LSAB

Making safeguarding personal

Safeguarding Adults Review

A Thematic Review of Financial Exploitation (TH19) Overview Report

Independent Author:
Sylvia Manson

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Executive Summary

1. Introduction

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

1.2 Lincolnshire Police worked with the multi-agency safeguarding partnership to investigate the alleged offences and to safeguard the victims involved. This investigation revealed individuals had been subject to exploitation for many years.

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

1.4 This Safeguarding Adults Review has looked in detail at the experience of ten people. Their stories detail some harrowing accounts of their day-to-day lives.

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

1.6. The review identified many examples of committed practitioners and agencies, working hard to help the individuals reduce risks. The review also identified valuable learning regarding how well agencies worked individually and collectively to safeguard those ten people.

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

2 Summary of the Learning Points from the Review

The following themes and learning were identified from the review.

2.1.

Prevention and Vulnerability Factors: Key Learning Points	
i.	Mental health needs and problematic drug and alcohol use are often associated with life circumstances that may further increase risk. This includes loneliness, dependency, impaired decision making and susceptibility to coercive control. Learning from the review reflects the inter dependency between mental health needs, problematic drug and alcohol use, homelessness and financial exploitation.
ii.	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.
iii.	People may be viewed as reckless and acting unwisely when ‘choosing’ to associate

	with acquaintances who have exploited them in the past. The reasons behind these behaviours may be complex, for example, due to poor self esteem, loneliness, complicated social dynamics or fear. 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.
iv	The individuals had complex needs and multiple risk factors. There were particular challenges for services in keeping the person engaged in care. This contributes to the person's level of vulnerability and the ability of services to reduce risks of abuse.
v	Risks of exploitation were by and large well known. 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.
vi	Police efforts to gather information and secure prosecutions was severely impaired by the limited information recorded by agencies about the alleged perpetrators and the lack of witnesses. 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.

2.2

Decisions Surrounding Referrals: Key Learning Points	
i	**Low Referral Rates** Given the frequency and severity of the allegations of abuse, the numbers of referrals to Police and to Lincolnshire County Council Safeguarding Adults service were very low. Some reasons identified 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. Had information been shared between agencies at an earlier stage, patterns of abuse may have been identified and earlier action taken to protect those involved.
ii.	**Self Determination and Intervening Without Consent** Practitioners were not confident in applying the Mental Capacity Act, particularly where the person's capacity may be fluctuating due to their substance misuse. Making Safeguarding Personal, 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. Decision making must take account of mental capacity; decisions influenced by coercion and control and wider duties surrounding public and vital interests. Referring agencies and the Local Authority safeguarding team did not give sufficient attention to this. 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. Related learning from the field of domestic abuse needs to transfer across to the safeguarding partnership.
iii	**Added Value of Multi-Agency Safeguarding** 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 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. In some areas, a Multi-Agency Safeguarding Hub (MASH)[1] has been successfully used to provide a multi-agency safeguarding adults response. No such provision was in place in Lincolnshire during the scope period.

2.3

Multi-agency Responses: Key Learning Points	
i	There are multiple partnership forums in place that contribute to safeguarding adults and community safety. However, in respect of the ten people, there was inconsistency in how well these forums were used. Agencies were not aware of the role and functions of these forums, the referral criteria or their interface with safeguarding. These forums need to be aligned to make best use of stretched resources when safeguarding adults.
ii.	The context in which financial abuse was occurring required a multi-faceted protection plan to support the individual and disrupt offenders. 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. 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. 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

[1] 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/

	hard together, exploring every avenue to try and reduce risks.
iii	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.

2.4

What has Changed? Key Learning Points	
i.	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. 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. The development of more detailed procedures, tools and guidance will support multi-agency working.
ii.	The introduction of the Safeguarding Lincolnshire Together Team provides the opportunity to strengthen multi-agency working. However, it appears the potential benefits of this multi-agency model are not fully utilised. Lincolnshire Adult Social Care is revising their Safeguarding Adults structure. Learning from this review should be used to inform this process.
iii	The development of national resources provides opportunities for the LSAB to engage communities and businesses in preventative approaches to financial exploitation.

Main Body of the Report

3. Context of Safeguarding Adults Reviews

3.1 Under section 44 of the 2014 Care Act 2014, Safeguarding Adults Boards (SABs) must arrange a Safeguarding Adults Review (SAR) if:

i) There is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult and the adult dies as a result of abuse or neglect, whether or not it was known or suspected before the adult died (s44 (2)) OR,

ii) If the adult is still alive and the SAB knows or suspects that the adult has experienced serious abuse or neglect (44(3)).

3.2 In addition, SABs are free to arrange for a SAR in any other situations where it is thought there is valuable learning for the partnership (s.44(4)). It is on this basis that this SAR was commissioned.

3.3 The decision to undertake this SAR was made by the Chair of the Lincolnshire Safeguarding Adults Board (LSAB) based on a recommendation from the LSAB SAR sub-group.

3.4 The LSAB commissioned an Independent Author, to provide the SAR report. The author is an experienced chair and author of reviews and holds a professional background in mental health services and safeguarding adults. The author is independent of LSAB and its partner agencies.

3.5 The purpose of SARs is described in the statutory guidance [s.14.164]: '[to] *promote as to effective learning and improvement action to prevent future deaths or serious harm occurring again'*.

3.6 A SAR is not designed to hold any individual or organisation to account. Other processes exist for that purpose. A SAR enables all of the information known to agencies to be seen in one place. This is beneficial to learning but the SAR also recognises that this benefit of hindsight was not available to individual practitioners at the time.

3.7 The Department of Health's six principles for adult safeguarding should be applied across all safeguarding activity[2]. The principles apply to the review as follows:

Empowerment:	Understanding how the service users were involved in their care; involving service users in the review.

[2] Department of Health, (2016) *Care and Support Statutory Guidance Issued under the Care Act 2014*

Prevention:	The learning will be used to consider prevention of future harm to others.
Proportionality:	Understanding whether least restrictive practice was used; being proportionate in carrying out our review.
Protection:	The learning will be used to protect others from harm.
Partnership:	Partners will seek to understand how well they worked together and use learning to improve partnership working.
Accountability:	Accountability and transparency within the learning process

4. Background for this Safeguarding Adults Review

4.1 In 2014, a Police Officer followed up some information about a small number of vulnerable people being targeted by others in a market town. Police began an investigation called 'Operation Dungeon', and worked with Lincolnshire Partnership NHS Foundation Trust (LPFT) to explore the background to the cases.

4.2. In November 2014, LPFT submitted a Significant Incident Notification Form (SINF) to Lincolnshire Safeguarding Adults Board (LSAB).

4.3 The SINF referred to 34 people who were considered to be victims of financial exploitation in the market town. It was believed the people had been targeted because of their vulnerabilities.

4.4. A Strategic Co-ordinating Group[3] was formed in February 2015 to manage the enquiry. This strategic group was led by the Police and was the multi-agency response to the Police investigation 'Operation Dungeon.'

4.5. A report from Operation Dungeon highlighted:

Lincolnshire Police: Tactical Group Progress Report February 2016

'Although it was initially suspected offenders may have been operating together as an Organised Crime Group (OCG), the police investigation found no evidence to support this.'

'In a number of cases there was insufficient evidence to support a prosecution either due to victims failing to co-operate with officers or a lack of available corroborative evidence required to support such a prosecution'

'It is clear that a lack of knowledge and awareness of the referral process, and what constitutes a referral, exists in a number of agencies and it is necessary for partners to

[3] Operation Dungeon Multi-Agency Strategic Coordination Group Terms of Reference February 2015

ensure their front line staff are sufficiently trained to ensure information is referred via the appropriate channels.'

4.6. Ultimately, Police were able to prosecute one person on four counts of harassment. This person (referred to in this review as [Adult1]) received a 19 month custodial sentence and a restraining order to protect all victims for a five year period.

4.7. The LSAB considered the SINF alongside findings from Operation Dungeon and determined that a thematic SAR should be commissioned.

4.8. Of the cohort of thirty-nine individuals who were considered under Operation Dungeon, nineteen of those cases were considered to meet the criteria for the SAR.

4.9. The LSAB was mindful of the principle of proportionality in carrying out a learning review. The LSAB decided to review ten of the nineteen cases in greater depth. These cases were selected based on age, gender, type of and severity of alleged abuse and included the four individuals cited as victims of the only individual charged with offences around this case.
This aimed to achieve a proportionate review that maximised learning.

4.10. The material submitted to this review by agencies relating to these ten people was in excess of 2000 pages.

5 Terms of Reference and Methodology

5.1. Terms of Reference

5.1.1 The SAR will consider the responses from agencies working with the ten individuals who are subject to this review.

5.1.2 The scope period for this review is from October 2007 to November 2014, with a focus on the dates April 2013 – November 2014. The start date represents the fact that multi-agency procedures were in place from 1st Oct 2007 and the end date is when the matter was reported to the Board.

5.1.3. The specifics are as follows:

Terms of Reference
1. Safeguarding & Mental Capacity Policies and Procedures
2. Risk Management
3. Information Sharing and Communication
4. Line-Management, Advice Guidance and Resources
5. Agency Information & Data Systems
6. Competencies, Training and Development
7. Diversity & impact on Engagement

5.2. Involvement of the People who are the Subject of this Review

5.2.1 Understanding the experiences of those receiving support from agencies is central to learning.

5.2.2. The ten people were all receiving support through LPFT. LPFT approached those individuals to ascertain if they wished to engage in the review and, where indicated, to assess capacity in relation to this.

5.2.3. The author endeavoured to meet with the ten people to hear their experiences and insights directly. The author is grateful to two people who agreed to be interviewed and allowed their anonymised views to contribute to the report. Both chose the pseudonym that they wished to be known by within the review – 'Rob' and 'Firdo.'

5.2.4. A third person, 'Julie' agreed to be interviewed by the LPFT safeguarding adults lead. Her views have also made a valuable contribution to the learning.

5.2.5. In relation to accessing information for the review, six out of the ten people who are subject to this review, consented to their information being used.

5.2.6. Under Section 45 of the Care Act 2014, the SAB may require agencies to supply information to it for the purpose of enabling or assisting the SAB to exercise its functions. This provides the statutory basis to share information lawfully in accordance with professional and regulatory

guidance.

5.2.7. All agencies involved, with the exception of some General Practitioners, either obtained consent or agreed grounds were met to share relevant information without consent.

5.2.8. The people referred to in this review as 'Emma', 'Billy,' and 'Gerry' declined to give consent for their GP records to be shared for the review. Although GP's are permitted to share information[4] and had a duty to do so under section 45 Care Act 2014, three GP Practices, decided to respect the individual's decision to restrict the disclosure and use of their information.

5.2.9. The LSAB and CCGs should work with the GPs to develop a joint understanding of the circumstances when information may be shared in accordance with statutory and national guidance[5]

5.2.10. The LSAB should make explicit how it applies the Safeguarding Adult Principles[6] in making a defensible decision about the use of the information, with due regard to Making Safeguarding Personal i.e. weighing the circumstances of each case against the principles - making a **proportionate** decision, balancing **empowerment** alongside the value of using learning for **prevention** and **protection** of others.

5.3. Methodology

5.3.1 The methodology applied for this SAR combined individual management reports (IMRs) and a chronology from each agency with a learning event.

5.3.2 The reports were reviewed and discussed in detail at a meeting between the panel and authors. The learning event brought together agencies and frontline practitioners to draw out learning and recommendations for improvement.

5.3.3 Participating agencies were encouraged to apply a systems approach[7] to the review i.e. explore all contributory factors in order to identify changes needed at an organisational level as well as at individual practice level.

5.3.4. The role of participating agencies is outlined in the table below

[4] General Medical Council guidance on confidentiality 2009
[5] http://www.scie.org.uk/care-act-2014/safeguarding-adults/sharing-information/
[6] Department of Health, (2016) *Care and Support Statutory Guidance Issued under the Care Act 2014*
[7] SCIE, *Learning Together*, Available from: http://www.scie.org.uk/children/learningtogether/about.asp

Participating Agencies and Context of Involvement	
Lincolnshire County Council	The Lincolnshire County Council (LCC) is the lead for multi-agency safeguarding. During the scope period, this was under 'No Secrets.'[8] During the scope period, LCC used Section 75 (National Health Service Act 2006) to commission LPFT to deliver Assessment and Care Management, preventative support, Best Interest Assessments and Approved Mental Health Professionals. All ten people who were subject to this review were known to LCC Safeguarding Adults (LCC SA) service during the scope period. Seven of this number were also in receipt of Direct Payments being provided through managed accounts.
Lincolnshire Partnership NHS Foundation Trust	Lincolnshire Partnership NHS Foundation Trust (LPFT) provides mental health services for adults and children. During the scope period, LPFT also provided substance misuse services and social care services commissioned by LCC through section 75 (National Health Service Act 2006). LPFT provide a number of services relevant to the people involved in this review. These include: • Community Mental Health Teams (CMHT) – multi-disciplinary teams supporting people with mental health needs in the community • Assertive Outreach Teams (AOT) – intensive case management for people with complex mental health needs, for whom services had difficulty engaging. • Crisis Resolution Home Treatment (CRHT) – responding to mental health crisis and seeking to avoid admission. • Inpatient and Rehabilitation units • Drug and Alcohol Recovery Teams (DART) All of the ten people were known to mental health services, eight were known to the AOT team. Most had also accessed the other LPFT listed above.
Lincolnshire Police	Police were involved with all ten people. Involvement was as potential victims of financial exploitation and, for some, in relation to their offending. Lincolnshire Police also led the investigation 'Operation Dungeon.'
General Practitioners	General Practitioners (GPs) provide Primary Care to citizens across Lincolnshire. GP's are independent contractors, commissioned by NHS England. GPs are supported and guided by the Clinical Commissioning Groups (CCGs) Federated Safeguarding Team. There were five individual GP Practices providing Primary Care to the people subject to this review. For the person referred to in the review as 'Joe,' it was not possible to identify which GP practice (if any) he was currently registered with. GP Practices within the scope period both provided direct care and received information from other services such as LPFT and ULHT about specialist care

[8] Department of Health, (2000) *No secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse*

	provided.
South Kesteven District Council	South Kesteven District Council (SKDC) Housing Service provides Estate Management which covers tenancy services, and Housing Solutions which covers statutory duties under the Housing Acts and Homelessness legislation. During the scope period, the Council's Community Safety Team (CST) was based at the Police station, enabling joint working on anti-social behaviour. SKDC had involvement with eight people subject of this review either through their primary role as Housing Officers, Homeless Officers and/or as Community Safety (Anti-Social Behaviour) Officers.
United Lincolnshire Hospital Trust	United Lincolnshire Hospital Trust (ULHT) provide acute care across 3 Lincolnshire Hospitals. The Trust also provides outpatient and day case care. ULHT had involvement with nine out of ten of the people subject of this review.

6. The Story of Ten People

This section provides a summary of the ten people who are the subject of this review. It provides an outline of key events, and highlights where referrals were made to Lincolnshire County Council Safeguarding Adult (LCC SA) and to Police.

Section 7 of this report provides analysis of these key events.

6.1 'Julie's story'

Julie is a white British woman in her early 50's. She had a long history of mental illness. Julie received a high level of support through mental health services. Julie was in receipt of a personal budget which was provided through a managed account.

Julie had problematic drug and alcohol use which she struggled to address and this had a highly detrimental effect on her mental health. Her lifestyle involved some offending behaviour leading to prison sentences and drug treatment orders.

Julie was highly vulnerable and had multiple risks both to herself and, at times, to others. Her mental health needs and drug use significantly impacted on her levels of dependency, susceptibility to coercion, her ability to appraise risks and to self-protect from abuse. When mental capacity assessments were carried out, Julie was deemed to have capacity for all decisions.

From **2008**, Julie made repeated allegations of exploitation. It appears Julie was subject to repeated and sustained financial exploitation. This involved repeated theft of possessions, stolen bank cards and money obtained through extortion that amounted to thousands of pounds.

