Teeswide Safeguarding Adults Board

Learning from Regional and National Safeguarding Adult Reviews (SARs) Involving Financial Abuse

Title of Review: A Thematic Review of Financial Exploitation/Coercion

Theme of Review: Financial Exploitation from Perpetrators in the Community
Local Authority: Swindon
Date Published: Unknown – post 2020
Link to Full Reports: Thematic Review of Financial Exploitation/Coercion from SAR – Alison

Case Summary

Alison was 49 years old and lived alone. Her contact with family was limited as they lived some distance away. She had a history of trauma and a pattern of alcohol misuse. Alison had chronic mental health problems such as anxiety, depression, a diagnosis of emotionally unstable personality disorder, self-harm episodes including cutting, burning, overdoses, alcohol abuse and drug use. In particular, she had an extensive history of previous suicide attempts. Practitioners often found it difficult to help her, nonetheless she received extensive support and interventions. Alison also had poor physical health with chronic liver disease (she was hepatitis C positive) and asthma.

Police received a report from Alison's GP that she had visited the surgery to say goodbye. Alison had stated she was going to the woods to hang herself. She was found in a stream in woodland near her home. It was determined that she had taken her own life through the use of a ligature.

Evidence provided to the review suggests that Alison may have been subject to exploitation by her neighbours. Swindon Safeguarding Partnership requested that in addition to the SAR a thematic review be carried out to consider the issue of financial exploitation and coercion of Alison.

During the scoping period for the SAR (October 2018 – July 2020) there were a number of reports via different agencies regarding her suicide and self-harm attempts and sexual and financial exploitation allegations against her neighbours.

Financial exploitation was first raised by her GP in December 2018. On one occasion in January 2020, she was found sleeping in a shed, with no explanation recorded of why. In February 2020, she disclosed to paramedics that every two weeks upon receipt of her benefits 'they' enter her property and make her hand money over. She later told police that she had made the story up to gain attention. In March 2020, mental health services raised a Safeguarding Concern and records that Alison had disclosed that she was in fear of repercussions from the two men who were known locally as drug dealers and so didn't want police coming to the property. She was sometimes going without electricity and the two men would often walk into the property demanding other items such as toilet paper and tobacco. In May 2020 her GP raised a Safeguarding Concern saying they had observed Alison visibly shaking in fear when approached in the surgery by her neighbour. Alison disclosed to her GP that her mental health was suffering from the negative effects of the neighbour and mentioned again that the neighbour had borrowed large sums of money and was refusing to pay it back. The Section 42 Enquiry progressed and requested to assess capacity of Alison in managing her finances and to try and obtain her views and wishes. Information was passed to the safeguarding adult's investigation team within the police. No further

actions took place with regard to the financial abuse/exploitation allegation before Alison sadly passed away in July 2020.

The police reported that after Alison's death they found a book in her belongings that had recorded amounts of money owing to her from other people.

Key Findings

The full analysis and key learning points from the thematic review are included within the report. A summary of the key points for TSAB are included below:

- Financial exploitation often co-exists alongside other forms of abuse and often being abused by someone they know can make it difficult for them to support a criminal prosecution.
- There was an escalation in Alison's case; she initially described her concerns and the pressure she felt to lend money which escalated over time to her being extremely fearful of the perpetrators which was impacting significantly on her mental wellbeing.
- Alison lived alone and was experiencing a degree of isolation, compounded later by the pandemic. This may have increased her risk of exploitation.
- Alison was known to multiple agencies, however the alleged exploitation from her neighbours was not fully explored. It was noted that repeated visits and attempts to gain more detailed information was met with resistance from Alison. She was regularly reported as 'not engaging with services' or in one report 'admitting she made it up'.
- Many people with a combination of mental health, drug and/or alcohol issues can be more at risk from impairment of judgement and susceptible to coercion. The issue of financial exploitation did not seem to be looked at on its own merit. Most of the support to Alison was taking place outside of a safeguarding process and not in a multi-agency arrangement.
- Limited professional curiosity or exploration that Alison may be withdrawing her allegations to keep herself safe.
- Many agencies are developing their understanding of coercion and control in relation to domestic abuse and mate crime. This learning should be extended to the recognition that some people who do not fit the definitions of domestic abuse but have similar non-engagement issues and may be reluctant to progress issues through fear. Alison repeatedly requested service intervention/attention however there was no consistent joined up approach or lead agency identified. The mental health service could have led the S42 Enquiry on behalf of the LA and reported into multi-agency safeguarding arrangements.
- There was no information recorded as to whether the alleged perpetrators were the same person(s) and whether the person(s) were aware of Alison reporting them or not. It is not known if the neighbours posed a threat to others.
- Alison had expressed a preference to see female workers. Given Alison's circumstances other considerations could have also been made to support her in disclosing information, such as seeking an alternative/neutral location to see her.
- There seemed to be an over-reliance on Alison contacting mental health and other services with little regard to helping her with coping mechanisms to deal with pressure from neighbours, lockdown and welfare issues.
- There was no exploration whether a move of location for Alison would have been helpful. This may not have been acceptable to Alison, however there may have been ways of looking at security of the premises or identifying risks to other neighbours and whether more could have been done to deter perpetrators.

