A Thematic Review of Financial Exploitation/Coercion

From SAR Alison

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2. Introduction.

2.1 Under the 2014 Care Act, Safeguarding Adults Boards are responsible for Safeguarding Adult Reviews (SAR).In Swindon this is the Swindon Safeguarding Partnership (SSP).

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

2.3 A SAR *may* be conducted in any other situation where it is thought that there is valuable learning for the partnership.

2.4 A SAR (Alison) was conducted following the death of a 49 year old adult on 2nd July 2020. The Coroner determined that Alison had taken her own life.

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

2.6 Swindon Safeguarding Partnership agencies from across Social Care, Police, and Health services contributed to an independently commissioned SAR that presented a full report to the Safeguarding Partnership Board that was signed off in November 2021.

2.7 The SSP requested that a thematic review be carried out to consider the issue of financial exploitation/coercion of Alison. The Care Act 2014 details financial abuse in S42(3) as '*abuse includes financial abuse and for that purpose financial abuse includes-*

a) Having money or property stolen
b) Being defrauded
c) Being put under pressure in relation to money or other property, and
d) Having money or other property misused'.

2.8 The aims of the review to consider the following:

- Explore the learning from SAR Alison in relation to financial exploitation/coercion
- Provide an evaluation of the multi-agency response
- Identify what an effective partnership response should look like for vulnerable adults who are being financially exploited/coerced.

2.9 This report should be read in conjunction with the full SAR Alison for the chronology of the numerous agency involvements that took place over many years. The significant years for this thematic review cover the agency contacts with Alison from October 2018 up to the date of her death in July 2020.

3. Relevant learning from SAR and multi-agency responses.

3.1 Alison had a long history of mental health issues and was reported in earlier documentation to receive medication for schizophrenia and in later years was recorded as having an Emotional Unstable Personality Disorder (EUPD). During the latter part of her life her quality of physical and emotional health was affected from a number of significant issues including the effects from Hepatitis C, alcohol usage, smoking and aspects of a self-neglect lifestyle.

3.2 It is of note that there were reports via a number of different agencies regarding her suicide and self-harm attempts and sexual and financial exploitation allegations against neighbour(s).

3.3 The SAR concluded that during 2020, the effects from the COVID pandemic not only had an effect on Alison who was required to isolate on health grounds and experienced hospital treatment for a suspected COVID infection, but also in the way that services were able to

be delivered to her. This was covered in detail in the main SAR and is addressed in this report where relevant to the issues raised in 1.7 above.

3.4 Alison was reported as a person who had over many years had periods where she regularly contacted the agencies involved in her mental and physical health. These services had a full input to the main SAR and were also involved in a SAR learning event that outlined areas for improvement and responses to the SAR recommendations.

3.5 Alison would make known her preference to engage with female staff and it was noted by the GP and mental health support services that Alison found engagement with 'strangers' difficult. The GP reported that Alison had a long history of self-harm including suicide attempts. This had resulted in a number of referrals to various mental health services.

3.6 Alison had received a variety of support episodes from mental health services both in hospital and the community. The SAR makes clear findings and recommendations regarding improved practice in the risk assessment and support that could have been offered to Alison during 2019/20. Had Alison received a more comprehensive mental health support during these periods then this would have explored her coping mechanisms regarding coercion/exploitation allegations in more depth.

3.7 Alison was also known locally to the police who had numerous visits to her documented over a 20 year period. Sometimes there were a number of call-outs in a short time and others where a few years would pass between visits. The reporting of sexual abuse of Alison was sometimes coupled with financial abuse and fear of particular neighbours. It is well documented in the SAR that Alison would raise an allegation and when visited by the police would retract it or refuse to discuss it. The SAR findings made recommendations regarding this issue. This review will consider the aspect of Alison's non-engagement in this report in relation to her allegations of coercion and financial exploitation.

