 1:1 carer each, both the Police and ambulance service were called for support.

1.6 Following the incident Kenneth was arrested and detained by Police under Section 136 and later Section 2 of the Mental Health Act (1983)[5]. Dorothy was taken to the Emergency Department (ED) of a local hospital and was found to have multiple bruises to her thigh. Dorothy was later returned to the care home following discussion with her family, given a new bedroom, and continued to be supported 1:1 by a carer.

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[1] The legal definition of rape in England is when someone intentionally penetrates the vagina, anus or mouth of another person with their penis, without that persons' consent. Sexual Offenses Act 2003 https://www.legistlation.gov.uk

[2] The Mental Capacity Act (MCA) 2005 is a UK law designed to protect and empower individuals aged 16 and over who may lack the capacity to make decisions for themselves. https://www.nhs.uk

[3] If you make a decision for someone who does not have capacity, it must be in their best interests.

[4] Discharge to Assess (D2A) is a collaborative model of care where people who are clinically optimised and do not require acute hospital care are provided with short-term funded care until assessed needs are re-evaluated https://www.local.gov.uk

[5] Section 136 of the Mental Health Act gives Police the power to remove a person from a public place to a place of safety if they appear to be suffering from a mental disorder and need immediate care. Section 2 of the Mental Health Act (1983) allows for a person to be admitted to hospital for up to 28 days to assess whether they are suffering from a mental disorder. https://www.legislation.gov.uk

1.7 Following the incident, Liverpool City Council (LCC) Adult Social Care (ASC) led a Section 42 safeguarding enquiry[6] to determine how the event occurred and to identify and share any learning and good practice across the LCC boundary.

2.0 Commissioning of the Safeguarding Adults Review and Key Lines of Enquiry.

2.1 Liverpool Safeguarding Adults Board (LSAB) has a statutory duty under the Care Act 2014[7] to arrange a SAR involving an adult in its area with care and support needs (whether or not the local authority has been meeting any of those needs) if a – there is reasonable cause for concern about how the Safeguarding Partnership, members of it or other persons with relevant functions worked together to safeguard the adult and b – condition 1 or 2 is met.

- Condition 2 is met if:

a. the adult is still alive, and

b. the Safeguarding Adults Board knows or suspects that the adult has experienced serious abuse or neglect.

2.2 SAR panel members are required to participate in the review process to identify lessons learned and apply those lessons in the future. The goal is not to assign blame or responsibility, but to find ways to improve how agencies operate both independently and collaboratively, in order to assist and protect adults with care and support needs who are at risk of abuse and/or neglect and cannot protect themselves.

2.3 The initial SAR referral was submitted to Liverpool City Council (LCC) ASC on 15th May 2023. Two screening meetings were held to assess the referral, and to review summaries of the partner agencies' involvement, concluding on July 17th 2023. The recommendation that criteria 2 for a mandatory SAR was met was agreed on August 24th 2023. The independent chair of the LSAB approved the progression of this SAR on September 23rd 2023. The LSAB subsequently sought an appropriate independent author to lead the review: Michelle Grant was commissioned on March 10th 2025.

2.4 The initial panel meeting was conducted on May 13th 2025, to discuss the primary lines of enquiry for the review and to determine the additional information needed to create a first draft report. It was decided that contact with both Dorothy's family and Kenneth's family would be made to enable the independent reviewer to understand the lives of Dorothy and Kenneth.

[6] This Section of the Care Act 2014 applies when a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there) has experienced abuse or neglect https://www.legislation.gov.uk

[7] Care Act 2014 sections 44 (1), (2) and (3) https://www.legistlation.gov.uk [Accessed April 2025]

The screening panel members agreed the following concerns identified as below:

Topic	Details
Hospital discharge process, full disclosure of known information about Kenneth	Pathways shared on health needs analysis of Kenneth
Risk minimisation	Focussed on female staff, not a wider risk assessment considering females more generally
Male only care environment	Should Kenneth have been placed in a male only care environment
Placement of Dorothy	Against a history of CQC inspection reports
How well trained are partner agency staff in being able to talk to people with care and support needs about their sexuality	Sexual preferences were included in the care plans at the care home, but this didn't identify potential risks

2.4 The above became the key lines of enquiry for the SAR and were mapped against the six principles of adult safeguarding: empowerment, prevention, proportionality, protection, partnership and accountability[8].

