Safeguarding Adults Review

A Thematic Review of Financial Exploitation (TH19) EXECUTIVE SUMMARY

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1. Introduction

1.1. Under the 2014 Care Act, Safeguarding Adults Boards (SABs) are responsible for Safeguarding Adults Reviews (SARs).

1.2. A SAR *must* be conducted where there an adult has died as a result of abuse or neglect or experienced serious abuse or neglect.

1.3. A SAR *may* be conducted in any other situations where it is thought there is valuable learning for the partnership. It is on this basis that this SAR was commissioned.

1.4. The purpose of a SAR is to promote effective learning and improvement action to prevent future deaths or serious harm occurring again.

1.5. Lincolnshire agencies from across Social Care, Health, Police and Housing contributed to the learning for this review.

1.6. The full details and learning from the review are available within the overview report. This Executive Summary offers key points of learning and recommendations.

2. Background to this Safeguarding Adults Review

2.1. In 2014, the Lincolnshire Safeguarding Adults Board (LSAB) received information relating to thirty- four people who were victims of financial exploitation in a Lincolnshire market town. It was believed the people had been targeted because of their vulnerabilities.

2.2 The Police led a multi-agency investigation that revealed individuals had been subject to exploitation for many years.

2.3 The LSAB commissioned a SAR to identify if there were lessons regarding how agencies had worked together to safeguard individuals experiencing financial exploitation in these preceding years.

2.4 The review considered the period from October 2007 to November 2014, with a focus on the dates April 2013 – November 2014.

3. Stories of the People Involved

This SAR looked in detail at the experience of ten people. Three of the people were willing to contribute their views into the review.

The following accounts give a snapshot of those people's lives and the challenges they faced.

3.1. **'Julie'**

Julie had a long history of mental illness and problematic drug and alcohol use. Her mental health needs and drug use significantly impacted on her dependency, susceptibility to coercion, her ability to appraise risks and to self-protect from abuse.

During the scope period, there were multiple accounts of Julie experiencing financial exploitation and extortion. Julie's house was 'taken over' by drug users. She provided the review with a harrowing personal account of what her life was like living with the abuse. She was fearful and intimidated, a victim of physical, emotional, psychological abuse, domestic abuse and sexual abuse.

Julie received a high level of support through mental health services who worked hard in attempts to help her stay safe. Julie was also referred to the Community Safety Team.

Despite this, Julie continued to experience abuse. She repeatedly declined for incidents to be reported to the Police – when reports were made, there was insufficient evidence and Police were unable to progress charges.

Julie's risks in relation to domestic abuse were not assessed as meeting the criteria for MARAC.

Julie declined LCC Safeguarding Adults service's involvement and was deemed to have capacity for this decision. No further action was taken under safeguarding procedures.

Julie continues to be vulnerable to exploitation and agencies continue to work together to support her.

3.2. **'Darren'**

Darren had a diagnosis of schizophrenia. He was well engaged with mental health services and Primary Care and received support from his parents.

In 2014, Darren disclosed that he had been financially exploited for the last 6 years. Police made an arrest and this formed part of their wider investigation that ultimately led to the perpetrator receiving 19 months in custody along with a restraining order for a 5 year period.

3.3. **'David'**

David had mental health needs arising from schizophrenia and personality disorder. David struggled with addiction to illicit substances and his lifestyle resulted in him having difficulty retaining a tenancy.

David received support through Primary Care and mental health services.

David was a victim of intimidation, physical assault, theft and exploitation throughout

the scope period and this was known by agencies involved.

There were a number of occasions when David self-reported incidents to the Police but the Police being unable to progress due to lack of evidence**.**

Reports indicate David informing his Primary Care and mental health workers of abusive incidents – advice was given but no formal follow up through safeguarding adults procedures.

In 2014, David disclosed having been held hostage for 2 weeks and physically assaulted including being hit with a dog lead and punched until he was unconscious. He consented to this incident being reported through safeguarding adults procedures but declined to report it to the Police as he was worried about the consequences. The Police were not informed by any of the three agencies who were aware of this allegation.

David remains vulnerable to exploitation and agencies continue to work together to support him.

3.4. **'Emma'**

Emma had mental health needs arising from schizophrenia. She lacked mental capacity for some decisions relating to her care. She was supported by her brothers and mental health services, Primary Care and Compass day care.

In 2013, Emma reported to the mental health team that people were coming into her home, keeping her up and making her buy food for them.