- Alison's diagnosis of EUPD may have influenced her decision-making processes. It is unfortunate that further therapy was not offered to support Alison with her allegations of her neighbour's taking money from her. It may have helped to have offered ways of accessing her money in a different way or assisting a more confident manner to refuse requests. If it was the case that the allegations were not true, then the process of bringing that to a close by further investigation may well have helped inform future allegations. Decision making needs to take into account any influence from coercion and control.
- There are no specific multi-agency financial coercion/exploitation procedures available to Swindon. Leicester & Rutland have a good practice example regarding Managing Risk.

Title of Review: Ella

Theme of Review: Financial Abuse by a Care Worker
Local Authority: Devon Safeguarding Adults Partnership
Date Published: Unknown – post 2021
Link to Full Reports: Ella SAR

Case Summary

Ella was 77 years old and was murdered in her home in January 2021 by an employee of an independent care provider.

The murder followed an allegation of financial abuse and fraud committed by Mr M against Ella while he was her care worker. He had used her bank card to steal money while undertaking shopping for her. When this was discovered, he was suspended by his employer, but he returned to her home on two occasions, the second of which he committed the murder. Mr M was found guilty and sentenced to life imprisonment with a minimum tariff of 30 years.

Ella lived alone and did not have many contacts with her family. She suffered from osteoarthritis, degenerative disc disease in her lumbar spine, historical alcohol dependence and recurrent depression. Her mobility decreased and in later months she slept downstairs. She was admitted to hospital on several occasions, often because of falls. She became more dependent upon carers for daily personal care, shopping, to prompt medication, support nutritional requirements and home environment and ensuring the dogs were fed. The provider was also advised about Ella's previous experience of domestic abuse at the hands of her second husband.

Mr M became Ella's sole carer in October 2020. He had no previous experience as a care worker. He had a number of previous criminal offences. Police were also called to attend domestic incidents and arguments between Mr M and his wife on several occasions, both parties had reported they had been assaulted by the other on one occasion, but no formal action resulted

Key Findings

The full analysis and key learning points from the SAR are included within the report. A summary of the key points for TSAB are included below:

- Assessment and management of the risks faced by Ella – care and support plans did not reference financial abuse, despite Ella making disclosures of this.
- Assessment of Ella's Mental Capacity to manage her financial affairs – no formal capacity assessment was completed.
- Communication and information sharing between agencies and with the independent provider – further information held by police could have allowed the provider to make a more comprehensive assessment of the risk Mr M may have posed as a care worker.

- Recruitment, training and supervision by Mr M by his employer and his suitability to be a care worker – Mr M could have been dismissed from his post in accordance with the company's alcohol and drug police before he was introduced to Ella had this information been made known to the provider.
- Equality and diversity considerations – Ella requested female carers due to previous experience of domestic abuse.
- There is a need to be vigilant when a service user is predominantly in the company of a single care worker.
- Were there any missed opportunities to identify and prevent the financial abuse and subsequent murder? Police did not visit Ella within 24 hours because there was a named suspect and he had been suspended from work and there was thought to be no safeguarding concerns. Police were not informed after the first occasion when Mr M visited Ella despite being suspended and instructed by the provider not to contact clients – had this been known the risk assessment may have been raised to a higher level and could have deterred Mr M from returning to the house for a second time.
- Good practice – one worker established a rapport with Ella and liaised with her bank to establish that there were thefts being made from her account.

Title of Review: Sandra

Theme of Review: Financial Abuse by a Family Member
Local Authority: West of Berkshire Safeguarding Adults Board
Date Published: July 2023
Link to Full Reports: SAR Report Learning Briefing

Case Summary
Sandra was 65 years old. She had a number of long-term health issues including obesity, orthopaedic problems, and poor mobility. Sandra had two children with whom she was in contact, including a son who suffered from poor mental health and himself had significant needs. Due to his vulnerabilities, she felt compelled to support his needs despite this severely affecting her own wellbeing.

Sandra's sister would visit her regularly to help with daily tasks. The first concerns for Sandra's safety were raised in 2013, with a report that her son had moved into her flat after being evicted from his own accommodation. There were concerns about him physically assaulting her, causing damage to the flat, and moving in a large volume of possessions that made it difficult for her to move around and access rooms. Shortly after these concerns were raised, Sandra was evicted from the property due to its condition and was supported by the local authority in being rehoused. She was provided a flat with a single occupancy tenancy and a condition that no other person should reside with her. It later transpired that the son was living her which was a breach of her tenancy.