Julie's house was also 'taken over' by drug users. She was fearful and intimidated, a victim of physical, emotional, psychological abuse, domestic abuse and sexual abuse.

AOT identified these risks and worked with Julie to try and help her address the abuse, including **making a referral to Multi Agency Risk Assessment Conference (MARAC) in October 2011**.

In May 2013, **the first referral through Safeguarding Adults procedures and to the Police was made.** This was by SKDC. Julie's home was being used as a drug den and she was voicing she was subject to intimidation.

Police made an arrest but could not pursue due to problems with consistency of evidence. Julie did not want to engage with LCC Safeguarding Adults. No further action was taken as she was being supported by mental health services and was due to go to prison. SKDC Housing made a referral to their Community Safety Team.

Later that month Julie attended ULHT A&E with laceration to her ear. She informed staff that she had accepted a lift from strangers (two males) who refused to let her get out so she jumped out. **ULHT record reporting the incident to Police** (Police have no record of this)

During **2013,** Julie made repeated statements about continued financial abuse and '*being scared*.' AOT were also concerned about sexual exploitation. AOT attempted to support Julie to be less risky in her social contacts and lifestyle. Julie repeatedly declined referral to Police and to LCC Safeguarding Adults service.

By **December 2013**, Julie expressed to AOT that she felt '*a prisoner in my own home*'. She stated she was pressured to withdraw money from her bank account to give to people living in her house. She was '*scared, intimidated, threatened, under pressure and scared to do anything*' **AOT informed Police who interviewed her and provided an emergency phone** (though Julie states she never received this.) **A referral to LCC SA service led to a professionals meeting being convened**.

Police were not able to progress charges due to unreliable evidence. 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.

In **June 2014**, neighbours reported concerns about Julie's welfare. AOT were concerned about domestic abuse but Julie did not disclose information. **AOT completed a Domestic Abuse Stalking and Harassment (DASH) form.** This referral was not assessed as meeting the criteria for MARAC as it was not high risk.

In **July 2014**, neighbours again raise an alert, believing Julie was being held in her house against her will. Julie denied this but AOT remained very concerned about her. **AOT, Housing and Police worked together to address concerns about domestic abuse**. Julie had a mental health relapse and was admitted to hospital.

Julie was discharged from hospital toward the **end of 2014**. She declined to consider a move of accommodation and returned home.

Within 1 week of discharge, Julie was again viewed as being at high risk from the individuals that were believed to have previously held her against her will.

In **December 2014**, Julie was again disclosing being intimidated and having unwanted contact by 'friends.' **Julie consented to AOT referring her to Police and to LCC SA services**. However, on follow up by Police, Julie retracted her statements and denied or minimised any risks. There is record of liaison between AOT and LCC Safeguarding Adult services in **December and January 2015** but no information about actions arising.

Concerns about exploitation and abuse to Julie continued well beyond the scope period of this review.

Julie's circumstances formed part of the Police intelligence response, Operation Dungeon. None of the prosecutions arising from Operation Dungeon were based upon evidence of exploitation to Julie.

When interviewed for this review, Julie reported she was due to be interviewed by Police in connection with further allegations of exploitation. Agencies continue to work together to support her.

6.2 **'Darren's story'**

Darren is a white British man in his mid-forties. Darren had a diagnosis of schizophrenia. He received support through the mental health services and Primary Care. Darren had good insight into his mental health and services were able to engage and work with him on relapse prevention.

Darren lived alone but received support from his parents. From **2008**, Darren lived in a housing association flat. He coped with most aspects of daily living and had a part time job in a café. Darren was in receipt of a personal budget from LCC, which was provided through a managed account.

In **January 2014**, Darren told his parents he had been financially exploited for the last 6 years. The allegation related to one man [Adult1] who had continually asked Darren for money.

Darren, with support from his parents, reported this to the Police. Police determined that '*although no threats or intimidation had been made, it was clear that Darren's vulnerability had been taken advantage of*'. The alleged perpetrator was arrested and interviewed. An alert marker was placed on Darren's address to initiate an appropriate response by officers.

Darren informed mental health services that he '*now felt back in control*.' **The Community Mental Health team notified LCC SA.**

Darren's exploitation was investigated as part of Police intelligence response, Operation Dungeon.

His evidence contributed to the prosecution of the perpetrator [Adult1] who was found guilty in 2015 on four counts of harassment and sentenced to 19 months in custody along with a restraining order to protect all four victims for a 5 year period.

6.3 **'David's story'**

David is a white British man in his mid-thirties. David had some support from his sister but was estranged from parents.

David had a diagnosis of schizophrenia and personality disorder. He had a history of self-harm and attempted suicide. David struggled with addiction to illicit substances and new psychoactive substances. He was prescribed Methadone to manage his dependence.

David received support through Primary Care and mental health services.

David had a history of offences and had served periods in prison.

During the scope period, David was the victim of intimidation, physical assault, theft and exploitation. This was first disclosed in **2007** and escalated in frequency and severity.

In **2009**, David was released from prison. He was homeless at this time. David self-reported to the Police that he had been kidnapped but no evidence was found. SKDC provided David with accommodation in **2011.**

In **February 2012**, David reported to the Police that he had given a friend his bank card and asked him to draw out £210 for him. He had not seen this friend since. Police advised David about bank safety and '*the company he keeps'*

In **August 2012**, David reports a burglary. Police investigate but no crime was detected.

In **September 2012,** David reported to the Police that [Adult1] had approached David about not letting him in to his flat and produced a knife. Officers located [Adult1] and searched him but no knife was found.

In **November 2012**, David disclosed to AOT that he had been mugged when taking out £200. He refused to report to the Police. AOT organised a food bank voucher and advised David to get a crime number to help make a claim with the benefits agency.

David also informed the GP clinic nurse that he had had £50 stolen and that this was a common occurrence.

In **January 2013**, David reports to the Police that [Adult2] was trying to get into his

property – this was then retracted.

During **March 2013**, mental health records note that David owes money to drug dealers. AOT provided an advisory role in relation to lifestyle, friends and self-protection.

David took an intentional overdose and was admitted to psychiatric hospital. The inpatient record states that '*peers are abusing him financially, taking funds from [David] as he is being paid his benefits. [David] also believes there would be a physical threat towards him if he did not give them money'*

David did not want to formally report the matter to Police. Information was shared across AOT and DART and with David's GP. David then informed Police that he was being threatened by [Adult3]. However, Police were unsuccessful in engaging David in follow up interviews.

In **April 2013**, David reported a break in to Police. Police interviewed him but found discrepancy in the evidence and David retracted his allegation.

David gave notice on his tenancy to SKDC. SKDC and AOT discussed the consequences of this with him and encouraged him to reconsider. However, David insisted that he no longer wanted the tenancy. He moved in with [Adult4] in **April 2013.**

In **August 2013,** David disclosed to his GP and substance misuse nurse that he was feeling unsafe and was being bullied. He was advised to contact the Police.

By **September 2013**, David was making positive progress on addictions. He was heroin free.

David informed AOT that a man threatened to beat him up. The record notes that he did not appear too distressed and believed he would be protected by the friend he lived with and knew to contact the Police if he needed to. The AOT plan included
'3. *If there is further evidence of contact from this gentleman then safeguarding LPFT to be contact to ascertain if this needs to be logged with safeguarding adults with adult social care*.
4. *[David] to be further encouraged to contact the police if he feels at risk or in immediate danger. However [David] has stated that he feels protected by his friend whom he lives with*.'

During **January and February 2014**, David made a further report to DART and AOT that he had been assaulted. The risk assessment recorded '*Bullied and vulnerable to being exploited in the community. At risk from drug dealers and bullies in the prison. Aware of how to access help and reports will call for help*"

In **April 2014,** David moved accommodation again**.** He alleged that [Adult4] was taking money from him. David didn't have his own bank account and had arranged for his benefits to be paid into [Adult4's] bank account.

In **May 2014**, David reported to the Police that [Adult4] was threatening him. Police tried to arrange an interview but had difficulty in engaging David in this and in getting a mental health worker to act as appropriate supporters for the interview.[9] No further action was taken.

David next phoned the Police in **June 2014.** He alleged that [Adult4] had threatened him with a knife. The Police could not find any evidence of an offence and noted the '*on/off relationship'* between David and [Adult4].

David was arrested for shoplifting later that month. He reported to AOT '*felt bullied in to it by a man named [Adult4], as he is taking money from him. He states that he owes [Adult4] £500- he is unsure of why it is this much*.'

Further reports of exploitation were made in **July 2014** with David stating to his substance misuse nurse that 'housemate' had taken all his money. He moved in with a different friend and was back injecting MCAT.

In **August 2014**, David was admitted to ULHT. David disclosed to the AOT that '*[Adult-full name not recorded] held him hostage for 2 weeks and would not let him go anywhere, would barricaded the doors shut to prevent him from leaving. Stated he was physically assaulted by [Adult] on numerous occasions has been hit on his back with the chain of the dog lead and punch in the face so hard he was knocked unconscious*'

AOT asked David to report this incident to the Police. David declined stating he would be at more danger if he did this. However, he did consent to AOT contacting LCC Safeguarding Adults.

AOT liaised with ULHT to inform them of the disclosure and to request them to complete a body map of David's injuries. **AOT also referred to LCC SA – this was the first safeguarding adults referral made.**

LCC SA made contact with ULHT. They confirmed a body map had been completed. Records state that *'PP1 reviewed the case and sent contact to LPFT safeguarding team. [David] does not wish to report allegation to the Police. Refused to give full name. will not be returning to the address in [XX]. Housing Officer involved to assist with accommodation - risks therefore managed.'*

The LCC SA chronology notes *'Adults with capacity have right to make unwise decisions'* ULHT record response from LCC *'as [David] does not wish to report to Police the abuse he has suffered, she does not see a role for herself.'*

The DART records that David had informed the Police. However, the Police confirmed that David did not make this report and nor were Police informed by LPFT, ULHT or LCC SA of this incident.

9 LPFT do not provide the role of Appropriate Adult or supporter for a Vulnerable Witness Interview.

On discharge in **September 2014**, David returned to same address. AOT and DART remain concerned '*remains very vulnerable and is minimising the abuse he has suffered…*'

By **October 2014**, David was homeless again and making further allegation to AOT and SKDC '*friend [Adult3] at (XX) was pinching his money and abusing him*.'

AOT and SKDC Housing became concerned about David's whereabouts. **AOT report David missing to the Police** who locate him. He is now of no fixed abode.

LCC SA record a further referral to them by DART '*regularly complains of having money taken off him and scared to report it for fear of reprisals. Worker wanted safeguarding to be aware of [David's] current position as he is vulnerable to exploitation and is homeless.. Alerter wanted the contact logging for information only: NFA to safeguarding*"

In **November 2014**, David moved back in with [Adult4]. David had not kept any appointments with Housing homeless team and so, under Homelessness legislation, was no longer deemed homeless.

David took a deliberate over-dose with stated intent to end his life.

Post review scope period, David continued to sustain injuries reportedly due to being attacked by flat-mate. David continued to make statements about being '*too scared to return home*'

In June 2015, he was evicted from temporary housing due to persistent rent arrears. He made an allegation of being robbed at the local cashpoint and when advised to report this to the Police, responded he thought it was '*a waste of time*'. He remains vulnerable to exploitation and agencies continue to work together to support him.

6.4 **'Emma's' Story**

Emma is a white British woman in her mid-fifties. Emma had a diagnosis of schizophrenia and was supported by mental health services.

Mental health services who had some difficulty engaging with Emma. Emma was also supported through Primary Care and through Compass day care. She was in receipt of a personal budget which was provided through a managed account. Emma also received support from her brothers who were involved in her care and liaised with agencies.

Emma lacked mental capacity for some decisions relating to her care and treatment.

In **June 2013**, Emma reported to the CMHT concerns that people were coming into her home. The clinical record noted, '*conversing freely though delusional beliefs remain evident, believing that people come into her home at night and inject. Feels frightened but accepting of this, does not consider that she can do anything about this.*'

In **September 2013** Emma informed the CMHT that '*she had 2 women "barge" into her property, and that she had to buy them sausage and chips and let them stay for the night*.'

In **Sept 2013**, Emma informs the CMHT that '*the couple who had entered her property recently had again been in and she was feeling tired as they had kept her up all night*'

Emma had also shared similar concerns with Compass Care. **CMHT contacts police** '*for information purposes regarding the safeguarding concerns for Emma to request community police officers be extra vigilant when patrolling the area and to be aware of the situation*'. **CMHT makes a referral to LCC SA.**

A strategy followed for Mental Health Services, Police, ULHT, LCC SA team and SKDC worked together and with Emma to address concerns. There was a well-coordinated plan with all agencies working together to improve her safety.

Police were unable to progress any charges against the individuals exploiting Emma – the Police report noted '*the OIC was unable to proceed because he was unable to get information to the mental state*..'

6.5

'Gerry's' Story

Gerry is in his early 30's. Gerry was well known to mental health and had a diagnosis of a personality disorder and a history of drug induced psychosis. Gerry also had a mild learning disability.

Gerry had been known to mental health services since 2005. Gerry received support by his parents. He had periods of homelessness and had difficulty sustaining tenancy agreements. Gerry was in receipt of a personal budget which was provided through a managed account.

Gerry was viewed as challenging to support. When a mental health inpatient, he had difficulty in adhering to ward rules and to care plans. There were repeated episodes of verbal aggression toward staff. Gerry also had a record of bullying, intimidation and exploitation of his peers.

Gerry was also vulnerable. He had periods of drug induced psychosis and a history of overdosing. Gerry also had physical health needs. He had insulin controlled diabetes and during the scope period, had a fractured leg and was reliant on a wheelchair.

Gerry had periods of being financially exploited. He became so fearful of returning to his property that he gave up his tenancy.

In **January 2013**, Gerry's mum reported to his psychiatric nurse that Gerry had been receiving demands from 'drug dealers' in the market town. Gerry confirmed '*they had threatened to break his legs and put him in hospital*.'

Records from **March 2013** note '*Paranoia, he believes that he is being followed, lied to, raped and poisoned'*. Gerry is admitted to mental health hospital with diagnosis of drug induced psychosis.

During this admission, records indicate he was challenging to support due to threatening behaviour to staff and peers. There were repeated patterns of lending/borrowing from peers and incidents of exploiting others for money, cigarettes, medication and illicit drugs.

In **June 2013**, allegations from Gerry that he was being harassed and exploited began to escalate. Gerry was bringing drugs onto the ward and leaving the ward against advice to pay money owed for drugs.

By this time, Gerry had no signs of psychosis, but the hospital was unable to discharge him as he was homeless and had vulnerabilities due to his diabetes and fractured leg. Gerry remained in hospital until **July 2013.** A decision was then made to discharge him from hospital although he still had no fixed abode.

Gerry was provided with emergency accommodation by SKDC and offered support by the CMHT. In the period that followed, Gerry was misusing medication and illicit substances, declining support from DART, struggling financially and was under threat of eviction.

In **Feb 2014**, Gerry informed the CMHT: '*3 people jumped out on him asking for money & people ringing him asking for money'*. He was advised to keep text messages for Police evidence.

Gerry sought help from Housing in **April 2014** to ask a male acquaintance to stay away from the property. Gerry stated the male had got in through the window and would not leave. Housing informed the CMHT. Gerry also reported a burglary at his flat to Police.

In **May 2014**, Gerry informed the CMHT that he had no money as when benefits are paid people wait for him and demand money. There is some question raised about truth of this but the CMHT asked Adult Supporting Adults (ASA) service to accompany Gerry to get his benefits. Gerry made a further allegation to ASA that a 'friend' had taken £270. **Gerry consented to a Safeguarding Adults referral being made to LCC SA and this followed**.

LCC SA liaised with the CMHT and Gerry. Gerry declined to pursue matters with the Police or accept support from ASA to collect benefits – he was viewed as having capacity to make this decision and to manage his financial affairs. No further action was taken through multi-agency safeguarding.

The CMHT and DART continued advising Gerry on self- protection strategies and protecting his finances. The potential for a financial appointee was explored but not followed up.