Information was shared with Police and a referral made under Safeguarding Adults procedures. A successful multi-agency protection plan followed involving Housing, Police, Social Care and mental health services working with Emma and her brothers.

3.5. **'Gerry'**

Gerry had been known to mental health services for many years due to a personality disorder, episodes of drug induced psychosis and a mild learning disability. He was viewed as challenging to support as he had difficulty in adhering to care plans or tenancy requirements. There were also episodes of verbal aggression toward other.

Gerry was also vulnerable. Gerry had periods of being financially exploited with people waiting for him when he received his benefits. He became so fearful of returning to his property that he gave up his tenancy.

Gerry had made various allegations of exploitation throughout the scope period. He was given advice and assistance by mental health services and Housing.

When a referral through Safeguarding Adults procedures was made, Gerry declined

support from Adult Social Care or to report to the Police. As he was viewed as having capacity to make this decision, no further action was taken through multi-agency safeguarding.

A later and subsequent referral through safeguarding led to no further action based on Police and mental health services already being involved.

Police were unable to pursue charges due to evidential difficulties and undermining material as Gerry was still asking the alleged perpetrator to visit so he could buy drugs from him.

3.6. **'Firdo'**

Firdo had a long mental health history associated with schizophrenia. Firdo was vulnerable to exploitation and violence as well as having a history of violence to others. During the scope period, he made repeated allegations of being harassed and subject to extortion and exploitation by 'friends.'

Firdo made some self-reports of exploitation to the Police but due to the lack of evidence, retracted or false allegations, police were unable to pursue any charges.

Mental health services provided a high level of support to Firdo including advice about safety. They also liaised with Police.

A referral through Safeguarding Adults procedures led to a home visit by Adult Social Care. Firdo declined any involvement and also declined an offer of alternative accommodation.

Firdo's information formed part of the police's wider investigation and ultimately led to the perpetrator receiving 19 months in custody along with a restraining order for a 5 year period.

His exposure to abuse remains a challenge but agencies continue to work together to support him and reduce risks.

3.7. **'Rob'**

Rob had a long standing mental health needs due to a personality disorder. He received a high level of support from Primary Care and from mental health services. Rob also had attendances at ULHT A&E for non-medical needs.

Rob had a history of threatening suicide. He also had incidents of violence both as victim and perpetrator.

Rob was also the victim of exploitation and harassment. He made repeated allegations that people were taking his medication; taking his money; and coming to his house

uninvited.

Despite self-protection work carried out by agencies to help Rob to reduce risks from others, Rob struggled to put advice into practice.

When referral through Safeguarding Adults procedures was made, no further action was taken under these procedures as Rob was assessed as having capacity and was willingly inviting these individuals into his home.

There were occasions when Rob self-reported to Police though there were inconsistencies in his statement, occasions when allegations were retracted or falsely made.

Rob remains vulnerable to exploitation and agencies continue to work together to support him.

3.8. **'Joe'**

Joe had a diagnosis of schizophrenia exacerbated by problematic drug use. He was supported by mental health services.

Joe was identified as presenting a risk to others and was well known to the police.

Joe would borrow money from loan sharks and drug users who then charged him high interest. He had suffered violent consequences from these individuals when he could not pay back the money. His exploitation by others was referenced in his mental health risk assessments.

On many occasions, no referral to safeguarding or police followed, often due to Joe declining support to manage the exploitation.

On occasions when a referral was made, no further action was taken as Joe was not willing to make complaint.

3.9. **'Stevie'**

Stevie had been well known to mental health services for many years due to schizophrenia and episodes of drug induced psychosis. Stevie also received a high level of support through Primary Care and was a high user of ULHT A&E.

Services struggled to keep him engaged in his care plan and he had periods of homelessness.

Stevie was also well known to the Police for episodes of violence, anti-social behaviour, drugs and theft.

Stevie was able to self-report to the Police allegations of being assaulted and attempts to kidnap him. This formed part of the police wider investigation into financial exploitation though charges could not be progressed because of evidential difficulties.

3.10. **'William'**

William had physical health needs due to partial paralysis. He also had a diagnosis of depression. He received support through mental health services.

William was known to the Police for violent offences, dealing in illicit drugs and domestic abuse.

William was also vulnerable to intimidation from others and was a victim of domestic abuse perpetrated by his sons.