2.5 A second panel meeting was held on July 3rd 2025, to discuss the first draft report and agree the arrangements for the Practitioner Learning Event (PLE) planned for July 10th 2025. It was agreed that this could be held over Microsoft Teams due to the smaller number of staff who had had direct contact with both residents and to gain an understanding of how care was provided using a person-centred approach.

2.6 A further panel meeting was held on September 10th 2025 to discuss the revised draft report and to agree the questions to the LSAB. Additional comments made on the draft report and further documentation was scrutinised by the independent author prior to the final draft report being presented and agreed by LSAB Board Members on February 2nd 2026.

3.0 Methodology

3.1 The review methodology was established as an adapted version of a SAR in Rapid Time[9] due to the short timeframe and the limited number of agencies involved. Agencies were requested to provide a summary of their involvement with Dorothy and Kenneth from January 2021 until August 2022. After reviewing the information provided, the independent reviewer posed additional questions to the agencies to address any gaps in information and to confirm understanding. The summaries included identifying aspects of agencies involvement with both Dorothy and Kenneth that were successful and those that could be improved upon to enhance system learning.

3.2 The independent reviewer who has no connection to either the LSAB or any of its partner agencies was also given the opportunity to review the Rapid Review SBAR completed by

[8] Six Principles of Adult Safeguarding https://www.scie.org.uk

[9] Safeguarding Adult Reviews (SAR's) in Rapid Time model (SARiRT) provides a process that supports reviews to draw out systems learning to promote practical improvement using a timely and proportionate approach https://www.scie.org.uk

Hospital following the discharge of Kenneth and the care plans of both Dorothy and Kenneth shared by the care provider.

4.0 Panel Membership

Role	Agency involvement
Independent Reviewer	
Divisional Director of Nursing and Safeguarding	**Hospital NHS Foundation Trust**
Head of Safeguarding and Assurance	**Liverpool City Council Adult Social Care (ASC)**
Detective Superintendent Area Investigations Protecting Vulnerable People	**Merseyside Police**
Named GP for Safeguarding	**Integrated Care Board – Liverpool Place (ICB)**
Safeguarding Practitioner	**Northwest Ambulance Service (NWAS)**
Head of Quality and Safety Improvement	**Integrated Care Board – Liverpool Place (ICB)**
Named Nurse Safeguarding Adults	**Mersey Care NHS Foundation Trust (MCFT)**
Director of Operations	**Care Provider**
Board Manager	**Liverpool Safeguarding Adults Board hosted by Liverpool City Council (LSAB)**
Minute Taker	**LSAB Business Support hosted by LCC**

5.0 Equality and Diversity

5.1 Equality and Diversity Considerations

The Equality Act (2010) serves to protect individuals from discrimination, harassment, and victimisation on the basis of nine defined "protected characteristics". In Dorothy's case, relevant protected characteristics included her age, her status as a female, and her diagnosis of dementia. These factors are central to understanding the context and the responses that followed the serious safeguarding incident involving Dorothy.

5.2 Access to Services Following the Incident

This was reviewed in full by panel.

5.3 Mental Capacity and Investigation

This was reviewed in full by panel.

6.0 Findings

6.1 Information sharing to allow for holistic risk assessments and care planning

6.1.1 Reflecting with the benefit of hindsight, it is evident that alternative actions might have led to different outcomes. This review has endeavoured to evaluate the decisions made at the time based on the information available, which informed the risk assessments and care plans.

6.1.2 During his inpatient stay at Hospital, staff did observe Kenneth demonstrating challenging behaviours and some inappropriate comments towards female staff. It was confirmed that challenging behaviour can be commonly experienced by staff when caring for patients with cognitive impairment, staff at the Trust have received appropriate levels of training to manage these risks. Staff were asked by the SCDT to document Kenneth's behaviours on charts so that this could be risk assessed. Due to his presentation a DoLS application was made by hospital staff and he was placed on 1-1 supervision to minimise risk although it is noted that on one occasion when there were insufficient staff to provide this level of supervision Kenneth managed to abscond from the ward. Kenneth's family also shared their concerns with health and social care staff about their brother's unpredictable aggressive behaviours; this information was shared with the care home staff, but there was no risk identified that would have predicted that an alleged Rape of a female resident might occur.