3.8 The first time an issue of financial exploitation was raised regarding Alison was in the Safeguarding referral from her GP on **03/12/18.** Alison disclosed that a local female resident had asked her for sums of money and had given her cocaine as repayment. The GP raised this concern that Alison may be subjected to coercion and was experiencing a deterioration with her mental health.

3.9 The safeguarding service received the referral and screened it out to the mental health service with a request to consider the risk taking behaviour. It was not deemed necessary to progress to a Section (42) Enquiry. The analysis and reflection carried out by the Safeguarding service as part of the SAR did not pick up on how this referral could have been dealt with differently. There was no evidence of a discussion or report of anyone from the safeguarding service contacting Alison or the police about the money for the cocaine transaction.

3.10 In **October 2019** Alison told her GP that she had been sexually assaulted by two neighbours. There is reference from the police that Alison may have **'borrowed'** money from these neighbours but in spite of the police making several visits accompanied by mental health workers Alison refused to discuss the allegation(s). It is worth noting that when reading written notes from various professionals regarding Alison's allegations of financial abuse there are examples of differing usage of wording such as *loaning money/borrowing money /asking for money*. It was not always clear whether the money was taken from Alison or she was lending it. 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.

3.11 The **October 2019** incident was referred to the Safeguarding service and progressed to a Section (42) 2 Enquiry. A multi-agency meeting took place involving Mental Health, GP,

Police and Safeguarding representatives. A plan was put in place to support Alison that included a visit to discuss the allegations further and to assess her capacity and risk management. There were actions regarding her mental health and physical health and risk from sleeping in a shed in winter and leaving her main accommodation door open when she was in there. Alison was reported as not wishing to discuss the issues with either the police or the safeguarding service. The police closed the case and the safeguarding process continued with a safeguarding plan and actions to complete with a review date in January and a plan to refer to the Risk Enablement Panel REP as a next step. Case notes date **16th January** recorded that *The GP will monitor the situation, CPN will refer Alison to MIND for a community based worker and Safeguarding will review Alison's case within 3 months. Enquiry to be closed down.* There was no explanation recorded of why Alison was sleeping in the shed and the risk assessment on the records was very basic.

3.12 **On the 19th February 2020** the Police raised a safeguarding referral following an incident involving Alison that was responded to from the ambulance service. Alison had disclosed to the ambulance crew that every two weeks upon receipt of her benefits, 'they' (no names identified) enter her property and make her hand the money over. This allegation also included one of a sexual assault. Alison told the visiting police officers that she had made the story up to gain attention from the ambulance crew. No action was taken by the police apart from referring it to the safeguarding service. The referral recorded the abuse types as sexual, financial and physical and further states that Alison is well known to services and therefore has support should she need it.

3.13 The referral was screened out as not meeting S (42)1 part b *at risk of or experiencing abuse or neglect was not evident.* It was noted that there was a safeguarding plan in place. This referral in the safeguarding record detailed the type of abuse as Financial.

3.14 A further safeguarding referral was received on the **2nd March 2020** from a mental health worker at Avon Wiltshire Mental Health Partnership (AWP). This referral is recorded as having Alison's consent. It details a repeat of the allegations made on the 19th February regarding two people demanding money from her every two weeks, it has been happening for months and over a £1000 has been handed over to them. There is more detail given and the mental health worker records that she explained that a police involvement would need to take place to which it is recorded that Alison understood. It is further stated that Alison was down to her last 10p and sometimes going without electricity and the two men would often walk into her property demanding other items such as toilet paper, Rizzla's and tobacco . She further expressed 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. Alison denies using drugs and denies sexual assault from them. It is noted that Alison had received a visit from the police the previous day regarding her welfare but there is no recordings about people taking money from her.

3.15 The safeguarding referral was screened and further enquiries made that involved a visit to Alison by an Enquiry officer and Enquiry manager (*both male- the reason for stating this is that there are previous references to Alison relating better and requesting female professionals*) from the safeguarding service. During the visit the safeguarding officers checked by asking Alison to send the neighbour a text about the owed money and determined that £50 was owed not a £1000. The officer checked that there was food in the cupboards. There is no mention of any discussion about not having electricity at times as unable to afford it.