William did report incidents to the Police and accepted a referral being made through Safeguarding Adults procedures. Agencies were able to work together with him and a protection plan was coordinated between Adult Social Care, Police, Housing and mental health services.

William's circumstance information formed part of the Police's wider investigation and ultimately led to the perpetrator receiving 19 months in custody along with a restraining order for a 5 year period.

4. Summary of the Learning Points from the Review

The following themes and learning were identified from the review.

4.1. Prevention and Vulnerability Factors: Key Learning Points

4.1.1. Financial exploitation often co-exists with other forms of abuse. Some of the people who were subject to this review also experienced physical and sexual abuse, psychological abuse and self-neglect.

4.1.2. Professionals need to be sensitive to the context of individuals' lives in order to work effectively with them toward preventing abuse.

4.1.3. People with mental health needs and problematic drug and alcohol are often in highly vulnerable situations. They are at greater risk of homelessness. They may be more isolated, have fewer supportive social networks and have greater exposure to manipulative and violent individuals. Their mental health needs and problematic drug and alcohol use may increase dependency, impair decision making and make the person more susceptibility to coercive control.

4.1.4. Professionals need to recognise that under such circumstances, individuals may have to do what

they can to keep themselves safe.

4.1.5. People may be viewed as reckless and acting unwisely when 'choosing' to associate with acquaintances who have exploited them in the past. However, the reasons behind these behaviours may be complex, for example, due to poor self-esteem, loneliness, complicated social dynamics or fear.

4.1.6. Agencies are developing their understanding of coercion and control in the context of domestic abuse. Agencies need to extend this understanding to other safeguarding adults work, recognising the complex contributory factors including how a victim may try to protect themselves in situations of chronic fear.

4.1.7. For many people who were subject of this review there were particular challenges for services in keeping the person engaged in care. Services were working hard to help people reduce the risks and vulnerabilities in their lives. This work was largely occurring outside of multi-agency Safeguarding Adults procedures.

4.1.8. Where individuals informed professionals about incidents of exploitation, the agencies did not routinely record the details of the alleged perpetrator.

4.1.9. This lack of recording severely impaired the Police efforts to gather information and secure prosecutions.

4.1.10. Agencies rightly have strict guidance on information governance. However, recording systems need to make provision to record and retain information regarding alleged offenders, in order to support prosecution.

4.2 Decisions Surrounding Referrals: Key Learning Points

4.2.1. There were many missed opportunities where incidents could and should have been reported to the Police and referred through safeguarding adult procedures but weren't.

4.2.2. In 2014, Police began a wide scale investigation of exploitation when one Police Officer began to piece together information about a small number of individuals. This officer was proactive in following this up and escalating to his managers. This was notable good practice.

4.2.3. This exploitation was wide reaching and had been going on for years. Had information been shared more widely with Police and through Safeguarding Adults procedures, these patterns may have been identified at an earlier stage and action taken to protect those involved.

4.2.4. Some reasons for not referring were:

i. There was not a clear understanding of when lending and borrowing should be defined as exploitation and extortion.

ii. Practitioners who continually work with people in chaotic and dangerous situations, may be susceptible to becoming blunted and normalising high levels of risk.

iii. Value judgements about people's lifestyles may impact upon decisions to refer through safeguarding e.g. exploitation is viewed as an unfortunate consequence of a drug-using lifestyle.

iv. The person declined referral to Police or safeguarding services.

v. There was an over reliance on the person self-reporting to the Police without sufficient regard to the person's ability to follow this through.

vi. There were misguided expectations on other agencies to make the Safeguarding Adults referral.

vii. Mental health practitioners questioned the value of referring to safeguarding – that the procedures would not add anything and that a referral would be screened out.

4.2.5. • **Self Determination and Intervening Without Consent**

A major factor in both under reporting and decisions about progressing referrals, related to consent and a laudable wish for the person to self- determine how they managed their safety.

4.2.6. Practitioners were not all confident in applying the Mental Capacity Act, particularly where the person's capacity may be fluctuating due to their substance misuse.

4.2.7. Making Safeguarding Personal[1], had rightly become a focus in Safeguarding Adult procedures. However, the focus on the Mental Capacity Act and the rights of a capacitous person to make an unwise decision, had oversimplified decisions about when a referral should be made without the person's consent.

4.2.8. Decision making must take account of mental capacity; decisions influenced by coercion and control and wider duties surrounding public and vital interests.