July 2014 Gerry reported to Police that a person he had let into his property had stolen £50.

During **August 2014**, Gerry continued to inform his CMHT and DART worker of further allegations of being exploited. '*harassed by people at his bungalow who are coming in taking his things…. doesn't want to go home if people are in bungalow*.' There was no record of multi-agency information sharing.

Gerry reported to the Police that an acquaintance had been to his flat and threatened him. Police investigated further and noted a group that exploited vulnerable adults in the area. This information was shared with mental health services.

In **Sept 2014**, Gerry made a further allegation to the Police of threats and exploitation by (Adult4). (Adult4) wanted payment for the drug Cat and was asking for Gerry's medication. Police fed this information into Operation Dungeon.

Gerry requested mental health services make a referral to LCC SA Team which they duly did. The LCC SA team contacted Gerry and confirmed Police were involved and that Gerry had ongoing self-protection advice from mental health service. Gerry also wanted help to manage his finances, but he was already receiving this from ASA. No further action was taken through multi-agency safeguarding.

During this period, Gerry attended A&E on 4 occasions- he had problematic drug use, generally unkempt and having no money for food.

The local pharmacist informed the DART team that Gerry alleged (Adult4) was taking his money and medication from him but he was too scared to do anything. Gerry was locked out of his house. Police arrested (Adult4). **The DART team made a referral to LCC SA team.** A multi-agency meeting was suggested but there is no further record that this occurred.

Gerry's GP contacted mental health services as Gerry was not wanting to go home. He believed he would be harmed if he returned. Shortly after, Gerry's mental health deteriorated and he was detained in hospital.

In **2015**, (Adult4) was interviewed for offences against Gerry as part of Operation Dungeon. Police reported no further action was taken due to evidential difficulties and undermining material as Gerry was still asking (Adult4) to come round to buy drugs from him.

6.6 'Firdo's' Story

Firdo is a man in 50's. He had a long mental health history with a diagnosis of schizophrenia. He was receiving mental health services since 1999.

Firdo was supported by his parents. Police had Critical Incident Markers on both Firdo's and his parents homes due to Firdo's aggressive conduct. Firdo was involved in a number of criminal incidents.

Firdo was also vulnerable to exploitation and violence. During the scope period, he made repeated allegations of being harassed and subject to extortion and exploitation by 'friends.' The allegations were that sums in the region of £26,000 to £32,000 had been removed from his accounts.

Records from **2007** note Police warning Firdo about being exploited by a female. There were concerns of girls taking over his flat but Firdo was apparently consenting. There was liaison at this time between Police, AOT and SKDC anti-social behaviour officer.

In **2008**, Firdo moved back to his parent's house and reported to AOT – '*fearful of going back and feels vulnerable reports named individual (Adult1) – regularly taking money from him*'. Firdo was advised to contact Police. He returned home but concerns continued. AOT had tenuous engagement with Firdo at this time and he was not willing to discuss concerns with them.

This pattern continued over **2009 and 2010**. There were occasions when Firdo contacted Police regarding giving money to (Adult1) but it appeared the money was given willingly. On other occasions, Firdo made allegations of money being demanded but then retracted the allegation. There was liaison between Police and AOT and advice given to Firdo.

Firdo moved to warden housing in **2011**.

In **June 2011**, Firdo informed AOT that he was having problems with a person going round to his flat and asking for money. In **December 2011** the AOT record states '*friend had recently stolen £19,000 from his bank account. (Firdo) stated the same person had been visiting his home and kicked his front door in. (Firdo) kept a knife in his flat for protection and would not let individuals into his flat as he believed they will exploit him financially'*

Similar reports continued into **2012**. Firdo reported to AOT an individual having been in his flat and injected him with heroin and then the person stole his keys. He had reported the matter to the Police. New locks were fitted. Firdo was adamant he did not want to move. In **December 2012** when Firdo was admitted to mental health hospital, he informed staff that around £28,000 had been stolen from his accounts.

In **2013**, Firdo reported to the Police he was having problems with unwanted visitors. Police attended and spoke to the visitor and liaised with AOT. AOT tried to talk to him about safety and exploitation.

In **February 2014**, Firdo reported to the Police that someone had been knocking on his door and that he felt vulnerable. He believes it could have been (Adult1) and other drug

users. Officers attended and offered advice.

In **June 2014** Firdo claimed £2500 had been stolen from his home –Police found money at Firdo's home. Firdo also reported to the Police that he has been held at gun point and forced to write a cheque out for £1000. This was found to be a false accusation.

SKDC contacted the CMHT and reported that Firdo may be 'vulnerable' or 'victimised' from another service user (Adult1) and requested CMHT support in seeking a statement from him.

By **July 2014**, Firdo had moved back to his parents because individuals had taken over his property. Police assisted in moving them out. Police were then called to remove Firdo from his parent's house due to his aggression toward them.

Housing met with Firdo to discuss allegations of noise nuisance.

In **August 2014**, Firdo informed the Police that he had been forced to hand over cash over a period of time to (Adult5) and he has been threatened with a knife to do this. Firdo refused to make a statement and then denied being threatened. Police liaised with AOT and SKDC. Firdo continued to make statements to AOT about *"Local chavs" harassing him for money every time he goes out, states that they have taken £32,000 off him and he dare not leave his flat or they will harass him for money*'.

Police made a referral to LCC SA. LCC SA attempted a home visit with mental health service but this was unsuccessful. LCC SA made a home visit on their own. Firdo was aggressive and declined any involvement. LCC SA had not been informed by Police or AOT of Firdo's history of assaults. No further action was taken by LCC SA

In **September 2014**, an offer of alternative accommodation was made – Firdo declined a move.

Firdo's information was used within Operation Dungeon. (Adult1) was found guilty on four counts of harassment and sentenced to 19 months custody and a restraining order to protect all the victims for a 5 year period. Firdo was one of these victims.

Firdo was interviewed in **April 2017**, for this SAR. Firdo reported he continued to be harassed by 'local chavs' and exploited.

'*They took advantage of me, stealing my food and my money – its still happening. I had £70 stolen this week…. But what can I do? There's thousands involved. Unless I move away from the area completely*.'

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

6.7

‘Rob’s’ Story

Rob is a man in his early 50’s. During the scope period, Rob 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 was also in receipt of a personal budget which was provided through a managed account.

Rob had a diagnosis of personality disorder. There were occasions when he made false allegations and his recall could not be relied upon.

Rob had a history of threatening suicide. He also had incidents of violence both as victim and perpetrator and was known to Police for drug offences, anti-social behaviour, domestic abuse and affray.

Rob was also the victim of exploitation and harassment. He made 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.

Between **2007 – 2011,** there were various records of people going into Rob’s flat and of money and medication going missing.

Mental health and Primary Care were aware of Rob’s situation and the risks were recorded in clinical notes. Rob was advised by his mental health workers to report to police.

In **November 2011**, Police contacted Rob’s psychiatric nurse. Rob had contacted Police about people taking money from him. Rob had been lending money but not getting the loan repaid. **The psychiatric nurse offered self-protection & assertiveness advice to Rob and with his consent, referred to LCC SA team**. (LCC SA have no record of this)

In **May 2012**, **Rob’s psychiatric nurse again contacts LCC SA team**. Rob agreed with LCC SA that they would write a letter to the perpetrator advising them to stay away from Rob. Rob was advised to call the Police if there were further problems. Case closed to LCC SA team.

During **2012 – 2013**, there were various references to Rob being exploited or susceptible to exploitation. This included medication being taken from him, property taken and peers accompanying him to an ATM. Mental health records noted:
“*(Rob) often feels victimised. (Rob) is vulnerable in that he is easily swayed and influenced by others in doing things that (Rob) does not want to do which can cause (Rob) anxiety and distress….(Rob) has a lot of social contacts though recognises that some of these people are not positive’*.

Rob self-reported to Police though there were inconsistencies in his statement and a

lack of evidence

In **June 2013**, SKDC contacted Rob's mental health social worker as Rob wanted to terminate his tenancy as '*did not want to live near drug dealers*.' His social worker tried to intervene as they were concerned Rob's decision was impaired by his mental health.

Further allegations followed in **Nov 2013** regarding a stolen wallet – advice was given about cancelling credit cards and not letting people into his property.

In **January 2014,** Rob informs the CMHT that his bank cards and medication had been taken by a peer. This peer was someone he had previously agreed not to let in due having taken money and medication before. Workers reiterated the importance of keeping property safe but Rob reported that it was because he felt lonely.

In **March 2014**, Rob informed the CMHT that someone had taken £400 from his account. It transpired that Rob had given the person his card. He stated he would not give it to them again.

Rob had ongoing financial pressures **May 2014.** The CMHT worked with him on finance expenditure and on social activity to divert him from loneliness and gambling. Rob declined work on social inclusion.

In **June 2014**, Rob informed the CMHT '*…man would not leave and pestered (Rob) for 45 minutes for money.*' This was a peer, Rob had been advised against letting in. A neighbour intervened for him. Rob declined to go to Police.

Rob made various allegations to the Police about (Adult4) taking money and goods from him- Police followed up but there was no evidence of an offence.

Police were alerted by the bank. Rob had attended with another male who was reported to be "in drugs". The bank was concerned that Rob was being pressured into giving money. Police visited but Rob did not wish to make a complaint.

Police reported to LCC SA team – logged for information. No further action taken.

In July 2014, Rob made a number of allegations about harassment and exploitation to CMHT and Primary Care. At this time, Rob had moved in with (Adult4).
Rob contacted the Police saying he needed help but when Police attended he '*initiated an unprovoked frenzied attack on the officer*' Rob's mental health was thought to have deteriorated at this time.

The CMHT refer to LCC SA team for advice due to his exploitation and vulnerability whilst his mood was elated. LCC SA advised that if Rob has capacity and is willingly inviting these individuals into his home, Safeguarding can't stop this. No further action.

Between **August and October 2014** Rob continued to report incidents of his belongings being taken though evidence was often difficult to find. In **November 2014**, **Rob was**

referred to LCC SA team as part of police Operation Dungeon "*(Rob) is a vulnerable male with mental health issues. Drug addicts are drawn to his address. Believe that male called XX is taking (Rob's) disability money from him*".

(Adult4) was interviewed for offences against Rob as part of Operation Dungeon. Rob withdrew the complaint because he was satisfied at the outcome of safeguarding efforts and didn't want to go to court.

Rob was interviewed in **April 2017**, for this SAR. Rob reported that the problems of being exploited had started again. He remains vulnerable to exploitation and agencies continue to work together to support him.

6.8 'Joe's' Story

Joe is a white British man in his 40's. Joe was well known to mental health services. Joe had a diagnosis of schizophrenia exacerbated by problematic drug use. Joe also had a history of suicide attempts, dangerous impulsive acts and self-neglect. He was not always accepting of his prescribed medication and at times disengaged from services. He was supported by mental health services.

Joe had a history of violence towards others when unwell or frustrated. Joe was identified as presenting a risk to others.

The Police had attended incidents involving Joe, many associated with his drug and alcohol use. These included anti-social behaviour, breaches of restraining orders, domestic abuse incidents and dishonesty.

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.

Joe was in receipt of a personal budget which was provided through a managed account.

In **2008**, Joe informed AOT he had been hit and kicked in the face and his head pushed into a wall as he owed money to a person that he then paid. No record of follow up action.

In **2009 – 2010**, Joe's mental health records referred variously to (Adult6) taking money from him and him owing money to (Adult6). His exploitation by others was referenced in his mental health risk assessments.

In March 2011, LPFT phoned LCC SA team and explained Joe's situation regarding potential financial abuse by (Adult6). The record notes LCC SA view that if Joe did not see the situation as a problem and was not willing to make a formal complaint then nothing would be done with regard to safeguarding. LCC SA advised LPFT to try and work with Joe to get a better understanding of the situation and refer to safeguarding in

the future is necessary.

In **August 2011**, Joe reported to mental health staff that an acquaintance (Adult7) had stolen his medication and £20.

In **March 2012**, Joe reported to mental health services that he had given his peer (Adult6)) £150 towards some drugs but the peer had been arrested and Joe had lost his money.

During **November 2012** Joe was stating he wanted to move away from the market town. LPFT discussed with him concerns of him being exploited. Joe stated he was able to say no and didn't need any support in this area. The LPFT record noted that '*if this continues safeguarding referral will need completing again*.'

During **December 2012**, Joe disclosed to a mental health worker, he owed £140 to a dealer so wasn't able to buy any food. Joe received several phone calls from dealers asking for money owed and stating they were waiting for him when he got back home.

In **January 2013,** Joe spoke to AOT about peers who had taken money from him at the cashpoint. The potential for an appointeeship was discussed but Joe declined. Joe and AOT agreed a plan to speak to LCC SA team, community Police within his area and to Housing. (there was no record that this plan was acted upon.)

Throughout **2013**, Joe continued being threatened for money owed for drugs. AOT advised on financial management, substance use and assertiveness.

One record referred to Joe borrowing £10 for tobacco but the lender was going to charge him £50 when he gets his benefits. The record notes he recognised the repayment rate was high and had capacity to make the decision.

In **November 2013**, informed AOT of £200 missing from his bank and that '*they must have taken all his money when they took him into [market town] at 1am'*.

Through **June and July 2014**, there are further records of Joe paying back loans of up to 400% interest. Joe was reliant on food from food banks. Joe also attended ULHT A&E due to reported mental health needs.

In **October 2014**, Joe was again paying debts at extortionate interest rates. Joe alleged he had been taken to a cashpoint and handed over £100, hit in the face and handed over his bankcard to a neighbour he owed money to. AOT asked if they could call Police but '*(Joe's) irritability increased and declined this option*.'

In **November 2014,** a neighbour contacted the Police due to Joe's behaviour. **Police contacted LCC Adult Social Care** and LPFT were then informed.

AOT social worker completed a capacity assessment relating to Joe's ability to manage finances and understanding of exploitation. Joe was considered not to have capacity.

AOT referred to LCC SA team. A strategy meeting was called.

Joe was subject to Police investigation, Operation Dungeon. Unfortunately, Joe refused to make any complaints against the suspect stating that he was a friend and no offences or threats had been made. The neighbourhood Police team were tasked with monitoring Joe. No further action was taken.

6.9 **'Stevie's' Story**

Stevie is a white British man in his 40's. Stevie had been well known to mental health services for many years. He had a diagnosis of schizophrenia and drug induced psychosis. Stevie was addicted to heroin. He was prescribed methadone managed by his GP. Stevie was also a high user of ULHT A&E – attending 16 times within the scope period, mainly associated with mental health needs.

Stevie was supported through mental health services. Services struggled to keep him engaged in treatment. Stevie was in receipt of a personal budget which was provided through a managed account.

Stevie received some support from his mother. There were incidents of domestic abuse toward his Mother and wife.

Stevie was also well known to the Police for episodes of violence, anti-social behaviour, drugs and theft. Police had also responded to concerns for his safety, as a missing person and incidents relating to his mental health.

In **December 2013**, Stevie was homeless and sleeping rough. SKDC found him temporary accommodation but by **January 2014**, SKDC asked Stevie to leave due to his behaviour. Stevie was admitted to mental health hospital. He did not attend follow up appointments with the homeless team.

Stevie periodically attended A&E without medical need and Police were called to assist due to breach of the peace. ULHT, Police, LPFT and SKDC liaised and Stevie was found emergency housing.

In **June 2014** Stevie had again been asked to leave accommodation due to his behaviour. SKDC discussed his housing options at a case conference. Though it was thought Stevie would likely be deemed to be intentionally homeless, it was agreed an application would be made to supported accommodation and that Stevie would be on a week to week contract.

In **October 2014,** Stevie called the police to report that (Adult1) and (Adult8) had attempted to kidnap him and had beaten him up. This enquiry was then taken on by the officer attached to Operation Dungeon.

Stevie consented to information to be shared with LCC SA team. Police requested LCC SA not to make contact due to their investigation.

(Adult1) and (Adult8) were arrested, interviewed and bailed with eventual Crown Prosecution advice to take no further action because of evidential difficulties.