3.16 The case notes for the safeguarding service regarding the **2nd March** visit and dated 5th March were not referenced in the SAR return and contained more detail than the

Screening form. The case notes reported that a further concern divulged from Alison to the EO and EM was her distress and fear about repercussions after reporting that her neighbours had a gun and a subsequent police visit. Alison felt that they would find out it was her and '*there would be hell to pay'*. It is further recorded in the case notes that Alison told of how the stress from telling police about her neighbours was causing her thoughts of suicide and how she would carry this out. The Enquiry officer sent these concerns to the police and to the PCLS involved with Alison. The safeguarding referral did not progress further. This referral did not prompt a fresh look at the safeguarding plan due for review at the end of the month.

3.17 During March and April there were a number of incidents reported regarding Alison expressing suicidal thoughts culminating in police, ambulance and PCLS input. There is no further mention recorded regarding her neighbours or any financial concerns until the GP contacts Alison's PCLS on **11th May 2020.** During this time Alison was asking services for face to face contact and expressed her concern at feeling isolated.

3.18 The GP had received information from volunteer medication delivery drivers that Alison was telling them that she was very upset and tearful and had suicide ideations. This report included the issue of the neighbours taking money from Alison.

3.19 On the **28th May 2020** a further safeguarding referral was made by the GP and a letter was also sent to the mental health service requesting for Alison to be put back on their caseload. The GP detailed the safeguarding referral with information that staff at the GP practice had observed that Alison was visibly shaking and showing fear when approached in the surgery by her neighbour. Alison disclosed to the GP that her mental health was suffering from the negative effects of the neighbour and also mentioned again that the neighbour had borrowed large sums of money from her and was refusing to pay it back.

3.20 The safeguarding referral was screened and progressed to a Section 42(2) Enquiry. The screener noted the repeat financial exploitation concern as a significant issue to progress and enquire more deeply. The screener contacted the PCLS and was told that they were arranging a multi-disciplinary meeting on behalf of Alison. They were requested to assess capacity of Alison in managing her finances and to try and obtain her views and wishes. A safeguarding representative was planning to attend the multi-disciplinary meeting. The screening was thorough and had oversight from the Assistant Team Manager for the safeguarding service. Information was passed to SAIT the safeguarding adult's investigation team section of the Police.

3.21 No further actions took place with regard to the financial abuse/exploitation allegation before Alison sadly passed away on the **2nd July 2020.** The coroners' report concluded that Alison had taken her own life.

4. Analysis and key learning points.

4.1 Financial exploitation often co-exists alongside other abuse situations. Alison raised allegations of both sexual and financial concerns over the two year period. The statutory guidance for safeguarding gives more detailed guidance on situations of financial abuse than any other form of harm (*sections14.24-1432).* Whilst financial abuse can be fairly simple to identify the prevention of further abuse and impact is more difficult. In 2017/18 66% of adults at risk who were the subject of a section 42 Enquiry into alleged financial abuse were being abused by someone they knew thus making it difficult for them to decide on criminal prosecution (*NHSDigital2018).*

4.2 Coercion and exploitation are strong words with implications of intimidation. Alison described her feelings at first in a slightly softer manner of pressure and persuasion from others to hand-over/lend money further explaining that this left her short of paying for her electricity and also the emotional stress she felt. It was clear that the pressure and persuasion appeared to be building during March 2020 where Alison spoke to two male safeguarding officers in greater detail about her fears during a face to face visit. This was just prior to the first lockdown. It is unfortunate that further multi-agency investigation/support/risk assessment was not able to be explored at this stage.

4.3 During the rest of 2020 Alison was experiencing a degree of isolation and worry culminating from the effects of her mental and physical health alongside the effect of restrictions during the pandemic.