6.1.3 It was recognised that Kenneth required a secure discharge placement so that further assessments could be undertaken to establish his longer-term needs for care and support. This resulted in discharge paperwork being completed by both ward staff and a Social Worker, neither document reflected that Kenneth required a male only placement. Kenneth's sister shared with Police that the Social Worker had indicated to her that if they were to disclose all relevant information known about Kenneth's behaviours then ASC would struggle to find a placement that would accept him. This statement is unfortunate and has not been confirmed.

6.1.4 The Brokerage team at Mersey Care was involved in identifying an appropriate placement for Kenneth. The selected care home had undergone a CQC inspection in 2021. The report rated the care home as 'inadequate'. As a result, the care home was required to develop and implement an improvement action plan due to breaches of regulation. A subsequent inspection noted some improvements; The overall rating of the care home in this report was 'requires improvement'.

6.1.5 Incomplete information about Kenneth and his care and support needs were shared with the care provider who accepted him based on the information shared with them. As has been identified earlier Kenneth had been on 1-1 supervision at the hospital but this information was missing from the HNA. The care home placed Kenneth on hourly

observations overnight to allow them to establish if he had any patterns of behaviour that needed additional support.

6.1.6 In the days leading up to the alleged Rape, there were missed opportunities to review Kenneth's risk assessments and care plan. The behaviours documented by staff, such as Kenneth being awake at night, knocking on other residents' bedroom doors, harassing a resident, entering Dorothy's bedroom, and inappropriate touching of a female staff member, were reported to the home managers at the time they occurred, but these incidents did not prompt an earlier review of his care plan.

6.1.7 As part of the section 42 safeguarding enquiry following the alleged Rape of Dorothy the care home maintain that they were able to demonstrate that they had relevant policies and procedures in place at the time despite the enquiry reflecting that this was not the case. The most recent CQC report on the care home found that staff received training and understood the actions they must take if they felt someone was being harmed or abused. This was evident immediately following the alleged Rape in the actions taken by both staff and the duty manager.

6.2 Response by agencies when the alleged Rape happened

6.2.1 ASC were quick to act on their statutory safeguarding duties and followed local procedures as would be expected. A strategy meeting was convened with all appropriate partner agencies in attendance. A risk assessment and risk management plan were completed and implemented with the involvement of both Dorothy and her family. The Social Worker acted sensitively being mindful of the principles of Making Safeguarding Personal.

6.2.2 The Social Worker referred both Dorothy and her family to the Rape and Sexual Abuse Centre[10] (RASA) in Merseyside who offer counselling services. The Social Worker also checked with Dorothy's family whether they had had any contact with their GP following the incident, as they stated they had not the Social Worker also followed this up. The safeguarding enquiry following the incident was thorough; Dorothy and her family were provided with regular updates.

6.2.3 Internal departments within LCC including assessment and care delivery, quality assurance and commissioning worked well together in reviewing if policy and procedures had been followed correctly by the care home manager and their staff.

6.2.4 Dorothy's family informed the independent reviewer that they understood that Kenneth had been interviewed about the alleged Rape of Dorothy following his arrest by Police. Merseyside Police have confirmed that Kenneth was never considered to have the mental capacity to be subject to interview, either under arrest or not under arrest. The

[10] RASA https://www.rasamerseyside.org

provision of an appropriate adult or intermediary would not have been an enabler to conducting an interview under these circumstances.

6.2.5 Following Dorothy been medically examined at HOSPITAL Police made enquiries with Liverpool SARC to request an examination. This was not possible due to capacity issues at Liverpool SARC. The Police were subsequently advised to contact the Manchester SARC. They too were unable to see Dorothy as they were already dealing with five Liverpool cases, they were advised to call back the following day. From the Police records it is not clear that Dorothy was forensically examined at any SARC following the alleged Rape. The documentation held by the Police reflects that it cannot be forensically confirmed or discounted that Dorothy was subject to a S1 rape contrary to the Sexual Offenses Act (2003), or whether this was a sexual assault under the same legislation. Evidentially a confirmed rape would not enable a pathway to prosecution in the absence of the suspect having the mental capacity to understand the concept of consensual sex.