6.10

'William's' Story

William is a white British man in his early 60's. William had partial paralysis of his pelvic region due to a past injury and had personal care needs arising from this.

William also had a diagnosis of depression and at times had suicidal ideation. He had received support through mental health services from 2011.

William was known to the police for violent offences and using and dealing in illicit drugs. Police also had records of a long history of domestic abuse from William to his wife.

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

In **January 2014**, William informed SKDC that he was feeling suicidal due to his housing and that he was being abused by young people. The Housing Officer contacted the Community Safety Team. William was advised to contact the Police and was referred to the floating support service.

William reported to LPFT threats from his in-laws and multiple physical assaults by his son and feeling suicidal as a consequence.

A safeguarding referral was made to LCC SA team in relation to financial exploitation and physical assault by William's ex-partner and son. **LPFT also liaised with local Police** to ask if they could do routine safe and well checks to reduce William's vulnerability and informed William's GP.

LPFT records response from LCC SA team '*Safeguarding can support but need clarification that (William) has given permission for this. They cannot put any financial barriers in place but can advocate and communicate with ex-partner. (LCC SA worker) was clear that issue of threats from son is serious and needs to be taken to the police*.'

LCC SG planned to joint work with LPFT who continue to support William

In **February 2014**, William contacted the Police to report youths coming round to his house selling food and threatening to damage his windows when he declined to buy. Police attended, no complaints were made and advice was given to William.

William informed LPFT that he had been asked to act as a getaway driver. He stated he

did not want to do this but was frightened that the men would assault him. **LPFT made a referral to LCC SA team who agreed a referral was appropriate. LPFT also phoned police who offered to send plain clothes officers to William's home or for him to attend the station to make a statement**.

Following repeated allegations of being threatened if he didn't get involved in robbery, LPFT offered William respite accommodation. **Referral made to LCC SA team and LPFT contacted Police**. LCC SA team offered to take William to the Police station but refused.

The safeguarding strategy meeting was held on 27th February and William attended. SKDC were unable to attend but provided information for the meeting. William was offered a move to place of safety and lifeline button - William declined this. The plan was to seek suitable accommodation outside of the market town and allocate a Care Coordinator.

In early **March 2014**, SKDC offered William a new tenancy in the market town which he accepted. It transpired SKDC had not received the safeguarding meeting action plan in time stating a need to seek accommodation out of area.

LPFT continued working with William in his new tenancy, advising not to give his son his new address.

April 2014 – William's son contacts Police alleging William was pushing him around. Police attended and noted a heated exchange but no offences. Police completed a DASH form relating to William's son as the victim.

LCC SA team contacted William to check his situation before closing the case. William reported his son had threatened him with a knife and wanted money.
In **May 2014**, a local milkman reported a verbal altercation between 3 youths and William at his home address. The youths were his son, (Adult1) and one other. Police attended and recorded no complaints and no offences.

William informed LPFT the youths had threatened to smash the windows if he did not open up his house. LPFT plan was to discuss with Housing Officer.

In **July 2014** SKDC sought the Police and LPFT's help to gather a statement from William about anti-social behaviour in order to raise an injunction. '*Council are keen to increase security at the flats as well as gaining an injunction against perpetrators*.'

William moved back with his wife and by **August 2014**, William had given up his tenancy reportedly due to financial harassment.

In **November 2014,** William's circumstance formed part of the police investigation Operation Dungeon**.** Adult1 was found guilty of four counts of harassment and sentenced to 19 months custody and a restraining order to protect victims for a 5 year period. William was one of the named victims**.**

7. Analysis of themes and learning

The themes that emerged from the review are considered at three stages of the safeguarding pathway:

- Prevention and vulnerability factors
- Decisions Surrounding Referrals
- Multi-agency working

The review then considers 'What would be different now?'

7.1 Prevention and Vulnerability Factors

7.1.1. • **Vulnerability Factors**

The factors that increase vulnerability to neglect and abuse are well established.[10]

7.1.2. The stories of the ten people who are the subject to this review, exemplify these vulnerability factors and their susceptibility to financial exploitation.

7.1.3. All of the individuals had long standing, extensive mental health needs. Eight out of the ten people also had poly-substance and/or alcohol dependency.

7.1.4. Mental health needs and problems with drug and alcohol use, are often associated with life circumstances that may further increase risk.

7.1.5. The factors that increased the vulnerability of the ten people are exemplified in table 1 below.

Table 1: Vulnerability Factors

	Julie	Darren	David	Emma	Gerry	Firdo	Rob	Joe	Stevie	William
Mental health	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

[10] SCIE 39 Report: Protecting Adults at Risk: London Multi-agency policy and procedures to safeguard adults from abuse 2011

needs										
Physical needs	✗	✗	✗	✓	✓	✗	✗	✗	✗	✓
Substance or alcohol dependence	✓	✗	✓	✗	✓	✓	✓	✓	✓	✓
Poverty or financial dependency	✓	✗	✓	✗	✓	✓	✓	✓	✓	✓
Homelessness or tenancy at risk	✗	✗	✓	✗	✓	✓	✓	✓	✓	✓
Impaired or fluctuating capacity	✓	?	✓	✓	✓	✓	✓	?	✓	?
Limited support from family	✓	✗	✗	✗	✗	✗	✓	✗	✗	✓
Isolation or harmful social networks	✓	✗	✓	✓	✓	✓	✓	✓	✓	✓
Focus of anti-social behaviour	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Vulnerable to insecure housing or homelessness	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

7.1.6. For many of the ten people, the financial exploitation co-existed with other forms of abuse. The documentation identifies physical and sexual abuse, psychological abuse and self-neglect.

7.1.7. Alongside the risk of abuse, the ten people had multiple additional risk factors.

7.1.8. These risks included deliberate self-harm and suicide, mental health relapse, disengagement from treatment and homelessness. For some people, risks included aggression and violence toward others including children, family members and care workers.

7.1.9. Most of the people subject to this review were in receipt of disability benefits. This higher level of benefits and the medications that some were prescribed, further heightened their risks of being exploited.

> *'she was expecting a back pay payment on Wednesday of £2000, she said she was planning on buying a new sofa, TV and stereo with this money…..'*
> *'I asked her if she had any money - she said Friend3 had her bank card. …'*

LPFT Record -Julie, 2013

'(Rob) stated that he had not got any medication, someone had stolen it even though it is hidden in the house they can still find it'

LPFT Record -Rob, 2010

7.1.10. There were repeated examples where the use of illicit substances led the person into a lifestyle of poverty. Their dependency made them susceptible to coercive control by violent individuals and being a victim of extortion.

'(Joe) said someone was going to see him and loan him £10 and take him a small pouch of tobacco but was going to charge him £50 when he gets his benefits.'

LPFT Record -Joe, October 2013

'Yesterday two men knocked at his door and asked him to commit a crime with them. They wanted him to rob a local drug dealer and he refused although they said that they will come back this weekend to physically assault him if he doesn't go with them.'

LPFT Record -William, February 2014

7.1.11. These excerpts provide examples of the inter dependency between substance misuse; homelessness and financial exploitation.

7.1.12. Even where risk of violence is not an immediate factor, the person's ability to appraise risks could be impaired by their mental health needs and/or the influence of illicit drugs and alcohol.

7.1.13. Throughout the LPFT chronologies, there is reference to an absence of assessing mental capacity at times when an assessment was indicated.

7.1.14. At the SAR learning event, practitioners reflected that the person's ability to weigh and use information, may well be impaired by the effects of their mental illness, and/or drug use. During the scope period, mental health practitioners were not confident in assessing fluctuating mental capacity.

7.1.15. However, even where the person has capacity, their dependency on substances may significantly influence their judgement i.e. understanding risks but dismissing them due to the need to access drugs.

7.1.16. Where the person also had low self-esteem and loneliness, this compounded their susceptibility to undue influence and coercion.

7.1.17. The interviews with Rob gave some insight to this.

'sometimes its ok sometimes it's not. I live alone most of the time. Basically, they come round and want money off me or to borrow money – most of my friends rip me off. I've been told not to let people in but I've got to let some people in. I have got some good friends.'

Interview with Rob April 2017

7.1.18. Excerpts from Rob's chronology also demonstrate the well-intentioned advice that was

repeatedly given - but advice that was difficult for the person to act upon.

> *'Ongoing contacts by casual callers which he is advised against having contact with due to vulnerability of not keeping belongings safe and secure. However is reluctant to stop people coming to door.'*
>
> **LPFT Record -Rob, November 2013**

7.1.19. Throughout the agencies' records, there are similar references to the person being given advice about keeping their door shut, not giving out their pin number and staying away from some acquaintances – the records are littered with episodes where this advice was not followed.

7.1.20. The reasons behind the person's actions are complex. For many, their histories of abuse within relationships may have adversely affected their self-esteem, sense of worth and expectations about how they should be treated. Reasons may also be rooted in loneliness and isolation. Action may also be based in the complex and changing dynamics of friendships and co-dependency with 'friends' and associates who are also drug users. The Police IMR provided repeated accounts of this.

7.1.21. As will be seen in section 7.3, the concept of choosing to invite 'friends' who were abusive into the house, was given as a reason for not progressing referrals through Safeguarding Adults procedures.

7.1.22. However, these behaviours and actions need to be viewed in a wider context. In recent years, there has been a growing understanding of coercion and control in the context of domestic abuse[11]

7.1.23. Chronic fear i.e. fear of consequence, may lead victims to do what they can to self-protect. Actions such as 'inviting' the perpetrator in, may be misinterpreted and judged by others to be 'encouraging' or 'asking for trouble' or 'evidence that the risks can't be too bad.'

7.1.24. What we know from victims is that far from being 'reckless', opening the door to risky individuals may be the only thing they can do in that moment to manage their safety.

7.1.25. For some people such as Julie, her exploitation co-existed with domestic abuse. For others, while their circumstances may not meet the definition of coercive control in domestic abuse,[12] there are common factors in how the victim tries to protect themselves that agencies need to understand.
[Recommendation 1]

7.1.26. The interviews with Julie and Firdo described their experiences:

> *'[Adult1] injected Julie with drugs (she showed us her scars all over her arms and wrists). He often used tea or whisky in the needle and injected her and charged her for heroin. They then*

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[11] Dr Jane Monkton-Smith https://avaproject.org.uk/wp-content/uploads/2016/03/Jane-Monckton-Smith-2016.pdf

[12] Section 76 of the Serious Crime Act 2015 Controlling or Coercive Behaviour in an Intimate or Family Relationship

used her money to buy themselves drugs.

They weren't physically violent – Julie described not going out of her house for days. If she needed bread or milk she would walk miles in the dark out of the way to a shop that avoided their houses.'

Julie described changing address and estate to avoid and hide from [Adult1]. She even altered her surname. One day [Adult10] and [Adult11] (drug dealers) saw her they told [Adult12] who domestically abused her. He kicked her in the face and she lost a tooth (early 2015)…. He sexually, financially and mentally abused her. This is how [Adult1] and the others found her again.

Interview with Julie April 2017

'they would come in. I'd try and be friendly like and show them around. They would go through my belongings. They'd be eying things up. They took advantage of me, stealing my food and my money – it's still happening. I had £70 stolen this week.'

Interview with Firdo, April 2017

7.1.27 • Preventative Responses

7.1.28. All ten people received a high level of services from agencies. Police had extensive involvement in all cases, responding to people's mental health needs, responding to their self-reporting as victims and, in some cases, as offenders. Some people, such as Emma, William and Rob, also had substantial support through SKDC Housing Officers.

7.1.29. All individuals received Primary Care, with some receiving specific support such as methadone prescribing and counselling. Some also regularly accessed ULHT A&E, Social Care services such as Adults Supporting Adults and Compass.

7.1.30. In the interviews with Rob and Julie, they had different views of the support from agencies:

'Police were really good though - PC (XX officer initiating Operation Dungeon), I miss him. Some other police are not very good with mental health… they only get 6 weeks training.'

'Housing were really good with me. They got me involved with a Housing Officer who got me this place and came round all the time when I was having problems. They've bought me food.'

'….Hospital is a good place to go. They've been brilliant to me. I had to go there to get away from the people who were taking off me – place of safety if you know what I mean.'

'Mental health supported me very well – (keyworker) listened and understood but all of them helped in their own way. What advice given by agencies and did it help? ….. My social worker was very good – she used to come round really quickly. She did things like help me get the flat decorated. '

Interview with Rob, April 2017

AOT made me feel safe, they were a great service- that helped me feel safer. "Brilliant" felt safe. AOT changed due to funding and CPN only visited once a week to deliver medication.

Police? No, they would pick me up for shop lifting and called me a "loveable rogue" they didn't seem to pay attention when [Adult10] abused me. "[Julie]- she's the mad woman" (quotes police officers).
When [Adult12] stole her camera and she reported it they said "she's a thief herself". [Julie] described being arrested and the police radioing to the station to report that they were bringing her in and for them to make her a lasagne. So they looked after her but didn't protect her, only arrested her. They recognised that she was vulnerable she thinks.

… they arrested me for nicking a kettle to boil water to wash up but took no notice when I was having things stolen. Until Op Dungeon until they took my statement they didn't listen.
Housing? There used to be a place that helped with furniture and food which was good.
Churches? Good for food when hungry but met the abusers there
Safeguarding Team LCC? Doesn't recall as she hasn't met any SWs that weren't LPFT AOT.

Interview with Julie, April 2017

7.1.31. The service with greatest involvement with all ten people was LPFT.

7.1.32. For many individuals, their engagement with mental health services was tenuous and their concordance with care and treatment plans sporadic. Eight out of the ten people subject of this review, had additional support through the AOT.

7.1.33. AOT services were set up under the National Service Framework for Mental Health[13] The original model provided for a multi-disciplinary team with a small case load, to enable work with service users with severe and enduring mental illness, who were challenging for services to keep engaged in treatment. The AOT approach was pro-active, flexible and holistic, finding creative ways to support the person's needs. An extract from Julie's record exemplifies this approach.

'On the way to (Julie's) we called and got her fishcake and chips. (Julie) let us in and sat and ate all the food. We started cleaning the kitchen; there were a lot of flies, also mould on the plates. I spoke to (Julie) about going out tomorrow to get some money and she stated she hasn't got any as the girl across the road has her cash card, she has it back now, we will still go and check tomorrow, also she agreed to come to [rehab unit] for a bath and we will try get some clean clothes for her….'

LPFT Record -Julie, 2011

7.1.34. LPFT reported that at the beginning of the scope period, they were working according to the original service model. However, by 2013, the AOT was amalgamated into an integrated CMHT with a substantial increase in caseloads as a consequence. At the learning event, practitioners felt this had detracted from their ability to provide the intensive multi-disciplinary relational based approach that was often required and valued by their service users.

7.1.35. Six of the ten people also had specific support from drug and alcohol services. The work focused on drug and alcohol harm reduction and also had the potential to provide skills highly applicable to reducing vulnerability factors, for example motivational interviewing and drug refusal (social skills) training.

7.1.36. Given this intensive involvement by services across Health, Social Care, Housing and Police, there

13 Department Health (1999) National service framework: mental health

is a question about how well the vulnerabilities and risks of abuse were recognised.

7.1.37. Learning from published Safeguarding Adults Reviews and Serious Case Reviews, often highlights that risks were hidden from view and urge practitioners to exercise greater professional curiosity to identify abuse.

7.1.38. Within this review, the agencies identified some missed opportunities for practitioners to explore individual's presentations in more depth.

> *'A&E records at these attendances record him being unkempt, having no money and using illegal substances. There is no evidence in records on any occasions of these occasions that staff used professional curiosity to explore these issues with (Gerry).'*
>
> **ULHT IMR**
>
> *'… in the case of (William) who in January 2014 is recorded as having suicidal ideation and presenting as tearful and not eating, whilst a referral to LPFT was made, greater professional curiosity, probing more closely and recognition of 'red flag' elements in the patient narrative pertaining to his deteriorating mental health state could have enabled the GP to identify the alleged threats of violence and financial abuse.'*
>
> **Primary Care IMR**

7.1.39. However, in the vast majority of instances, practitioners from all agencies were well aware of the level of vulnerability the person had and the incidents of exploitation.

