

**Safeguarding Adults Review**

**Tower Hamlets Safeguarding Adults Board**

**Title**: Mr V: Allegations of financial abuse.

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1. Summary

1.1 This Safeguarding Adults Review has considered the care and support Mr V received from the London Borough of Tower Hamlets (LBTH) adult social care services and its partners and the role AA played in that support from 2012 to 2014.

1.2 After Mr V’s death in March 2014 it came to light that the person who had been identified as Mr V’s next of kin was not his next of kin. In addition, safeguarding concerns were raised in relation to the management of Mr V’s finances – financial abuse.

1.3 The review concludes that Mr V was not adequately safeguarded while receiving support from LBTH social work teams. There was alleged financial abuse of Mr V by at least three different people recorded on three separate occasions, the first concern being raised in 2006.

1.4 The ability of AA, who purported to be Mr V’s next of kin, to be accepted as such was made easier or potentially only possible because of the poor practice of many of the workers and managers involved in the care provided to Mr V.

1.5 The report considers that too emphasis was placed on the concept of next of kin by all the agencies involved, rather than finding out whom Mr V wanted involved in his life and whom he viewed as his main carer and support.

1.6 The review highlights that practice was not person-centred; was not professionally curious; nor focussed on maximising Mr V’s own resources and ability. It was often disabling, process and output driven.

1.7 Care planning did not make appropriate use of the Mental Capacity Act 2005 and workers did not undertake decision capacity assessments fully or at key moments in MR V’s care when specific decisions were required such as his ability to manage his finances. When assessments were undertaken the actions were often unclear and in one specific case not followed through.

1.8 The report highlights learning for health and social care agencies. In particular:

* Ensuring that Making Safeguarding Personal (2014), with its focus on person centred rather than process driven safeguarding, is implemented. It is recognised however that Mr V’s care and support was delivered before this programme came into force;
* For all agencies to develop policies around allegations made against People in Positions of Trust (PiPoT)[[1]](#footnote-1)
* Making sure that local safeguarding policies and procedures are followed by all agencies.
* The need for a better understanding of the concept of next of kin
* That Leadership behaviours need to promote good quality, practice focussed supervision
* The need for a better understanding of the Mental Capacity Act undertaking assessments which should be decision specific, and understanding how these can be used to support and safeguard people;
* That the casework recording system needs to enable good quality, focussed social work; and
* The need for greater professional curiosity when working with people; with time spent getting to know them, their strengths and the outcomes they want

1.9 The report makes recommendations for health and social care partners on:

* The Making Safeguarding Personal programme
* Local safeguarding policies and procedures including PiPoT
* Information governance and information
* Next-of-kin
* Supervision
* Leadership behaviours
* Quality audits
* Mental Capacity assessments
* The casework recording system
* Working with relatives and family carers
* The use of an external organisation to assist social work staff in developing their practice

2. Background

2.1 Mr V background

2.1.1 Mr V was a black man of African Caribbean heritage. He was born in the Caribbean in 1929 and had lived in the East End of London for many years. He had worked at a motorcar factory. He used to attend Church. He has a daughter who has never lived in the UK and lives abroad.

2.1.2 Mr V’s first contact with Adult Social Care was when the Sight and Hearing Team assessed him in 2009, although there was mention in one record of a safeguarding investigation in 2006. Following this there had been at least two further alerts but documentation was inconsistent, and although they related to allegations of financial abuse they did not relate to the person considered in the SAR.

2.1.3 In 2009 it is recorded that he informed the staff at Sight and Hearing Team that he had a poor relationship with his daughter because ‘all her actions to him reflected an attempt to take money from him’. This is however disputed by his daughter who said she and her father were very close even though they lived apart. She said that even though she had never asked him for anything, she knew if she had he would have given it to her.

2.1.4 He was an active and independent person who, despite having suffered a stroke in 2006 that had left him with difficulty speaking, enjoyed the social side of a lunch club. He attended at a voluntary sector day centre. He did not feel that he had care needs.