4.2.9. Referring agencies and the Local Authority safeguarding team did not give sufficient attention to this.

4.2.10. Where risks are high and a capacitous person has declined a safeguarding response, there remains a duty of care to take reasonable steps to reduce harm to the person and/or others who may be at risk.

4.2.11. Related learning from the field of domestic abuse needs to transfer across to the safeguarding partnership.

4.1.12. • **Added Value of Multi-Agency Safeguarding**

[1] **Making Safeguarding Personal**. **Making Safeguarding Personal** (MSP) aims to develop an outcomes focus to **safeguarding** work, and a range of responses to support people to improve or resolve their circumstances.

There were occasions when referrals were made through Safeguarding Adult procedures but decisions made not to take further action under these procedures. This created missed opportunities to reduce risks to the person and wider community.

4.2.13. The complex presentations meant decisions about the next steps were not easy. Multi-agency strategy meetings would have aided this decision but they were under- used. Strategy meetings would have added value:

- Drawing together intelligence held by the different partners
- Gathering more detail about the person's experience from those who knew them well
- Generating multi-agency risk assessment
- Utilising the expertise and knowledge of other agencies
- Identifying patterns and recurring themes
- Agreeing, wherever possible with the person, the best multi-agency response
- Coordinating the response
- Drawing greater resources and specialist input to meet the complex needs
- Providing a structure to escalate concerns

4.2.14. No agency on their own had a ready solution. These were intractable problems that would have benefitted from a creative multi-agency response. In 41% of cases, referrals were not progressed through multi-agency safeguarding procedures. As a consequence, opportunities for a collaborative approach were missed.

4.2.15. In some areas, a Multi-Agency Safeguarding Hub (MASH)[2] has been successfully used to provide a multi-agency safeguarding adults response. No such provision was in place in Lincolnshire during the scope period.

4.3. Multi-agency Responses: Key Learning Points

4.3.1 Multi-agency partnerships enable information to be collated and used to assess the wider picture of risk. Partnerships also give access to the breadth of skills the multi-agencies hold.

4.3.2. There are multiple partnership forums in place that contribute to safeguarding adults and community safety, for example, Anti-Social Behaviour Risk Assessment Conferences and Joint Agency Meetings. However, in respect of the ten people, there was inconsistency in how well these forums were used.

4.3.3. Professionals across the agencies were not aware of the role and functions of these different partnerships nor the referral criteria or their interface with safeguarding. These forums need to be aligned to make best use of stretched resources when safeguarding adults.

4.3.4. The ten individuals who were subject to this review had highly complex needs. The context in which financial abuse was occurring required a multi-faceted protection plan to support the individual and disrupt offenders.

[2] MASH was initiated in Devon and referenced as good practice in Professor Munro's review of child protection http://www.communitycare.co.uk/2011/05/16/munros-pick-of-child-protection-good-practice/

4.3.5. This required effective coordination and communication between agencies, harnessing the expertise and resources that each agency had. There was variable evidence of how well this was achieved.

4.3.6. This review has highlighted the challenges in pursuing prosecution. Provision of a supporter for a vulnerable witness interview is an important element in progressing a prosecution. This appears to be a gap in provision that the partnership should seek to address.

4.3.7. There were some excellent examples where positive outcomes were achieved through agencies working together. This was most evident where the person had less challenging circumstances i.e. did not have drug and alcohol dependency; were not caught in risky social relationships and were open to professionals' involvement.

4.3.8. The multi-agency partnership will not always be able to achieve positive outcomes where individuals are not able or ready to accept help. Nonetheless, such challenging and high risk situations are when the multi-agency partnerships should be working hard together, exploring every avenue to try and reduce risks.

4.4. What has Changed? Key Learning Points

4.4.1. The Care Act 2014 introduced statutory requirements for safeguarding adults. The scope period for the review, pre-dated the implementation of the Care Act.

4.4.2. Lincolnshire Local Authority and Safeguarding Adults Board have introduced new procedures and ways of working following the Acts implementation.

4.4.3. The new Lincolnshire Safeguarding Adults Policy and Procedures (2015) provide guidance on responses where consent is withheld. The document also states the requirements for multi-agency working. However, there are not detailed procedures to guide this multi-agency response.

4.4.4. Some agencies contributing to this review felt that the new policy is not yet being applied in practice and that more work is needed to develop multi-agency, evidence based decisions. This needs further evaluation by the LSAB.