7.1.40. Mental health case notes record numerous incidents where allegations of financial abuse were made. Risk assessments set out the risk factors in some detail. In general, there was good exchange of this information between Primary and Secondary mental health services.

7.1.41. It is also clear from records that services were working very hard with the ten people to support them to reduce the risks in their lives.

7.1.42. There were many examples of agency workers being tenacious and compassionate, often putting themselves in risky environments to try and provide support. Julie is just one example.

> *'he answered the door, I asked to speak to (Julie), he shouted up the stairs, (Julie) came down to the door, she was in her night wear, she appeared unkempt, very thin, she spoke in a very quiet voice, I asked her if all was ok, she stated it was, but the look on her face said different, (Julie) look frightened and kept glancing at the room door where he was. I informed (Julie) that I will come round tomorrow and take her out for a coffee and something to eat, ..'*
>
> **LPFT Record -Julie July 2014**
>
> *'(Julie) arrived at her home and then told (Housing Officer) that her home had been used as a drug den and that alleged prostitution has taken place there. Julie agreed to report these incidents to the police; (Housing officer) supported (Julie) back to the housing offices so that the police could attend an interview with (Julie).'*
>
> **LPFT Record -Julie May 2013**

7.1.43. There is repeated reference to practitioners trying to find ways to reduce risks.

‘Crisis team agree to plan and advised not to leave medication with him as it gets lost or stolen’

LPFT Record - Rob, 2013

‘(David) disclosed bullying - feels unsafe. Both GP and substance misuse nurse advise (David) to contact police re allegations of bullying

GP Record David August 2013

‘Admitted to giving her card & PIN to a neighbour recently who took money from (Julie’s) account and bought (Julie) drugs. Strongly advised not to do this and made clear that AOT cannot continue to provide food/ gas/ electric for her. Agreed to me contacting SKDC re Removal of bugs from garden. Also agreed to staff contracted DLA x Income support at visit tomorrow.

(Housing Officer) also stated that she had completed the risk assessment with Julie and she had scored 34 points which ideally would mean that Julie would be transferred to the community safety team.

LPFT Record - Julie, 2013

7.1.44. The issue was not that financial exploitation was unknown – nor was it a lack of commitment by practitioners to reduce the risk of exploitation.

7.1.45. Section 7.2. below, will explore decision making around referring through Safeguarding Adults procedures and to the Police.

7.2. Decisions Surrounding Referral

7.2.1. • Context

The policy and legal context that should have guided the decision at that time is briefly set out.

7.2.2. During the scope period, the policy framework for Safeguarding Adults was 'No Secrets'.[14]

7.2.3. Following a national consultation exercise,[15] further policy and guidance was issued.[16] This included a statement of principles for safeguarding adults[17] and a commitment to work with people in a way that made safeguarding personal.[18]

7.2.4. At the beginning of the scope period, the Mental Capacity Act (MCA) 2005, was relatively new legislation and generally was poorly applied.[19]

7.2.5. Application of the MCA and of Making Safeguarding Personal, rightly became a focus in Safeguarding Adult procedures, particularly that a person has the right to make an unwise decision.

7.2.6. Within Lincolnshire, the Safeguarding Adults procedures that were in place during the scope period were dated 2007[20].

7.2.7. These procedures referenced raising alerts where abuse is suspected.

7.2.8. The receiving liaison manager should hold a 'strategy event' with partner organisations to assess the immediate risk and whether to progress under multi-agency procedures and if so, which agency(s) will be investigating.

> - *is the alleged victim 'vulnerable' as defined in the multi-agency policy*
> - *is the alleged abuse within the category defined in the multi-agency policy*
>
> *If these two criteria are met, it must be placed within safeguarding adults.*
>
> **Lincolnshire SA Procedures 2007**

7.2.9. The procedures provided guidance on capacity, consent and best interests and how this applies in making decisions (5.1.). However, this section of the guidance does not make any reference to coercion and undue influence and how this affects consent i.e. that consent must be free and informed.

7.2.10. The procedures referenced disclosure of information in public interest but did not provide any

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14 Department of Health, (2000) *No secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse*
15 Department of Health, Safeguarding adults: report on the consultation on the review of No Secrets (2009)
16 Department of Health, (2011) *Safeguarding Adults The Role of Health Services*
17 Department of Health *(2011) Safeguarding Adults Principles – Government Statement*
18 LGA ADASS, (2014) *Making Safeguarding Personal*
19 House of Lords Post Scrutiny Committee Report (2014) Mental Capacity Act
20 Multi-Agency Safeguarding of Vulnerable Adults in Lincolnshire (2007) Procedural Guidance

further guidance on reducing risks for a person who has not consented, for example through targeted intervention with perpetrators. (this aspect is explored further in section 7.3. below)

7.2.11. The procedures did cite when referrers should make direct referral to Police.

7.2.12. Table 2 references the number of occasions during the scope period where an agency made a referral through Safeguarding Adults procedures or to the Police[21]. The figures exclude the referrals which were made under Operation Dungeon as this was beyond the scope period.

Table 2: Referrals Made Through Safeguarding Adults Procedures and to Police

	Julie	Darren	David	Emma	Gerry	Firdo	Rob	Joe	Stevie	William
Referral through Safeguarding Adults	3	1	1	1	3	1	4	3	1	3
Referring Agency	SKDC LPFT LPFT	LPFT	LPFT	LPFT	LPFT LPFT LPFT	Police	LPFT LPFT LPFT Police	LPFT LPFT Police	LPFT	LPFT LPFT LPFT
Referral to Police	3	0	1	1	0	0	0	0	0	2
Referring Agency	ULHT LPFT LPFT		LPFT	LPFT						LPFT LPFT

7.2.13. The information provided to the review describe multiple occasions when referral to LCC SA and to the Police was indicated but not made.

7.2.14. It is notable that the numbers of reports to Police directly from agencies is even lower than the numbers of referrals through Safeguarding Adults procedures to LCC SA.

7.2.15. The reasons for this are explored below.

7.2.16

- ### Decisions regarding reports to Police

Sharing information with Police is not only vital in protecting the person. Sharing information enables the Police to build intelligence that is essential to disrupting offenders and building safer communities.

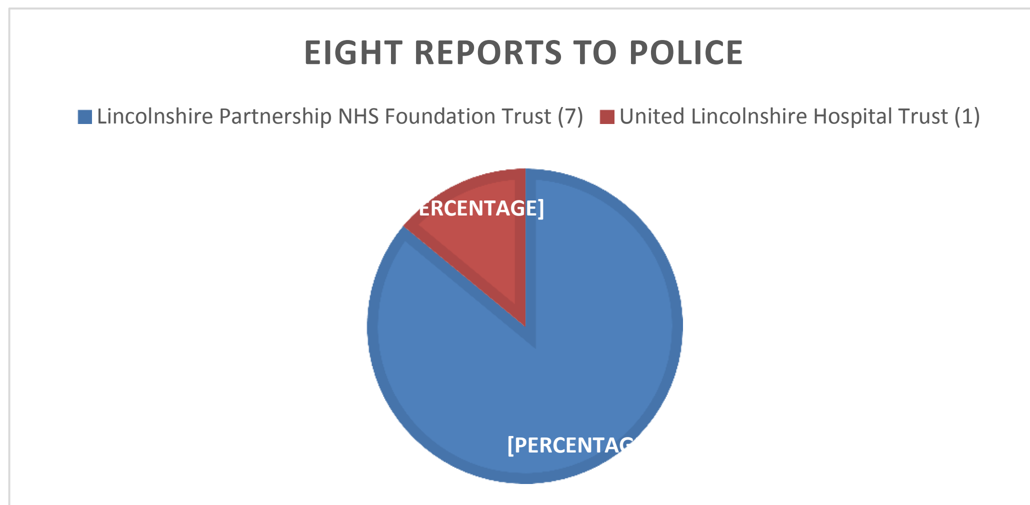
7.2.17. During the scope period, SKDC Community Safety Team had a Police Officer seconded to them.

[21] This is based upon information available to the author from approximately 1800 pages of chronology and IMRs.

This offered opportunities for intelligence to be shared between Housing and Police.

7.2.18. For six of the ten people, there was no report made by agencies to the Police, despite clear statements that serious crimes were alleged to have been committed.

7.2.19. The chart below demonstrates the breakdown of these reports.



7.2.20 It is notable that Julie and William had the highest number of reports made. For both, there were also concerns about domestic abuse. Indeed, in the case of Julie, LPFT completed a DASH risk assessment[22] and referral to Multi Agency Risk Assessment Conference (MARAC) on two occasions.

7.2.21. During the review, practitioners noted that referral to MARAC is based on presentation of risk and that capacity and consent are not barriers to referral.

7.2.22. Throughout the records, there were references to:

i) Practitioners advising the person to self-report the exploitation to the Police
ii) The person stating that they had informed the Police – however, no Police record of this existed
iii) Practitioners asking the person's consent for them to inform the Police but this being declined.

7.2.23. Making Safeguarding Personal rightly focuses on empowering the person to maintain control over their lives including how they wish to manage their safety. This respects the person's rights to determine risks they are prepared to tolerate, even where others may deem their decisions to be unwise.

7.2.24. For many of the people subject to this review, engagement with them was tenuous. Practitioners were challenged in sustaining contact and maintaining concordance with treatment.

7.2.25. Given this tenuous engagement, acting against the person's wishes by reporting incidents to the Police, may have caused their disengagement from services. This is likely to have created higher

[22] Domestic Abuse, Stalking and Honour Based Violence (DASH 2009)

risk for them. Practitioners were therefore treading a fine line, weighing risks of disengagement against risk of further harm by not reporting the concerns to Police.

7.2.26. Victims may be conflicted and have well based fears about the repercussions of informing the Police. The Police records reflect numerous accounts of allegations against peers being retracted.

7.2.27. It was not clear from records whether there was discussion with the individuals about their options in reporting to Police i.e. that there are two distinct options

1) Would the person consent to their information being shared with the Police *and/or,*
2) Is the person willing to support prosecution?

7.2.28. This would have enabled individuals to make a more informed decision.

7.2.29. The review also identified a gap in providing support for a vulnerable witness interview. This was highlighted in the case of David.

7.2.30. Police had requested David's mental health worker attend as a support for his interview but this was declined. LPFT reported their policy was not to provide the role of Appropriate Adult or supporter for a Vulnerable Witness Interview as this is provided by a trained service commissioned by LCC and it may conflict with their role. However, the LCC representative indicated there was no provision for a supporter for a Vulnerable Witness Interview.

7.2.31. 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.
[Recommendation 5]

7.2.32. In making decisions about reporting to Police, practitioners are called on to weigh a number of factors:

- Whether the incident may constitute a crime
- The ability of the person to report the incident to the Police for themselves including:
  - whether the person has mental capacity for the relevant decision
  - whether the person may be subject to coercion or undue influence
  - Whether the person is practicably able to self-report
  - The person's history of self-reporting
- The person's views and wishes
- Nature and degree of risk relevant to vital interests and public interests.
- Likely repercussions of acting against the person's views and wishes
- Responses from historic reporting

7.2.33. There is limited evidence of these factors being weighed.

7.2.34. There appears to have been widespread overreliance on the person self-reporting to the Police.

7.2.35. Given the presenting circumstances, there were many incidents when practitioners should have

been more proactive in supporting the person to report to Police or reporting without the person's consent.
[Recommendation 1]

7.2.36. David's situation was one example where there were significant vital interests and public interest factors that were not addressed.

> *'Informed staff that prior to going in to ward 2 his flat mate (Adult9) held him hostage for 2 weeks and would not let him go anywhere, would barricaded the doors shut to prevent him from leaving. Stated he was physically assaulted by (Adult9) on numerous occasions has been hit on his back with the chain of the dog lead and punch in the face so hard he was knocked unconscious.*
> *CPN1 encouraged (David) to report this incident to the police which he declined stating he would be at more danger if he did this.*
> *"I asked (David) if he consented for me to contact safeguarding adults which he agreed to but again declined the police involvement".*
>
> **LPFT AOT record -David August 2013**

7.2.37. This excerpt describes a serious assault to David. The nature of this assault was known to ULHT; LPFT; LCC SA and yet no agency informed the Police.

7.2.38. This incident was discussed in detail at the SAR learning event, attended by Police. There was no doubt in Police Officers' minds that this incident should have been referred to them, if necessary without David's consent.

7.2.39. The Police investigation, Operation Dungeon, began in 2014, when one Police Officer began to piece together information about a small number of individuals being targeted in a market town. This officer was proactive in following this up and escalating to his managers. This was notable good practice.

7.2.40. However, the Police efforts to gather information and secure prosecutions was severely affected by the limited information recorded by agencies about the alleged perpetrators.

7.2.41. Even where the individual had provided the names of alleged abusers, practitioners had not recorded these or only recorded initials with no identifying key.

7.2.42. Agencies rightly have strict guidance on information governance. However, recording systems need to make some provision to record and retain information regarding alleged offenders to support prosecution.
[Recommendation 2]

7.2.43. We now know that this exploitation was wide reaching and had been going on for years. Had information been shared more widely with Police, and had this information been brought together, these patterns may have been identified at an earlier stage and action taken to protect those involved.
[Recommendation 3]

7.2.44. The multi-agency working that did take place is reviewed in section 7.3. below.

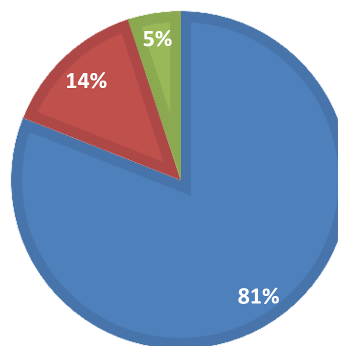
7.2.45.

- ## Decisions to refer to LCC Safeguarding Adults

There were only 21 Safeguarding Adult referrals made for the ten people during the scope period (excluding those made as part of Operation Dungeon). The chart below demonstrates the breakdown of these referrals:

TWENTY ONE REFERRALS TO LINCOLNSHIRE COUNTY COUNCIL SAFEGUARDING ADULTS

■ Linconshire Partnership NHS Foundation Trust (17) ■ Police (3) ■ South Kesteven District Council (1)



7.2.46. As LPFT had the greatest level of contact, this may explain their higher numbers of referrals. There were also occasions when LPFT took forward alerts that had been raised by others**.**

> *'Yesterday the Pharmacist told her that (Gerry) said that (Adult4) was taking his money and quetiapine [an anti-psychotic medication] from him. He dare not call the Police as (Adult4) was threatening him.'*
>
> **LCC SA record of Safeguarding Referral from LPFT – Gerry Sept 2014**

7.2.47. Though it was positive that the pharmacist took some action to follow up concerns, practitioners have a duty to make referrals where safeguarding adult concerns arise. Similarly, the chronologies and IMRs refer to Adults Supporting Adults and GP practices identifying concerns but relying on LPFT following through with a referral.

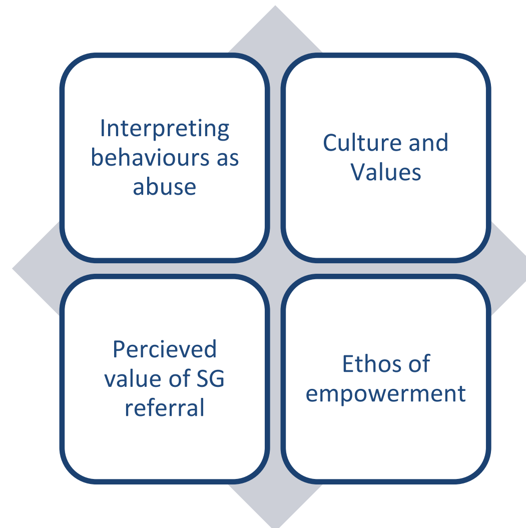
> *'It is of interest that in both the case of (David) and (Rob) reference is made to other services, namely LPFT and/or the police, being aware of the concerns.*
>
> *The practitioners should not have assumed that others involved in the care of the service user would act on information which they consider to be critical to the safety and well-being of the adult. If the practitioner identified concerns about the adult's welfare and believed that they are suffering or likely to suffer abuse or neglect a referral should have been made.*
>
> *It could be interpreted that safeguarding adults was viewed in these cases as the responsibility*

of others when stronger clinical leadership for vulnerable adults with complex needs in the community could have been provided by the GP.'