4.4 Professionals working during the difficulties of the pandemic needed to be sensitive to the context of Alison's life in order to work effectively with her. This review has noted extensive interactions with Alison from the full range of services available to her. Unfortunately the issue regarding whether Alison was experiencing exploitation from her neighbours was not fully explored. It is noted that repeated visits and attempts to gain detailed information from Alison was met with resistance and she was regularly reported as not 'engaging with services' or in one report as 'admitting she made it (*the allegation*) up'.

4.5 It is understood that many people with a combination of mental health, drug and/or alcohol issues have a vulnerability and can be more at risk from impairment of judgement and susceptible to coercion. From reading the reports submitted for the SAR and the main SAR report, it is clear that there was a willingness to support Alison. There were a number of areas that were agreed could have been improved. The issue of financial exploitation did not seem to be looked at on its own merit and at times the recording detail provided left the impression that it may be thought that Alison could be making the allegations up. Most of the support to Alison was taking place out of a safeguarding process and not in a multi-agency arrangement.

4.6 There was little professional curiosity from the safeguarding referrals made in 2018 and 2019. There was no evidence of exploration that Alison may be withdrawing her allegations in order to keep herself safe. It was unfortunate that the case was not subjected to more vigorous multi-agency risk assessment processes or the referral to the REP did not progress so that a robust look at what sat behind Alison's repeated calls could take place.

4.7 There was a safeguarding plan in place for Alison in late 2019 into early 2020 and it is unfortunate that this was not re-visited to see if it was still effective when a further referral was received during February 2020.

4.8 The Safeguarding team has gone through significant changes between the 2018 referral and the May 2020 referral. The May referral applied best practice approaches regarding Making Services Personal and professional curiosity. It is just very sad that Alison took her life before this could progress.

4.9 Many agencies are developing their understanding and intervention of coercion and control in relation to domestic violence and mate crime with guidance and legislation to support the processes. 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 may be reluctant to progress issues through fear. The difference with Alison was that she repeatedly requested service intervention/attention however there was no consistent joined up approach and lead agency identified.

4.10 From the various documentation recorded and provided for the SAR there was no indication whether the alleged financial abuse was from the same person(s) and whether the person(s) were aware of Alison reporting them or not. I have requested this information from the Police as part of this report but have had no reply. It is not clear whether the neighbours were posing a threat to others and whilst this information may not be able to be recorded on Alison's records this may well have had a bearing on any investigative process.

4.11 Information provided from the Police detailed the number of visits carried out regarding allegations and calls where Alison was threatening harm to herself. It is recorded that contacts were made to Housing and this was not responded to. There were attempts to be sensitive to Alison's needs by sending female officers where possible and visiting her in the company of a mental health worker. There were however some actions that could have been reflected on by the police as part of the main SAR and were not recorded as considerations;

- An alternative location to see Alison – possibly using the GP practice as a more anonymised place? (*I recognise that there were limitations once lockdown was imposed).*
- The use of recording cameras during a visit may have fuelled her fear even more.
- Was enough known by the police officers about how to react to people with the diagnosis of EUPD and the behaviour of Alison in particular, to be able to invoke a process for dealing with vulnerable people who refuse to progress or deny the allegation they make? It is stated that the officers would have had many contacts with Alison over the years. It was also stated that at least three years between 2015 and 2018 where there were no contacts at all. Had people 'sat around a table' or a virtual table to discuss and plan a combined approach, there may well have been more of an opportunity to unpick some of the questions above.

4.12 An intervention that did not appear to be raised in the SAR or learning event was the consideration that the Safeguarding referral could have been progressed as a **Caused Enquiry** to AWP as the lead. This may have been a better way to deal with the building of trust, using a fresh risk assessment approach reporting back to a multi-agency safeguarding group. This model is being used far more now as a way of supporting people through a process where the adult feels more comfortable.