During the subsequent years a number of further safeguarding concerns were raised about Sandra, all with similar themes relating to the risk of abuse from her son and the condition of her flat. Concerns included her son taking over her flat, whilst exposing her to physical, emotional, and financial abuse. During early June 2022, Sandra received a minor injury in her home that became infected and led to her hospitalisation. Following her admission, her condition continued to deteriorate, and she died.

Key Findings
Learning from this SAR was generally linked to improving general safeguarding practice, the referral process, information sharing, quality of care act assessments and management of risk.

Professionals recognised self-neglect due to the condition of Sandra's flat but did not fully demonstrate professional curiosity as to the reasons why this may have been. The fact that Sandra's son was a significant cause of her problems was not identified and therefore a critical and necessary aspect of any safeguarding plan was missed. The focus was instead on cleaning Sandra's flat. Sandra's son was having a detrimental impact on her physical and mental wellbeing, disclosing to police at one point that it was ruining her life and she felt trapped in her own home.

In the latter stages of Sandra's life, she had withdrawn from personal contact with her social worker, who was not able to arrange a face-to-face visit. The risk of disengagement was not fully identified and therefore a plan to manage not developed.

Considerations for TSAB
Having reflected on the learning and recommendations from all SARs, the key points for TSAB partners to consider are noted below:

- TSAB have previously considered financial abuse/scams as part of its Multi-Agency Audit programme in November 2021, followed by a themed discussion on financial abuse in December 2021. Should this topic be revisited as part of a future Multi-Agency Audit programme?
- The Operational Leads Sub-Group have recently discussed financial abuse as a topic for further exploration, particularly the challenges regarding family members who are the alleged perpetrators. This report can be shared with the OLSG for consideration and to support discussions when they meet again in May 2024.
- Is there a need for specific multi-agency guidance regarding financial abuse or can existing guidance/procedures be strengthened?
- Concerns involving financial abuse can also include other types of abuse, where financial abuse is not necessarily logged as the main category of abuse. How well are recording systems able to log repeated concerns that include similar patterns of abuse to spot trends or escalating concerns? This report can be shared with the PAQ Sub-Group for consideration.
- Reasonable adjustments – Alison and Ella expressed that she preferred relating to female workers. Do all agencies have the ability to record and highlight reasonable adjustments effectively? How is this information shared across agencies? (similar learning regarding reasonable adjustments links to James and SK SARs)
- How can information about alleged perpetrators be recorded and shared in line with data protection and legal parameters? In Alison's case, there was no information within her records regarding the perpetrators and whether the incidents related to the same person(s) making it difficult to build a more complete picture of what may have been happening and understanding risk.
- This report to be shared with Local Authority Housing Teams, Thirteen and Beyond Housing, to consider learning linked to risks associated with individuals who are being financially exploited, improving security of premises and considering potential risks to others to inform future practice.
- Where there is a safeguarding plan in place and a new referral is received, does this trigger a review of the existing safeguarding plan to see if anything needs to be changed?

• Is TSAB confident that those working within the care sector are suitable and that appropriate checks have been made with DBS and subsequent risk assessments are in place if a positive disclosure has been made? Are CQC doing any work around this? (This also links to findings from the Safe Care at Home Review).
• Historically, TSAB has reached out to banks to become Safeguarding Champions. The Communication and Engagement Sub-Group will be taking forward a piece of work during 2024/25 to target specific groups to raise awareness and improve engagement and a whole community approach. Should banks be added as a target group?
• This report to be shared with commissioning leads, care providers (including domiciliary providers), provider forums and DBS to raise awareness of preventing financial abuse, understanding and interpretation of DBS disclosures and safe recruitment practices, exercising professional curiosity when monitoring the performance of their staff and assessing the quality of care and being vigilant when a service user is predominantly in the company of a single care worker. In addition, that known perpetrators of domestic abuse should not be placed with service users who have experienced domestic abuse.
• TSAB are developing Engagement Strategies Guidance (which includes considering appointing a key worker) and Consent Guidance for professionals, which should support some of the learning identified from these SARs.
• TSAB are due to review the Professional Curiosity learning briefing, this report can be considered as part of the review.
• Loneliness and isolation features within these SARs and is a potential risk factor for financial abuse. This report can be shared with TSAB members which includes the voluntary and community sector to consider how to raise awareness of financial abuse.
• TSAB will continue to raise awareness of financial abuse through social media.

Useful Resources:

- Home Office Guidance for Frontline Professionals - Money Laundering Linked to Financial Exploitation
- What is Financial Abuse?