Primary Care IMR author

7.2.48 Practitioner's should not rely on other agencies who are involved to raise alerts. **[Recommendation 3]**

7.2.49. In examining the low numbers of referrals, the review identified a number of contributory factors.



7.2.50. • **Interpreting Behaviours as Exploitation and Extortion**

Though there were many instances when financial abuse and extortion were recognised, there were also some examples when it was less clear.

7.2.51. One example was with Gerry, during a period of mental health inpatient care.

7.2.52. There was a common practice of lending and borrowing between inpatients. Some incidents appeared to be consensual but there were other occasions when individuals reported feeling pressurised and threatened.

7.2.53. People within an acute inpatient mental health setting, are in particularly vulnerable situations due to the contained environment and their mental ill health.

7.2.54. Some hospitals[23] have worked in collaboration with service users, carers and advocates to develop standards of expected behaviours within the acute mental health inpatient environment. An information leaflet could reference expected behaviours around lending and borrowing and enable staff and service users to challenge at an earlier stage. **[Recommendation 5]**

7.2.55. There were also repeated instances where individuals made allegations about being exploited but when investigated by the Police, it transpired the person owed money for goods bought.

[23] Example CNWL Park Royal Centre

(Rob) contacted the police stating that (Adult4) had been staying with him for 3 days and that he had stolen £60 from his jeans pocket. (Adult4) has now left.

(Adult4) was spoken to and confirmed that he had given a pair of jeans to (Rob) for £20, also that (Rob) had accused him of taking money from him, which he denied, and that (Rob) had later phoned and apologised saying that he had now found the money.

NFA by the police unable to confirm a crime had been committed'

Police Record – Rob June 2014

7.2.56. It may be challenging to determine what is extortion and exploitation amid a social network where lending and borrowing is a cultural norm.

7.2.57. From the review, there did not appear to be a shared understanding amongst practitioners of when day-to-day financial transactions may be assessed as exploitation or extortion. Nor were practitioners clear about the circumstances when concerns should be referred through multi-agency safeguarding and/or directly to the Police. This is an area that the partnership needs to develop further.
[Recommendation 5]

7.2.58. • **Ethos of empowerment and self-determination**

There were repeated incidents where the person declined assistance and insisted they were '*ok and could handle it*'. At the learning event, an AOT practitioner gave a useful insight in relation to their practice ethos:

'Practitioners have become fearful of becoming too paternalistic.'

LPFT

7.2.59. The lessons from the No Secrets consultation[24] highlighted only too well, the negative outcomes for people whose rights to determine their own affairs had been eroded – the MCA provides vital legal protection against this.

7.2.60. Self-determination and empowering approaches should always be maximised within the circumstances of the situation.

7.2.62. As discussed in relation to referring to Police, there needs to be proper evaluation of mental capacity; decisions influenced by coercion and control and wider duties surrounding public and vital interests.

7.2.63. Interventions without the consent of a capacitous person clearly need to have a lawful basis that minimises intrusive action and is proportionate to the presenting risk.

7.2.64. The decision to share information with other agencies without the person's consent may be

[24]Department of Health, (2009), *Safeguarding adults: report on the consultation on the review of No Secrets*

justifiable dependent upon the nature and degree of risk. This is very different to imposing a protective intervention on a capacitous person who is objecting to that intervention.

7.2.65 Professionals needed to be clear about these differences and be able to convey this difference to the people they are aiming to support.

7.2.66. There was limited evidence that agencies were weighing these factors when making decisions whether to refer through Safeguarding Adults procedures or not.

7.2.67. • **Culture and Values**

At the learning event, there was discussion around the culture and values that can influence working with people who have problematic drug and alcohol use.

7.2.68. For some, their vulnerabilities may have been masked by their offending behaviour and the risk that they presented to others.

7.2.69. Many of the individuals were challenging to engage. Use of illicit substances can be associated with a chaotic, high risk lifestyle and being part of a sub-culture that may put the person at great risk of harm.

> *'[Gerry] has been well supported by other agencies, but not been able to change his lifestyle which comes with the risks of exposure to manipulation by others.'*
>
> **Police IMR**

7.2.70. There is a danger that practitioners who are continually working with people in these difficult social circumstances, may become blunted to seeing the high levels of risk – '*that's just how [Firdo] is*.'

7.2.71. At the learning event, mental health practitioners from AOT recognised this phenomenon of normalising high levels of risk.

7.2.72 Assertive Outreach Teams draw on their multi-disciplinary team's skills to try and meet the person's needs. While this is a positive approach, there is also a need to recognise when a wider multi-agency response is required.

7.2.73. Supervision is key in providing this opportunity for reflective practice.

7.2.74. The LPFT IMR, identified that during the scope period, the AOT practitioners were receiving supervision within their team. However, there was limited consultation with the LPFT safeguarding team who could have offered additional objective review and more specialist advice in relation to safeguarding responses. LPFT has subsequently worked to address this.

7.2.75. At the SAR learning event, agencies reflected on other values that may affect responses to people with problematic drug and alcohol use. Perceptions such as '*bringing it on themselves'* and '*lost cause'* may also influence decisions to refer and manage through multi-agency

safeguarding.

7.2.76. Nationally, the numbers of safeguarding referrals made where the person is primarily supported for substance misuse is very low – in 2013-14, 1% of referrals related to substance misuse.[25] This low percentage was reflected in Lincolnshire where the figure for 2013-14 was also 1%.

7.2.77. The reasons for the low referral rates may be multi-faceted. However, practitioners involved in this review felt the figures may in part reflect the perceptions surrounding people who misuse substances.

7.2.78. • **Views Regarding the Value of Multi-Agency Safeguarding**

7.2.79. A further factor that may have affected the decisions to refer, was the value that practitioners placed on the Safeguarding Adults procedures.

7.2.80 Mental Health practitioners reflected that due to previous experience of making referrals, there was a view of *'What more could be achieved through a multi-agency approach?'* Some of the records conveyed a sense of hopelessness and that everything had already been tried.

7.2.81. Some LPFT practitioners also believed that it was a waste of time to make referral through to LCC SA as the referral would not be progressed through safeguarding.

> *'The staff knew about safeguarding adult procedures … and they did use this upon occasion... however there was a general view within the AOT that safeguarding referrals of this complex and challenging service user group were not readily accepted by the Local Authority.*
>
> *The view was that service users who had capacity to determine whether to use safeguarding services and who chose not to engage with safeguarding staff were not accepted as per LSAB policy and procedures and on some occasions Local Authority safeguarding staff commented that the 'AOT's had done everything and no more could be done'*
>
> **LPFT IMR**
>
> *'You complete a 6 page referral form – it never goes anywhere so busy professionals stop bothering.'*
>
> **Learning Event**

7.2.82. The section below examines this decision-making by the LCC safeguarding adults team.

7.2.83. • Decisions Following Referral Under Safeguarding Adults Procedures

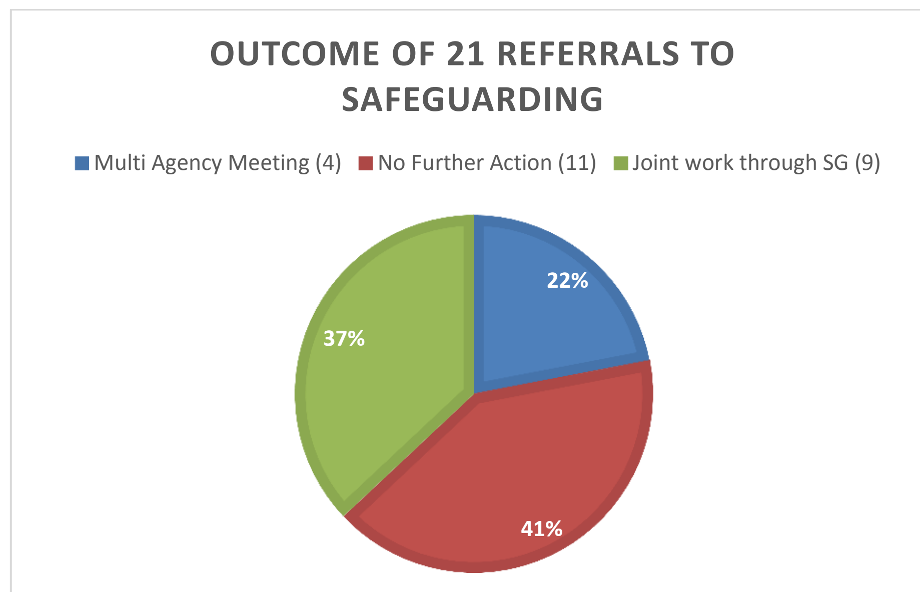
An analysis of the numbers of referrals made to LCC SA and their outcomes is provided in table 3:

Table 3: Outcome of Referrals Made Through Safeguarding Adults Procedures

[25] Safeguarding Adults Return Annual Report England 2013-14 Experimental Statistics: Oct 2014

	Julie	Darren	David	Emma	Gerry	Firdo	Rob	Joe	Stevie	William
Nos. of Referrals to LCC SA	**3**	**1**	**1**	**1**	**3**	**1**	**4**	**3**	**1**	**3**
Nos. Referrals Leading to Strategy Meeting	**1**	**0**	**0**	**1**	**0**	**0**	**0**	**1 *****	**0**	**1 *****
Nos. Referrals resulting in NFA by LCC SA*	**2**	**1**	**1**	**1**	**2**	**0**	**3**	**1**	**0**	**0**
Nos. referrals that resulted in joint work through safeguarding	**1**	**0**	**0**	**1**	**Partial ****	**1**	**1**	**1**	**1**	**3**

***Note: NFA following information gathering and initial review**
**** There was direct communication made with Gerry which then led to NFA**
***** 2 referrals made during the same period resulted in the same multi agency strategy meeting**



7.2.84 An excerpt from the Police Operation Dungeon report highlights well the missed opportunities to provide a coordinated, multi-agency response.

> *Those remaining victims were referred to Adult Services but finalised as 'No Further Action' following initial screening and actions being carried out. No multi-agency planning meetings*

> *were held or concerns identified. ….. Recognising trends and themes, such as the targeting of vulnerable adults, is crucial in providing an accurate understanding of an issue on which effective resourcing decisions can be made'*
>
> **Operation Dungeon tactical group progress report Feb 2016**

7.2.85 Making decisions about the most appropriate next steps needs to carefully weigh all circumstances and evaluate the risks in order to make a proportionate response. This was no easy feat.

7.2.86. The LCC IMR author highlighted that the information contained within some referrals did not help this process.

> *''The quality of contacts from partners ranged from clear and succinct, to woolly and particularly vague. In very few cases full names were given, but occasionally a first name would be shared but in the main, the information shared was " yesterday two men knocked at the door and x says he doesn't know who the individuals are", alerter says that "someone (no name given), has been into his property and taken money". When the referrer was chased for more information the response was "as the individual is vague, I have to be"'*
>
> **LCC IMR**

[Recommendation 3]

7.2.87. The LCC IMR was also critical that referring agencies referred by phone rather than referral form. At this time, there was no requirement within the procedures for a written referral.

7.2.88. LCC questioned the quality of involvement by agencies before they made a safeguarding referral.

> *'There seemed to be little conversation by partner agencies with the individual about the circumstances surrounding the allegation, the outcome they wanted from the conversation/ sharing the information and how they could be helped by the professional in front of them, at that time…'*
>
> **LCC IMR**

7.2.89. The chronologies evidence that referring agencies did carry out substantial work with individuals and had made significant efforts to help them to self -protect prior to any referral being made.

7.2.90. The fact that this was not evident in the LCC SA records reinforces a picture of poor communication between agencies. Valuable information about work carried out prior to referral was being lost.

7.2.91. The referrals related to very complicated circumstances - complex mental health needs, fluctuating capacity, coercive control, serious harm and multiple risks.

7.2.92. The individuals had involvement with various agencies and for many, there had been repeat referrals.

7.2.93. The Lincolnshire Safeguarding Adults procedures referenced holding a 'strategy event' to determine whether to progress a referral through safeguarding.

7.2.94. Given the complex nature of the twenty-one referrals, a strategy meeting was warranted to include all relevant partners. However, the author could only identify six occasions when a safeguarding strategy meeting was held.

7.2.95. Many of the decisions appear to have been made with limited consultation with other agencies involved. This resulted in missed opportunities:

- to draw together intelligence held by the different partners
- to gather more detail about the person's experience from those who knew them well
- to generate multi-agency risk assessment
- to utilise the expertise and knowledge of other agencies
- to identify patterns and recurring themes
- to agree, wherever possible with the person, the best multi-agency response
- to coordinate the response and allocate appropriate resource
- to escalate where concerns warranted this

[Recommendation 3]

7.2.96. In many areas, these safeguarding functions have been delivered through establishing a Multi-Agency Safeguarding Hub (MASH)[26]. This co-locates agencies enabling shared intelligence and utilising expertise in risk assessment and risk management. No such provision was in place in Lincolnshire during the scope period.
[Recommendation 3]

7.2.97. At the SAR learning event, referring agencies described a sense of 'road blocks' preventing referrals being managed through multi-agency safeguarding procedures.

7.2.98. In reviewing the records, the primary road block was that the person had capacity and was not wishing to engage in safeguarding.

7.2.99. The Local Authority chronologies repeatedly referenced, '*has capacity, right to make unwise decisions.'*

7.2.100. As noted in 7.2.5, LCC SA were rightly focused on Making Safeguarding Personal and working with the person toward their outcomes. However, the decisions surrounding the referrals, appear to have focused almost exclusively on mental capacity.

7.2.101. There was very limited evidence that issues of coercion and control had been taken into account or evaluating risks in relation to public or vital interests.

> *'Spoke to ULHT1 at hospital to establish if body maps have been completed and bruising to back identified as (David) states he was whipped with a chain. Advised yes and he has a septic knee and will be in Hospital – 1 to 2 days. No discharge plan in place.*

[26] 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/

PP1 reviewed the case and sent contact to LPFT safeguarding team. (David) does not wish to report allegation to the Police. Refused to give full name. will not be returning to the address in XX. Housing Officer involved to assist with accommodation - risks therefore managed.

Initial Enquiry[27] completed by LPFT confirmed (David) did not wish the allegation to be reported to the police and was unwilling to share further detail in relation to the allegation. Adults with capacity have right to make unwise decisions.'

LCC Chronology – David August 2014

'CPN4 rang to report safeguarding concerns. Reported that (Rob) is vulnerable to exploitation and is inviting people into his home who may be seeking to exploit him. Advised that (Rob) has capacity to understand the potential risks….CSC took advice from CC01, Safeguarding Screening. Advised that if (Rob) has capacity and is willingly inviting these individuals into his home, Safeguarding can't stop this…..CSC liaised with Adult Care and advised CMHT are best placed to monitor compliance with medications and no role for Adult Care. No further action taken.'

LCC Chronology – Rob July 2014

'Safeguarding explained situation re (Joe) and potential financial abuse by peer (Adult6). Safeguarding stated that if (Joe) does not see situation as a problem and is not willing to make a formal complaint then nothing would be done with regard to Safeguarding, advised that they try and work with (Joe) to get a better understanding of the situation and refer to safeguarding in the future is necessary.'

LPFT Chronology- Joe March 2011

7.2.102. At the learning event, practitioners reflected that the Mental Capacity Act was being inappropriately used as a reason to screen referrals out.

7.2.103. Where a capacitous person has declined a safeguarding response, there remains a duty of care to take reasonable steps to work toward engaging the person in protection planning. This may involve seeking alternative avenues to reduce harm, for example offender disruption strategies.

7.2.104. The nature and degree of the risk will determine what is 'reasonable,' and must be proportionate and in keeping with Making Safeguarding Personal.