6.2.6 It was identified that Kenneth had a wait of five hours before someone could complete an MHA assessment on him while he was in Police custody and then a further three hours before a suitable placement could be found for him to be transferred to. The national guidance is that an assessment should begin as soon as possible, ideally within three hours. The Police have under section 136 of the MHA (1983) up to 24 hours to detain a person which can be extended for a further 12 hours if the assessment has still not been carried out.

6.2.7 The independent reviewer and panel members acknowledge the CPS will consider prosecuting rape cases even if the perpetrator has a mental capacity issue affecting their ability to testify, but only if there's sufficient evidence and it is deemed in the public interest[11]. The key is whether a realistic prospect of conviction exists, and mental health factors are considered within that framework it is not as an automatic exemption from prosecution.

6.2.8 Even with sufficient evidence the Police and CPS must also consider whether prosecuting is in the public interest this involves weighing various factors including the seriousness of the offence and the impact on the victim. The Police and CPS acknowledges the impact of rape and sexual assault on victims and is aware of the impact of the families of victims when prosecutions do not go ahead when felt not to be in the public interest. This is something that Dorothy's family reflected on when he met with the independent reviewer, they understand the rationale, but the Police decision to take No Further Action was still hard to accept.

6.2.9 Findings from research studies[12][13]show that only a few perpetrators were held accountable and that an assault often had no legal consequence, despite witnesses in several of the sexual abuse incidents. In cases where residents were abusers the patients were

[11] How we make a decision on what to do in your case – Rape and Serious Sexual Assault https://www.cps.gov.uk [Accessed June 2025]

[12] Teaster PB, Roberto K.A, Chapter 7 sexual abuse of older women living in nursing homes Journal of Gerontological Social Work 2004;40 (4) 105 -119 doi:10.1300/j083v4n04_608 [DOI]

[13] Burgess A.W, Prentky R.A, Dowdell E.B Sexual predators in nursing homes Journal of Psychosocial Nursing and Mental Health Services 2000;38 (8): 26 – 35 doi:10.3928/0279-3695-20000801-11 [DOI]

transferred to other hospitals or other nursing homes as in the outcome for Kenneth. Any change in existing protocols would require a significant review at a national level.

6.2.10 Research also finds that there are different definitions of what sexual abuse is some practitioners felt that being talked to in a sexual way that made them feel uncomfortable was more likely to be perceived as harassment and not sexual abuse[14]. The World Health Organisation (WHO) define sexual abuse as nonconsensual sexual contact of any kind with the older person[15]. They conclude that a universally accepted definition would be helpful in order for practitioners to have an agreed understanding of what sexual abuse was and have this included in training. The availability of sexual safety policies, guidance and quality standards to promote best practice, instil confidence in staff, and provide a framework for staff training was also identified by SCIE[16]

6.2.10 In their report, the CQC[17] concluded that a reluctance to discuss sexuality and consensual sex, which are fundamental human needs, can prevent individuals from receiving optimal care and support. This may increase the risk of sexually inappropriate actions due to a lack of awareness, support, or guidance, ultimately placing both the individual and others at potential risk of harm. They have a summary of their recommendations within this report which the LSAB and its partner agencies should reflect upon.

7.0 Good Practice

7.1 ASC

7.1.1 The Social Worker managed the safeguarding enquiry in accordance with policy and procedure, with the enquiry being closed when appropriate disclosure of information was shared. Missing information was professionally challenged with and by the care home.

7.2 The Care Home

7.2.1 Staff at the care home acted quickly and effectively once the alleged Rape was identified.

7.2.2 Kenneth was discharged and removed immediately from the care home on the day of the incident which was noted to be in line with the care home's policy. Re admission was refused by the regional manager following the incident, Dorothy was accepted back and provided with a different bedroom.