4.4.5. The development of more detailed procedures, tools and guidance will support multi-agency working.

4.4.6. In 2016, Lincolnshire instigated a new multi-agency safeguarding team -Safeguarding Lincolnshire Together (SLT). The introduction of the SLT provides the opportunity to strengthen multi-agency working. However, it appears the potential benefits of this multi-agency model are not fully utilised.

4.4.7. Lincolnshire Adult Social Care is revising their Safeguarding Adults structure. Learning from this review should be used to inform this process.

4.4.8. Nationally, there has been work on tackling financial exploitation. The development of these national resources provides opportunities for the LSAB to engage communities and businesses in preventative approaches to financial exploitation.

5. Conclusions

5.1. This review has centred on the stories of ten people over a seven-year period. Their stories detail some harrowing accounts of their day-to-day lives.

5.2. This was not a hidden picture. Their abuse was known to the agencies working with them.

5.3. Working together to safeguard the ten people presented challenges to the multi-agency partnership. Their circumstances where complex and the person was often unwilling or unable to accept help.

5.4. The review identified many examples of committed practitioners and agencies, working hard to help the individuals reduce risks and some good examples of multi-agency working.

5.5. However, the review also identified that there were substantial blocks in using the multi-agency Safeguarding Adults procedures.

5.6. The rightful focus on capacity and consent had eclipsed consideration of coercion and control and duties relating to public and vital interests. There were many missed opportunities to use the combined strength of multi-agency working to safeguard individuals and others in the community.

5.7. The multi-agency partnership will not always be able to achieve positive outcomes where individuals are not able or ready to accept help. Nonetheless, such high risk and seemingly intractable situations are when the multi-agency partnerships should be working hard together, exploring every avenue to try and reduce risks.

5.8. The learning from this review will help the partnership in their continued efforts to safeguard people in similar circumstances within Lincolnshire.

6. Recommendations

Each agency has made recommendations for their agency. These are detailed in the full report. The author has made some additional recommendations for the partnership.

Recommendations	
1.	**Safeguarding Responses to Non-Engaging Adults** The LSAB should use learning from this SAR to develop the safeguarding pathway for non-engaging, capacitous adults to include: I. Understanding responses to coercion and control and the barriers people may face in accepting support. II. Recognising circumstances where public or vital interests require involvement of the Police and the Community Safety Partnership. III. Developing single and multi-agency safeguarding responses to non-engaging adults that demonstrate defensible practice, balancing the Safeguarding Adult Principles of empowerment, proportionality, protection and accountability. This pathway should be supported by training, guidance and tools to aid practice. Learning from partnership responses to domestic abuse may be useful in developing this work.
2.	**Recording** Partner agencies should review their recording practices to: I. Enable a chronology of safeguarding concerns to be developed so that patterns of recurring abuse are readily identified and addressed. II. Record details relating to alleged perpetrators in a way that adheres to information governance requirements but also preserves information to support prosecution.
3.	**Multi-agency working**
3a	The LSAB should use the learning from this review to assure the effectiveness of current multi-agency safeguarding adults practice: I. The mechanisms available to share intelligence at an early stage in accordance with information sharing guidance II. The quality and timeliness of multi-agency involvement at initial referral, enquiry, safeguarding plan and restorative care. III. The availability of tools, documentation and guidance to support each stage of the procedures. IV. The efficacy of the Safeguarding Lincolnshire Together team as a multi-agency model.
3b	Lincolnshire County Council's evaluation and redesign of their Safeguarding Adults service should take account of learning from this SAR and any further learning arising from the LSAB assurance activity as set out in 3a.

4.	**Partnerships** The LSAB should work with the Community Safety Partnership to: i) Map out the partnerships forums, their roles and functions relevant to safeguarding adults ii) Agree the interface and governance between these partnerships to avoid duplication and make the most effective use of resources.
5.	**Recognition and responses to financial exploitation and extortion**
5a	Partner agencies should evaluate and report to the LSAB, the competence and confidence of their workforce in identifying and responding to financial exploitation and extortion and revise training and guidance accordingly.
5b	Partner agencies should consider how they work individually and collectively to provide information to people using their services about financial exploitation, strategies to reduce risks and sources of support.
5c	The LSAB partnership should review provision of a supporter for a vulnerable witness interview to ensure there is adequate provision and that the referral route to this service is known to the relevant agencies.
5d	The LSAB should consider opportunities to engage local communities in preventative work, for example, working with Trading Standards and engaging local financial institutions in protecting adults at risk against exploitation.

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