7.2.105. Where risks are high, agencies need to work harder to engage the person - this may require what is in effect, an assertive outreach approach to safeguarding.
[Recommendation 1]

7.2.106. A further reason for not progressing the referral through Safeguarding Adults procedures was that other agencies, such as Police and mental health services, were already involved.

7.2.107. This response seems to miss the point of multi-agency safeguarding. Safeguarding should be about stepping up to access the added value that a multi-agency response brings.

7.2.108. There were unrealistic expectations of what these agencies, on their own, were able to achieve.

[27] The term 'initial enquiry' does not refer to statutory enquiry under the Care Act. This incident pre dated the Care Act. LPFT were asked to provide information

7.2.109. The reality was that the Police action was curtailed by limited evidence, the person declining to pursue charges and the absence of information about perpetrators recorded by agencies.

7.2.110. There were also limitations to what mental health services could do to reduce risks. Rob was a good example of this. There are repeated entries advising him of ways to self-protect.

7.2.111. It was evident that AOT's 'Plan A' was getting nowhere. What they needed was a 'Plan B' worked up through a multi-agency safeguarding adults response, wherever possible with the person involved.

7.2.112. What happened, was the referral was passed back to LPFT who continued with Plan A.

7.2.113. As referenced in 7.2.81, these responses fuelled the perception of mental health practitioners that there was no point in making referrals.

> *' I do a safeguarding referral and either it's not accepted or they don't take account of the work already done and go out straight away on their own… it feels like a tick box exercise when we're meant to be focused on outcomes. What we need is to get people together to plan what we can do.'*
>
> **Learning Event LPFT Practitioner**

7.2.114. However, practitioners had a responsibility to escalate if they felt concerned about the response to a Safeguarding Adults referral.

> *'All the staff interviewed knew the processes for safeguarding adults and mental capacity as per Trust policy and procedures. They did however identify that they had not readily used the escalation process when referrals were not accepted by other agencies and gave examples of recent and successful use in 2016'*
>
> **LPFT IMR**

7.2.115. LPFT and UHLT have subsequently strengthened their escalation processes.

7.2.116. Practitioners at the learning event highlighted that across the agencies, there had been a tendency to view the incidents of abuse in an episodic way. Recording did not collate a chronology of concerns to build a wider picture.
[Recommendation 2]

7.2.117. Learning from the multi-agency approach to domestic abuse is again relevant here:
- i) the need to move away from incident based responses and work to identify patterns of abuse.
- ii) The ability of the partnership to intervene to reduce risks through community safety initiatives and disrupting the perpetrator.

7.2.118. This learning from the field of domestic abuse needed to be applied to the responses to these referrals.
[Recommendation 1]

7.2.119. No agency, on their own, had a ready solution. These were intractable problems. What was

needed was a multi-agency approach that respected the input and limitations of each agencies and brought them together in a collective attempt to address the concerns.

7.2.120. This eventually happened through the multi-agency response to Operation Dungeon but it took too long to get there. Had each case had earlier multi-agency input, including Housing and Community Safety Team, risks may have been reduced for those ten people at a much earlier stage.

7.2.121. The following section considers where multi-agency responses were made.

7.3. Multi-Agency Responses

7.3.1. The agency reports and chronologies identified some examples where good outcomes were achieved for the person, despite limited coordination between agencies involved.

7.3.2. Darren was an example of this. Darren received support from Police and from mental health services to stop the exploitation by [Adult1].

7.3.3. Although these agencies were working in isolation from one another, Darren reported good outcomes in that he felt empowered to say no to individuals and felt supported by services.

7.3.4 Participants at the learning review reflected that factors contributing to Darren's positive outcomes were:

- Darren wanted to engage so it had been easier to protect – this was a key factor
- Darren had a strong support network – his family were advocating for him
- Fewer agencies were involved
- He did not have a chaotic lifestyle.
- Darren was not dependent on alcohol or drugs
- Darren had housing and a job.

7.3.5. Sadly, this was not the picture for most of the other people subject of this review.

7.3.6. There were also good examples where professionals worked well together, but this was outside of any formal multi-agency structure. Examples are Rob and Julie.

> *'phone call received from [Housing Officer], I explained about [Julie] and how I am going to see her this morning, they are also concerned about her, if we manage to get [Julie] out for coffee I will ring [Housing Officer] and arrange to meet her with [Julie].*
>
> *Visited the home where the police were present following a request from mental health staff to do a welfare check as [Julie] would not respond to the door. The council were also present as they have changed the locks on the door at the request of the council due to concerns regarding [Julie's] partner living at the property. The police informed writer that [Julie's] partner had been back to the property and is now evicted, he has taken his belongings and has been advised to find himself somewhere else to live.*
>
> **LPFT Chronology Julie 2014**
>
> *'Telephone call received from SKDC housing dept. She informed [AOT social worker] that [Rob] had been into the council offices and handed his notice in on his tenancy… he wanted to hand his notice in as he did not want to live near drug dealers…. Agreed to meet with SKDC later this morning to visit [Rob] at home….Email sent to SKDC to rescind [Rob's] termination of tenancy reporting that [Rob] is making life changing decisions when his mental health is deteriorating.'*
>
> **LPFT Chronology Rob 2013**

7.3.7. • Responses through Multi-Agency Structures

As outlined in section 7.2, formal multi-agency forums are likely to be the most effective mechanism to collate information, assess the wider picture of risk and use the breadth of skills the multi-agency partnerships holds.

7.3.8. Multi-agency forums also provide vital information for a wider strategic view of risk within communities. This was exemplified well through Operation Dungeon.

7.3.9. There were various multi-agency forums in place whose aims and objectives were relevant to the ten people.

7.3.10. An overview of these is provided below:

Multi-Agency Forum in Place During Scope Period	Description	Involvement with the ten people (Note: excludes referrals where NFA)
Joint Agency Meeting (JAM)	Led by the Community Safety Partnership. JAM is a multi-agency approach to local anti-social behaviour and low level crime. Used to share information and formulate an appropriate response to the individual or community. Members include Community Safety Team; Housing Agencies; Homelessness team; LCC Anti-Social Behaviour Team; DART; Police; Fire and Rescue; Street Pastors; LCC Children's Services.	• David • Emma • William • Joe • Stephen
Anti-Social Behaviour Risk Assessment Conference (ASBRAC)	Process used to manage high risk victims, perpetrators and locations of anti-social behaviour.	• Emma
Multi Agency Risk Assessment Conference (MARAC)	MARAC: Multi Agency Risk Assessment Conference where high risk domestic abuse cases are assessed and appropriate actions agreed on a monthly basis	None
Care Programme Approach	The Care Programme Approach (CPA) assessment planning and coordination of care for someone with complex mental health problems. Involves all agencies contributing to the service user's care plan, managed by the Care Programme Coordinator	• Julie • David • Darren • Emma • Joe • Gerry

		• Firdo • Stephen • Rob
Multi-agency Safeguarding Adults	Procedures for multi-agency partners to work together to safeguard vulnerable adults as defined under No Secrets (during the scope period), and Lincolnshire procedural guidance	• Julie • Emma • Joe • Gerry • Firdo • Stephen • Rob • William

7.3.11. The Care Programme Approach (CPA) was in place for nine out of the ten service users. Given the Housing and Community safety issues facing many of the service users, LPFT should have sought the service user's permission to involve these agencies in their CPA plan. There is no record of this.

7.3.12. In reviewing the circumstances of the ten people, there appears to be inconsistency in relation to the use of the various multi-agency forums.

7.3.13. This is demonstrated through comparing the responses to Emma and to Julie.

7.3.14. For both, there was concern about their safety in their tenancy and that they were victims of anti-social behaviour within their neighbourhoods. Both individuals were highly vulnerable. However, Julie presented with higher risks due to her history of abuse, her dependency on drugs, association with risky individuals and vulnerability to multiple forms of abuse.

7.3.15. Emma was referred to the JAM and ASBRAC.

7.3.16. Julie had been referred to the Community Safety Team but it appears she was not discussed at the JAM or ASBRAC. The reasons for this are not clear.

7.3.17. Referral through Safeguarding Adults was made for Emma and progressed to a Safeguarding Strategy Meeting.

7.3.18. On two out of three occasions when referrals for Julie were made through Safeguarding Adults procedures, the decision was for no further action.

7.3.19. Referrals were also made for Julie to MARAC through completion of a DASH assessment. The referral was not accepted as meeting MARAC thresholds – this may have been because the nature of the domestic abuse was not fully understood.

7.3.20. In the interview with Julie, she reflected on her experience at that time.

> *[Julie] doesn't think that they noticed when she invited her [AOT worker] in to the kitchen and closed the door. That she was checking out her safety and wellbeing with lots of people hidden in the sitting room and bedroom that she was using heroin (snorting) and that people were hiding crack pipes in her house. These people would cut [Julie's] hair. She thinks AOT had an inkling but she didn't tell them the full extent. When she went for respite at [rehab unit] that is when she*

told them (AOT / LPFT).	**Interview with Julie 2017**

7.3.21. In contrast, the response to Emma achieved positive outcomes for her and appeared to be an excellent example of multi-agency working.

7.3.22. This involved:

- Emma and her family, LCC SA, SKDC teams, Police, mental health services, Primary Care, ULHT working together to address concerns
- The work was coordinated through a Safeguarding Strategy Meeting
- The community safety elements were supported through the JAM and ASBRAC
- The protection plan involved protective strategies for Emma as well as targeting the perpetrator
- Each agency played a key role in bringing together information, contributing essential expertise and developing and delivering the protection plan
- Planning was in place to sustain safety beyond the immediate safeguarding response
- Agencies were proactive, vigilant and person centred throughout

7.3.23 It was observed at the learning event, that out of the ten people subject to this review, the most positive outcomes were achieved for Emma and for Darren.

7.3.24. Neither Emma or Darren had problematic drug and alcohol use. Neither were caught in risky social relationships. Both were open to professionals' involvement. In short, they were the easiest to help.

7.3.25. As one practitioner reflected wryly:

> *'[Darren] was pleasant and engaging.....he behaved how we like people to behave.'*
>
> **Learning Event**

7.3.26. The response to Emma utilised Safeguarding Adults, JAM and ASBRAC. This appeared to work well for Emma. However the relationship between these forums was not clear and LCC SA were not present at the ASBRAC.

7.3.27. SKDC colleagues highlighted in their IMR, that pre-Care Act, Housing had had difficulty in liaising with statutory agencies and were not always invited to Safeguarding Adults strategy meetings in the cases that they were involved in.

7.3.28. Their perception was that this was because they were not viewed as 'professionals.' This may have been the case or it may simply have been due to the limited numbers of strategy meetings held.

7.3.29. Housing used JAM and ASBRAC for information sharing and then in 2015, instigated a Vulnerable Adults Panel to provide a multi-agency approach toward vulnerable adults.

7.3.30. There is clear overlap between what these different protection and community safety forums are aiming to achieve. However, practitioners within agencies were not aware of the different

forums, their role, functions and criteria for referrals. Nor were they clear about how these forums interfaced with safeguarding.

7.3.31 These forums need to be aligned to make best use of stretched resources and to coordinate the responses these forums make to individuals experiencing abuse.
[Recommendation 4]

7.3.32. Housing were in a prime position to contribute a wealth of intelligence to multi-agency strategy meetings. The stories of the ten people gave examples of how Housing contributed to protection plans – monitoring, engaging neighbours, intervening with tenants with anti-social behaviour, providing floating support, offering practical measures such as improved security in the tenancy and arranging alternative Housing.

7.3.33. While Emma was a good example of multi-agency working, LCC IMR also identified that there were situations when this could have been improved.

> *When the cases were formally allocated into the team the records indicate that there was in some instances poor quality exchange of information from partner's, poor joint working when requests for joint visits were made and variable attendance by those who needed to attend meetings to collectively plan the particular enquiry.*
>
> **LCC IMR**

7.3.34. This was demonstrated in the case of William. In February 2014, LCC SG had convened a multi-agency strategy meeting with William, Police, Housing, Mental Health.

7.3.35. Housing had sent information but been unable to attend. William attended the Safeguarding Adult strategy meeting and a protection plan was agreed with him. This included seeking a tenancy outside of the market town.

7.3.36. The plan to seek housing out of area may have been the only practicable way to manage the risk. However, this does not sit well with resolution for the victim – that they have to move away from their home and community. This reinforces the necessity to explore different avenues within the protection plan, focusing wherever possible on disrupting the offender.

The action plan from this strategy meeting was not communicated to Housing immediately following the strategy meeting.

7.3.37. On the same day, a tenancy within the market town became available and was offered to William. Within six days of the strategy meeting, William had signed up for the tenancy.

7.3.38. William was deemed to have capacity in relation to accepting the tenancy. However, had Housing been aware of the discussions at the strategy meeting, they may have been able to advise William regarding the tenancy and what his priority would be for securing an alternative tenancy out of area.

7.3.39. The consequence was that William moved to this new tenancy but within a short period, was again subject to threats and violence.

7.3.40. This demonstrates the importance of early communication by the Chair of the strategy meeting

of action plans.

7.3.41. Communication and coordination between agencies could also have been improved in relation to Firdo.

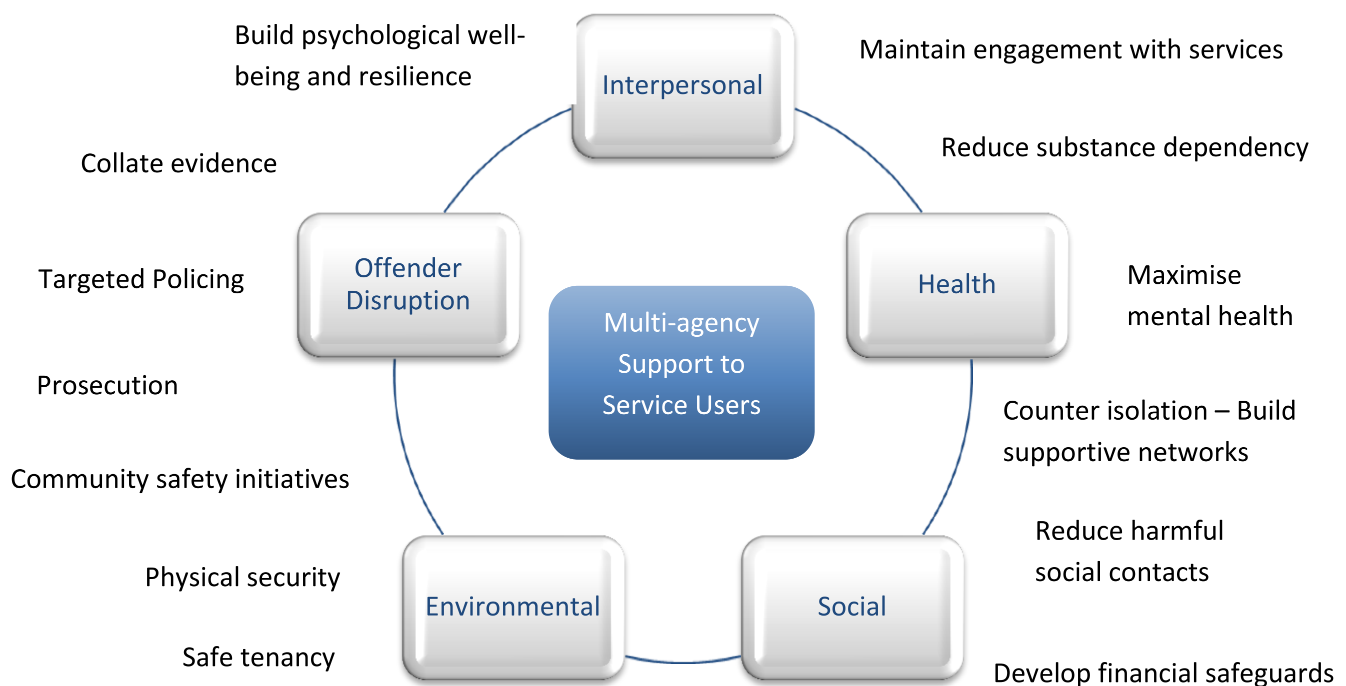
7.3.42. LCC SA had attempted to follow up the safeguarding referral jointly with mental health services but had ended up visiting Firdo on their own. LCC SA experienced a highly aggressive response from him.