7.2.3 Sexuality was referred to in both Dorothy and Kenneth's care plans at the care home. For Dorothy this was in respect of her contact with other male residents in the care home, and how she expressed her sexuality. In Kenneth's care plan it was noted as previously stated

[14] O'keeffe M., Hills M.I., Donnelly M., et al. UK Study of Abuse and Neglect of Older People: Prevalence Survey Report. London, UK: National Centre for Social Research; 2007

[15] WHO The World Report on Violence and Health. Geneva, Switzerland: World Health Organisation; 2002 https://www.who.int

[16] Ibid

[17] Ibid

that he identified as a heterosexual male and that he had made comments about a sex worker attending to his needs.

8.0 Agency Learning as a result of the alleged Rape

8.1 Merseyside Police

8.1.1 Since the alleged Rape of Dorothy the Vulnerable Persons Referral Unit that manage VPRF's has expanded to a team of twenty assessors and learning has been undertaken to ensure that officers and staff know when to submit VPRF's and when to make alternative referrals. Training is provided to officers around the appropriate use of VPRF's.

8.1.2 The Police investigation into the alleged Rape of Dorothy does not demonstrate regular contact between the Police and the suspects family. Police would have no lawful obligation to contact and update the suspects family. The suspect in this case lacked the mental capacity to understand what was happening as a result of his assaulting Dorothy and he had no appropriate adult. Under these circumstances and for a crime of this nature investigation teams in future should consider forming a contract with the suspects family with agreed criteria not to breach a victim's anonymity, the confidentiality of the investigation and not undermining any prosecution case. Each case would be considered on an individual basis.

8.2 The Care Home

8.2.1 Practice at the time of the alleged Rape of Dorothy was that risk assessments and care plans for an individual would be reviewed within seven days of their admission and then on an as required basis. Since this incident any inappropriate behaviour recorded within 72 hours of admission will trigger a review of a resident's risk assessment and care plan and telecare support systems.

8.2.2 Before accepting a new resident, the care home managers will now enquire about any sexualised inappropriate behaviours, previous convictions or police investigations.

9.0 Conclusions

9.1 The alleged Rape of Dorothy was a distressing incident for all those involved but especially for Dorothy, her immediate family as well as Kenneth's family.

9.2 The LSAB, its partner agencies and the independent reviewer would want to offer the families of both Dorothy and Kenneth their sincere sympathy for what they have had to experience.

9.3 It is clear from this review as described below that there are some areas for improvement in relation to communication with families and between agencies following this alleged Rape including reflection on how things could be done more compassionately and learning to be shared with practitioners.

9.4 After Kenneth's arrest, Dorothy's family were mistakenly under the impression that Kenneth had been interviewed under caution and provided a 'no comment' interview. In reality, Kenneth was not interviewed by the police following his arrest. This misunderstanding has contributed to her families belief that Kenneth's cognitive impairment was overstated, as it implied he possessed the capacity to understand the potential consequences of responding to police questioning. Additionally, Dorothy's family believe that the decision not to bring charges against Kenneth was made by the CPS; however, this was also inaccurate, as the decision not to pursue criminal charges was made by the Police.

9.5 Kenneth's family member was caused a great deal of distress when she was informed over the telephone by the care home that it was believed Kenneth had raped another of their residents, that it was not possible to come to the care home to support Kenneth and that he had been arrested. This conversation took place while they were in a public place, and were not asked if they were in a suitable place to receive distressing news and resulted in her experiencing what they have described as a 'panic attack'. The subsequent communication between Kenneth's family and the Police was also in the view of Kenneth's family 'poor' with little updated information about Kenneth provided.

9.6 After an incident, a manager at the care home asked Kenneth's family to collect his belongings and write a formal statement about information they had shared with the Social Worker regarding his past behaviours. Family member reported feeling pressured by two staff members while writing the statement and as such they were too distressed to inquire about its purpose or recipients. The care home later shared statement with the Police without offering family member a copy.

9.7 Both families reported to the independent reviewer an alleged comment indicating that full disclosure of information shared by Kenneth's family regarding his potential for violent and aggressive behaviours might reduce the likelihood of securing a care placement for him. Full disclosure of his behaviours was not documented on his HNA as previously identified. There was no evidence anticipated, known or shared about his potential to carry out rape which it would be inappropriate to conclude could have been anticipated. Comments of a sexualised nature made while Kenneth was in hospital were shared with the care home and he was heard to make similar comments when residing at the care home in the few days he was a resident there.