4.13 There seemed to be an over–reliance from AWP 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.

4.14 There is no mention in any of the SAR documentation or report exploring whether a move of location for Alison would have been helpful. It was noted that the Police had made an attempt to contact Housing but no detail about why or any follow-up. This may not have been acceptable to Alison however there may have been ways of looking at security of the premises with the landlord or whether there were any similar risks from neighbours or indeed from Alison to the neighbours. The issue of Alison sleeping at times in the winter in her shed should have had more exploration and risk assessment attached to the reasons for doing this. The question of whether Alison's behaviour was from fear or not affording electricity was not explained.

4.15 The focus of making safeguarding personal (MSP) seemed to oversimplify the decision not to make further investigation. There were missed opportunities for the safeguarding screening process to make arrangements to probe further in the referrals of 2018/Oct 2019 and February 2020 or re-visit the safeguarding plan once a fresh allegation was received.

4.16 Alison's diagnosis of EUPD may well have influenced decision making processes. It is referred to several times by agencies involved or reasons for actions. It easy to see from the reporting that Alison's communication skills were often led by swings of emotion. There was reference to her being '*spoken to about the constant calls'* to emergency services. A school of thought is that that people with EUPD are often vulnerable and as such could fall victim to abuse. It is unfortunate that further therapy was not offered to support Alison with her allegations of her neighbours 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. As it was, the views about the money being taken and not returned were down to conjecture.

5. What does an effective partnership look like?

5.1 There are plenty of research articles, professional guidance and books that highlight best practice for agencies undertaking involvement or a lead in adult safeguarding.

5.2 Lessons learned from SAR's have been published recently identifying the importance of a multi-agency approach to the process. Some authorities are forming Multi-Agency Safeguarding Hub's (MASH) in order to promote the most effective ways of working and taking on board the best practice learned from child protection MASH.

5.3 ADASS advice note in their *'Framework for decisions on the duty to carry out Safeguarding Enquiries'*

'' ***Making safeguarding personal does not mean walking away if a person declines safeguarding support or a S42 Enquiry. That is not the end of the matter. Empowerment must be balanced for example with the duty of care and the principles of the Human Rights Act (2005). Best practice in working with risk must be considered. The need for balance on this issue is within the Care Act in section 11, where it is explicit that although the local authority duty to carry out a needs assessment (S9) may be removed if the adult does not consent, this does not apply where the adult is experiencing or at risk of abuse or neglect.*** *S11 (2) (b) Refusal of assessment.''*

There are examples of authorities and agencies that have developed guidance on coercion/exploitation from their experience with self-neglect and domestic abuse investigations. These operate via safeguarding teams to a clear framework to manage the situation where the adult has capacity to make the decision(s) that is creating significant concern about the adult's well-being and the risks arising from the refusal to engage.
It is a challenge for professionals to balance the acceptance of the adult's choice and rights to make unwise decisions whilst taking reasonable and proportionate steps to help them to explore risks and alternatives. The inability or reluctance of the adult to accept advice should inform risk management.

5.4 It is pleasing to note as good practice that currently the Swindon safeguarding service holds a daily 'Huddle' to discuss cases received. This includes a consistent police representative as well as relevant staff requested from other relevant agencies. A nominated representative from the CCG is currently being arranged. This huddle does not and should not detract from other more formal multi-agency meetings. It is however a good way to share 'intelligence' and plan the first steps to the progression of a referral.

5.5 There are no specific multi-agency financial coercion/exploitation procedures or guidance available to Swindon safeguarding service. There are authorities that have devised such procedures. Looking at the increases for referrals for financial abuse that can also include coercion/exploitation both in Swindon and nationally it would make sense to provide this guidance. *Leicester & Rutland Safeguarding Adults Board have a Procedure 4.2.13 Managing Risk, this would be very useful to look at as an example of good practice.*

5.6 The main SAR made several references and recommendations about the assessment of Alison's capacity. Decision making needs to take account of mental capacity and for Alison this should have taken into account any influence from coercion and control regarding her allegations about her neighbours. It would be useful to consider approaches used from domestic abuse guidance and investigations to transfer across to a multi-agency procedure within safeguarding.