7.3.43. Police had Critical Incident Markers on both Firdo's and his parents homes due to aggressive conduct, his previous possession of knives and his attitude towards females. Mental health services were also aware of Firdo's volatility and aggression.

7.3.44. These risks should have been shared with LCC SA colleagues at point of making the referral.

7.3.45. Had there been a strategy meeting, this would also have provided the opportunity to share this risk history and agree the most appropriate response, including which agency is best placed to lead.

7.3.46. The stories of the ten people, demonstrated the multi-faceted approach to protection planning required by all agencies.



7.3.47. Each of the ten cases demonstrated aspects of these protective interventions but the review has

identified that the success in coordinating these protective measures through a multi-agency response was variable.
[Recommendation 3]

7.3.48. The final section will consider what has changed in the partnership since this scope period.

7.4 What would be different now?

7.4.1. • National Developments

The Care Act 2014, came into force in 2015 and brought statutory responsibilities for safeguarding adults.[28]

7.4.2. There has also been national focus on exploitation.[29] Recent work with financial institutions has led to initiatives such as offering adults with Care and Support needs additional protection against fraud[30]and toolkits for banks to help employees identify financial exploitation and work with customers to avoid scams and exploitation[31].

7.4.3. There was an excellent example in this review of the market town bank reporting exploitation of Rob. The national work may help the LSAB consider how they may extend such good practice and engage local communities in reducing financial exploitation.
[Recommendation 5]

7.4.4. As referenced in this report, there has been continued national development in responses to Domestic Abuse through the introduction of the Serious Crime Act 2015. There are more informed responses to situations of controlling or coercive behaviour.

7.4.5. At the SAR learning, representatives considered whether, in light of these changes, multi-agency responses would now be different to the ten people at the centre of this review.

7.4.6. • Lincolnshire Developments

The LSAB introduced new multi-agency procedures in 2015,[32] based on the statutory guidance

7.4.7. In relation to the themes in this review, the revised procedures offer improved guidance on areas such as consent, carrying out the enquiry and protection planning where the person is resistant.

> *Wishes need to be balanced alongside wider considerations, such as the level of risk or risk to others ...*

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28 As detailed in chapter 14 of the Care Act statutory guidance
29 http://www.antislaverycommissioner.co.uk/
30 https://www.cifas.org.uk/protecting_the_vulnerable
31 Age UK: Age-friendly banking What it is and how you do it http://www.ageuk.org.uk/Documents/EN-GB/For-professionals/Policy/money-matters/report_age_friendly_banking.pdf?dtrk=true
32 Lincolnshire Safeguarding Adults Board Multi-Agency Policy and Procedures 2015

> *The specific circumstances will often determine who is the right person to begin the enquiry. In many cases, a professional who already knows the adult will be the best person.*
>
> *Where an adult has capacity and declines assistance, this can limit the interventions organisations can make. The focus should be on harm reduction….In order to make sound decisions, the adults emotional, physical intellectual and mental capacity in relation to self-determination and consent and any intimidation misuse of authority or undue influence will have to be assessed.'*
>
> **LSAB Multi-Agency Procedures 2015**

7.4.8. In 2016, Lincolnshire instigated a new multi-agency safeguarding team -Safeguarding Lincolnshire Together (SLT).

7.4.9. The SLT consists of representatives from LCC SG, mental health and Police. The SLT is a team where referrals to Adult Safeguarding that have been screened out, are assessed and, where appropriate, information researched and shared.

7.4.10. At the SAR learning event, attendees discussed the new procedures and introduction of the SLT, and how this had addressed the themes from this review.

7.4.11. Many representatives gave a view that the changes in procedures had not yet consistently led to a change in practice. Specifically:

- Some referrals continue to be screened out based on lack of consent with insufficient attention to issues of coercion and taking reasonable steps to engage the person.
- There is insufficient multi-agency involvement throughout including low numbers of multi-agency strategy meetings.
- There is a lack of structure, tools and documentation to help guide enquiries and follow on protective measures

7.4.12. The LSAB, as part of their annual assurance programme, may wish to carry out qualitative review of safeguarding to evaluate whether there is a basis for these perceptions, specifically:

i) At point of referral, how well decision making is taking account of all circumstances of the case including coercive influences and matters of vital and public interests

ii) The quality of multi-agency involvement at initial referral; enquiry and safeguarding plan.

[Recommendation 3]

7.4.13. The SLT has the potential to provide a multi-agency response to referrals. However, practitioners confirmed that the SLT is not a decision- making entity and is not involved in the initial stage of the decision making.

7.4.14. Practitioners described a multi-stage process:

1. Referral submitted to LCC Customer Service Centre who may screen the referral out
2. Referral has an initial screen by the LCC Customer Service Centre
3. Referral passed to Adult Social Care for review by a Principal Social Worker
4. Where referrals are screened out, or more information is needed, referral to passed to the SLT for review

5. If SLT view is that the referral should be managed under safeguarding procedures, this recommendation is passed to the relevant Adult Social Care safeguarding team.
6. Principle Social Worker makes the decision and allocates case accordingly.

7.4.15. Practitioners' experience was that it could take some time for a referral to pass through these stages, particularly as the SLT only convenes 2 days per week.

7.4.16. While the SLT does offer multi-agency involvement, this process was not seen to be the most effective or efficient use of the partnership expertise.

7.4.17. All agencies are under immense pressure to sustain services in the face of significant resource constraints and increasing volume of safeguarding work. Lincolnshire Adult Social Care are currently carrying out a review of their Safeguarding Adults arrangements. The findings from this review should be used to inform this process.
[Recommendation 3]

7.4.18. The agencies IMRs all identified additional actions they have taken to improve services since 2014. These are briefly summarised:

- The Police introduced 'Stop Abuse' forms. This is raising the profile of safeguarding in attending officers.
- SKDC introduced a Vulnerable Adults Panel to provide a multi-agency approach toward vulnerable adults.
- Housing services across Lincolnshire work closely with 'P3,' - a county wide service providing tenancy support and tenancy sustainment interventions.
- LPFT has mandatory level 3 training on safeguarding adults and mental capacity. The LPFT internal safeguarding processes include questions on capacity and person's wishes.
- LPFT use their Trust safeguarding email to improve communication and escalate concerns. Audits demonstrate improved understanding of safeguarding and escalation processes.
- Each LPFT team has a safeguarding and MCA champion who receive additional supervision from the LPFT safeguarding and MCA team.
- The local Health economy is introducing a portal to access records from all the Trust's electronic clinical records.
- UHLT has created a homeless leaflet in Lincoln Emergency Department, to signpost people to services. This will be replicated in Grantham and Pilgrim.
- ULHT has employed a MCA lead.
- ULHT safeguarding training package has been revised, reinforcing the need for professional curiosity.
- Primary Care practices receive support, training and guidance on safeguarding adults through the CCGs' Federated Safeguarding Team.

8. Conclusions

8.1. This review has centred on the stories of ten people over a seven-year period.

8.2. Their stories detail some harrowing accounts of their day-to-day lives. The individuals were

highly vulnerable and subject to extensive and sustained financial exploitation. For many, they were also subject to other forms of abuse.

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

8.4. 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.

8.5. The review identified many examples of committed practitioners and agencies, working hard to help the individuals reduce risks.

8.6. The review also identified some good examples of multi-agency working that improved the person's wellbeing.

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

8.8. The rightful focus on capacity and consent had eclipsed consideration of coercion and control and duties relating to public and vital interests. There was limited use of the multi-agency partnership and so missed opportunities to use this combined strength to safeguard individuals and others in the community.

8.9 The multi-agency partnership will not always be able to achieve positive outcomes where individuals are not able or ready to accept help.

8.10 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.

8.11. Had there been more effective multi-agency working and escalation, the Police strategic response of Operation Dungeon, may have been triggered at an earlier stage.

8.12. We know that for at least some of the ten individuals, their abuse continues. Their exposure to ongoing abuse remains a challenge.

8.13. It is hoped that the recommendations from this review, will help the partnership in their continued efforts to safeguard people in similar circumstances within Lincolnshire.

9 Recommendations

Each agency has made recommendations for their agency. These are detailed in appendix 1. 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.

Sylvia Manson

Date: June 2017

Sylman Consulting

Appendix 1: Recommendations made by agencies contributing to the review

Lincolnshire CCG Federated Safeguarding Team and Primary Care	
1.	Learning from this cohort of service users should be added to the repertoire of case studies utilised by the Federated Safeguarding Team in adult safeguarding level 3 training.
2.	The Federated Safeguarding team should issue further signposting to safeguarding leads within GP practice on available guidance and support on financial abuse.
3.	Safeguarding Leads within Practices 1-5 to be signposted to further learning and development aimed at application of the mental capacity act in primary care settings.
4.	Practices1- 5 should review their policies and practice on the provision of health checks to service users with severe mental ill-health.
5.	Practices1- 5 should review their practice procedures for follow up of did not attends and A&E and Out of Hours Attendance.
6.	CCG(s) to seek assurance from practice 4: a) that actions against improvement plans are complete and b) that the physical health needs of service user 'Julie' have been addressed.
7.	Practices 1 - 5 should review their policy and practice for management of medication between GP and the specialist drug and alcohol team.
8.	Practices1- 5 should review their policies and practice on engagement in CPA reviews.
Lincolnshire County Council Adult Social Care	
1.	Adult Care need to review its safeguarding policy and procedures to make it clear that the safeguarding function is to ensure primacy of protecting the individual in parallel to any police investigation and ensure an audit trail of defensible decision making in all referrals.
2.	Adult Care to ensure that their workforce is capable and competent where legal literacy is concerned and provide refresher training where applicable.
3.	Adult Care to strengthen the reporting and accountability framework for the S75 Mental Health Agreement with LPFT to ensure that all cases which fall under the S75 are reported to and monitored through the Governance Board in order to identify common themes and patterns. Quality assurance audits should be carried out through the Agreements annual review.

Lincolnshire Partnership NHS Foundation Trust	
1.	Mental capacity workshops will be developed and completed with the locally involved teams including AOT and Integrated teams, CRHT and Rehabilitation Unit. This will be developed Trust wide in the 2017/18 safeguarding and mental capacity work plan.
2.	A review of the current Assertive Outreach Service against the fidelity to model and NSF guidance and the impact of combining specialist functions into generic teams.
3.	The Trust to support a review and development of the 'Safeguarding Lincolnshire Together' (SLT) role and function to look at increasing Trust resource and improve and strengthen existing pathways for multi-agency involvement and decision making within the SLT at a single multi-agency point.
4.	For the Trust to support the LSAB in developing procedures that identify what happens once a referral has been made, how a S42 enquiry is progressed and protection plan devised and monitored. This must all reflect hard to engage groups and the need for agencies to be tenacious and creative in engaging those who are unwilling or uncooperative at engaging in safeguarding plans
Lincolnshire Police	
1.	No recommendations
South Kesteven District Council	
1.	Further to the case review of TH19-5 [William]– it is recommended that, the council comply with any review of effectiveness of existing communication timelines where for example a SKDC representative is not in attendance at Safeguarding Meetings and key decisions are made in relation to a vulnerable adult.
2.	Further to the case review of all TH19 subjects – it is recommended that we review our data systems with a view to considering the potential for mapping key themes and trends
3.	Further to the review of all TH19 cases – All staff will be subject to safeguarding training and refresher training as part of existing planned training schedule
4.	Further to the case review of TH19-1 [David]– it is recommended that officers revisit the Temporary Accommodation procedures in relation to occupation and abandonment associated with vulnerable adults/Adults at Risk to confirm that current procedures are sufficiently robust.
United Lincolnshire Hospital NHS Trust	
1.	Escalation process for safeguarding to be sent out again to all staff. *Estimated completion date 31st January 2017.*
2.	Addaction leaflet to be sourced and available in all A&E departments and via the intranet. *Estimated date for completion 31st January 2017.*

3.	All staff, but with a specific focus on A&E services, to be reminded to liaise with MH services in all instances when a patient with Mental Health issues, or who is requesting to access MH services, leaves the department, even if this is before they have been triaged. *Estimated timescale for completion 31st January 2017.*
4	Liaisons to take place between ULHT and LPFT to agree recording requirements and ensure both agencies have full documentation. *Estimated timescale for agreements 31st March 2017*.
5.	Homelessness/support leaflet to be developed for Grantham and Pilgrim and all to be available via the ULHT safeguarding intranet. *Estimated date for completion 28th February 2017.*
6.	Training on Mental health to be made available to ULHT staff to support staff in the engagement and management of this vulnerable patient group. *Estimated date for Completion December 2017.*

Glossary

AOT - Assertive Outreach Team

ASB - Anti-Social Behaviour

ASBRAC - Anti-Social Behaviour Risk Assessment Conference

CCG – Clinical Commissioning Group, commissioners of local health care

CSC – Customer Service Centre

CMHT - Community Mental Health Teams

CPN Community Psychiatric Nurse

CPA The Care Programme Approach is a way that services are assessed, planned, co-ordinated and reviewed for someone with mental health problems or a range of related complex needs.

CRHTT -Crisis Resolution Home Treatment Team

CRU – Police Central Referral Unit

CST - Community Safety Team

DART - Drug and Alcohol Recovery Teams

DAsH (Domestic Abuse, stalking and Harassment and 'Honour'-based violence) risk identification checklist (RIC) is a tool used to help front-line practitioners identify high-risk cases of domestic abuse, stalking and 'honour'-based violence.

IMR - Individual management reports

JAM – Joint Area Meeting

LCC – Lincolnshire County Council

LPFT - Lincolnshire Partnership NHS Foundation Trust

Making Safeguarding Personal - is a personalised approach that enables safeguarding to be done with, not to, people.

MARAC (Multi-agency Risk Assessment Conference) is the multi-agency forum of organisations that manage high-risk cases of domestic abuse, stalking and 'honour' based violence.

MASH – Multi-agency Safeguarding Hub

Mental Capacity refers to whether someone has the mental capacity to make a specific decision or not at a specific time

LSAB –Lincolnshire Safeguarding Adults Board, statutory requirements under the Care Act 2014 – objective is assurance that local safeguarding arrangements and partners act to help and protect adults in its areas for whom safeguarding duties apply.

Public interest – a decision about what is in the public interest needs to be made by balancing the rights of the individual to privacy with the rights of others to protection.

PPU – Police Public Protection Unit

Safeguarding Adults is used to describe all work to help adults at risk stay safe from significant harm. Safeguarding duties apply to an adult who has care and support needs and is experiencing or at risk of abuse or neglect and as a result of those care and support needs is unable to protect themselves from either risk of, or the experience of abuse and neglect.

SINF - Significant Incident Notification Form

SLT - Safeguarding Lincolnshire Together

SAR - Safeguarding Adults Review

SKDC -South Kesteven District Council

ULHT - United Lincolnshire Hospital Trust (ULHT),

Vital interest - a term used in the Data Protection Act (DPA) 1998 to permit sharing of information where it is critical to prevent serious harm or distress, or in life threatening situations.

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About the reviewer

The review was conducted by Sylvia Manson, of Sylman Consulting. Sylvia is a mental health social worker by background and has many years' experience in Health and Social Care front line services and management.

Sylvia was the Department of Health NHS lead for safeguarding adults during 2010-11, developing Health guidance published by the DH in 2011 and the Safeguarding Adults principles now contained in the Care Act statutory guidance. Past roles have also included Department of Health regional implementation lead for Mental Capacity Act 2005; Deprivation of Liberty Safeguards and Mental Health Act 2007.

In addition to independent work, Sylvia Manson is Head of Safeguarding in a CCG and a specialist lay member of the Mental Health Review Tribunal

Sylvia Manson

sylmanconsulting@outlook.com
www.sylmanconsulting.com
Tel: 07890 400366