9.8 At the practitioner learning event, participants discussed whether staff across Liverpool receive adequate training regarding how to ask patients or clients about their sexuality and its expression, which may be relevant to care plans. The findings from earlier referenced research were considered. Practitioners expressed differing views: some reported having received training and felt prepared for these discussions with those in their care, while others identified a need for additional training in this area.

9.9 The availability of residential care providers with the ability to offer single sex care settings was something that was also considered at the practitioner learning event. It was acknowledged that there is limited availability of such placements across Liverpool.

Although this was not an identified requirement prior to Kenneth being placed in the same care home as Dorothy if it had been it may have made placing him more difficult.

9.10 The LSAB and its partner agencies will consider the findings from this SAR and develop an action plan with SMART[18] actions to address these areas of learning, aiming to reduce the likelihood of another incident of this nature occurring in Liverpool.

9.11 The independent chair of the LSAB will share the findings of this report at the national safeguarding adults' boards chairs network to allow other safeguarding boards nationally to consider whether they have sexual strategies, guidance and training for staff in place in their areas.

9.12 The LSAB will consider whether the findings from this report in relation to the capacity issues at the Liverpool SARC are an ongoing issue or were difficult at the time of the alleged Rape of Dorothy and should be shared with the Liverpool Domestic Abuse Partnership Board. It can be in nobody's interest for this to be a regular occurrence following an alleged rape or serious sexual assault.

[18] SMART actions: Specific, Measurable, Achievable, Relevant and Time-bound

10. Learning from SAR 'Dorothy'

Learning 1: There were significant gaps in the information that was shared on the HNA with the care home manager prior to their agreement to accept Kenneth as a resident under the EMI 28-day pathway. These omissions did not allow for a full assessment of risk
Question 1: How will the LSAB be assured that full disclosure of known risks is documented on HNA's and transfer of care documents when community placements are being sought? *(Multi Agency Partners)*
Learning 2: The care home that accepted Dorothy in July 2022 had improvement notices placed on it due to regulation breaches. The service was still rated as requires improvement.
Question 2: How does the framework used by LCC and Health to place vulnerable people into care utilise the CQC inspection findings? Should greater consideration be given to inspection outcomes? *(Liverpool City Council and Health)*
Learning 3: The possibility that there is no clear strategy across Liverpool for sexual safety, has the recommendation from the CQC report that providers and leaders across the adult social care sector develop a culture environment and processes that support people's sexuality, keep them and staff safe from sexual harm, and promotes people's human rights? Is it aligned with the updated skills for care September 2021 document?
Question 3: Is there more work that can be undertaken by the LSAB and its partner agencies in developing a strategy, guidance and training for staff around sexual safety improving their confidence in having these conversations with people when developing risk assessments and care plans and protecting people's human rights? *(Liverpool City Council)*
Learning 4: Kenneth was not identified as requiring single sex accommodation as part of his risk assessments, risks were considered towards female staff and not more widely to female patients/residents.
Question 4: How will this be reviewed and managed if it is found that there is a greater need for single sex accommodation across Liverpool?

Learning 5: There was no formal recording of the mental capacity of either Dorothy or Kenneth to understand the concept of consensual sex. Legislation requires that capacity should still be recorded if appropriate to do so even if someone has a documented mental health condition.
Question 5: How will Merseyside Police provide assurance to the LSAB that there are effective processes in place to ensure that legal frameworks in respect of the above are followed?
Learning 6: The Liverpool SARC was unable to examine Dorothy due to capacity issues, a neighbouring SARC was also not able to examine Dorothy on the day of the alleged Rape. As a result, she was not forensically examined, and an alleged Rape could not be excluded.
Question 6: Should the LSAB share this finding with the Liverpool Domestic Partnership Board to highlight this issue?
Learning 7: The learning from this SAR should be shared widely across Liverpool and escalated nationally
Question 7: How will the learning from this SAR be embedded into practice and how will it be escalated nationally? ***(Multi-Agency Partners)***