5.7 Safeguarding Referrals and Enquiries are reported on by many safeguarding boards across the country in relation to the length of times for aspects of the process such as screening time and investigation time. It is easy to get hung up on timescales and whilst there are good reasons to monitor them, experience with self-neglect cases is influencing authorities to consider the need for staff to gain trust and build a relationship initially enabling professionals to '*get a foot in the door'*. Some safeguarding services have introduced a more flexible timescale in order to achieve this.

5.8 The recent audit of cases on self-neglect carried out in Swindon showed some good practice examples where the professional curiosity from the safeguarding officer over time built the relationship and gained trust from adults who at first refused any input. (*self-neglect audits May to November 2021)* The audit reported significant improvements to the screening and investigation of self-neglect cases during 2021. It may well be that a similar look at recent referrals where the adult has refused to engage and in particular financial abuse cases, would give a clear picture of current trends and practice.

5.9 In order to share intelligence and bring quality and timeliness to safeguarding referrals a Multi-Agency involvement at an early stage of the safeguarding process is necessary. It is noted that the daily 'Huddle' within the safeguarding service has multi –agency attendance. This is not a replacement for a more structured and recorded approach where a case is discussed and planned.

6. Recommendations

Recommendation 1.

This review highlights the need for SSP to ensure that all practitioners working with vulnerable adults are equipped to have an understanding and effective analysis of financial coercion/exploitation allegations when a victim is reluctant to engage.

SSP should evaluate the competence and confidence of their workforce in responding to allegations of financial abuse and in particular where the adult has a vulnerability that compromises them as a witness. This must include:

- A clear multi-agency procedure for dealing with allegations of financial coercion/exploitation. This should include a risk assessment toolkit that considers the emotional and lifestyle impacts from financial abuse.
- Holding a multi-agency strategy meeting as early as possible in the process.
- The identification of a lead person/agency who may already have the adult's trust and knowledge of their mental health needs.

- The time and skills to hold sensitive conversations with the adult to enable engagement and/or
- A risk assessed conclusion that explains reasons for not progressing and proposals for reducing future financial abuse that enables challenge from involved partner agencies.
- An escalation to be triggered when persistent non-engagement undermines protection factors for the adult.

Recommendation 2.

The SSP should ensure that guidance and protocols are developed for single and multi-agency safeguarding responses to non-engaging adults that enables the balance between 'Making Safeguarding Personal' principles and the opportunity to utilise the strengths of working in partnership to build trust and protect the adult. *The use of 'real-life' examples from SAR's to be included in training and development are recommended to promote best practice learning.*

Recommendation 3.

Safeguarding Screening & Enquiry timescales should be raised for management consideration for a more flexible approach where there is a need to build trust to develop to progress.

Recommendation 4.

Partner agencies should review their recording practices to ensure that safeguarding referrals and repeat referrals contain a robust chronology so that patterns of abuse are detailed and able to be readily identified. Safeguarding Enquiry records in particular should have a dedicated section that enables a chronology to be recorded and shared appropriately.

Information about the adult such as relating better to females should be highlighted and shared across services.

Information about alleged perpetrators should identify (within data protection and legal parameters) whether suspects are the same or different each time.

Recording practices should be improved to ensure that the least ambiguity is drawn from the records such as the difference between lending/borrowing.

Recommendation 5.

SSP should consult with Housing partners to consider whether there are any lessons to be learnt from SAR Alison and this review regarding the issues about coercion/exploitation from neighbours or security of premises to inform future practice. *(N.B. the police did approach Housing but no response).*

Recommendation 6.

Where a safeguarding plan is in place and a fresh referral is received it should trigger a review of the plan, even if the fresh referral is a different category of abuse and the victim does not wish to engage. The plan should reflect all of this.