2.1.5 While at that club Mr V first came into contact with a student social worker on placement: AA. From the case records presented to this review, it is alleged that this man, AA, led health and social care staff to believe he was AA’s next-of-kin. AA later denied he had done so.

2.1.6 Mr V had a number of hospital admissions over the following years and was often assessed as confused and sometimes as lacking capacity. Reablement services were provided to Mr V who often wouldn’t let the reablement workers in to his flat. He became confused by people he didn’t know or in surroundings he was unfamiliar with.

2.1.7 Following a hospital admission in October 2012 he moved to a residential care home specialising in dementia, where he lived for 2 years. At the care home he liked to have his meals communally and would watch a film in the lounge, but didn’t like to participate in any more formal activities.

2.1.8 Mr V was diagnosed with Chronic Myelomonocytic Leukaemia (CMML) for which he received supportive treatment including blood transfusions; and dementia and prostate cancer.

2.1.9 There was evidence of some initial end of life planning taking place from July 2013 but neither Mr V, nor AA (who was by then seen as his next-of-kin) who was also involved in the discussions, were recorded as making any decisions. Shortly before his death in March 2014 he moved to a local hospice, where he spent his last hours.

 2.1.10 Mr V’s death certificate recorded his cause of death as:

 I. (a) Acute Renal Impairment

 (b) Sepsis

II. Advanced vascular dementia, Cerebrovascular disease, Chronic Myelomonocytic Leukaemia

2.2 AA background

2.2.1 Between September 2005 and July 2008 AA attended university where he obtained a BA in Psychology and Mental Health Nursing.

2.2.2 Between January 2003 and September 2008 an NHS Trust employed him as a Mental Health Support Worker. He then qualified to be a Registered Mental Health Nurse and was employed as a Mental Health Nurse.

2.2.3 AA was registered with the Nursing and Midwifery Council, a registration he maintained until he was struck off by a Fitness to Practice panel in March 2017[[2]](#footnote-2).

2.2.4 In September 2010 he commenced a full time course at university in London where he gained a MA in Human Sciences Social Work. As part of that social work training in 2011 he was placed by the university at the voluntary sector day centre Mr V attended in the London Borough of Tower Hamlets.

2.2.5 He then worked for another London Borough (London Borough 1):

 • 05/10/12 till 30/09/13– Agency Social Worker: London Borough 1 Assessment and Support Planning Team

 • 30/09/13 till 15/10/13 Full Time Social Worker: London Borough 1 Assessment and Support Planning Team

 • 01/08/14 till 20/7/15 Full time Social Worker: London Borough 1 Cluster Manager

2.2.6 On 20 July 2015 AA was dismissed as a Social Worker following a disciplinary hearing on 19 June 2015.

2.2.7 Following a hearing at the Health and Care Professions Tribunal Service, between 13 and 16 November 2017 AA was struck off the Health and Care Professions Council social worker register[[3]](#footnote-3).

2.2.8 The panel concluded:

 *For the reasons set out in this determination the Panel concluded that a
striking off order was the only appropriate order in the serious
circumstances of this case. The Registrant’s misconduct amounted to
serious dishonesty involving a breach of trust in relation to a vulnerable
service user for personal gain over a prolonged period of time.[[4]](#footnote-4)*

2.3 A note on the terms: next of kin and appointee[[5]](#footnote-5)

2.3.1 One of the key issues pertinent to this review were those relating to next of kin.

2.3.2 In her foreword to the leaflet: Next of Kin: Understanding decision making authorities[[6]](#footnote-6), Baroness Ilora Finlay, Chair of the National Mental Capacity Forum, writes:

The term ‘Next of Kin’ is often used in Health and Social Care as a euphemistic shorthand for ‘Who is the person we communicate with about you and who do we contact when you are dead?’

In law the term has no status when you are alive - it is misleading too because it does not clarify if this is the person who is your nearest relative or the person most important to you. Indeed, these are often different people.

2.3.3 The leaflet goes on to explain:

 The term Next of Kin (NoK) is commonly used and there is a presumption that the person you identify as your NoK has certain rights and duties. Health and social care colleagues should always consult the people closest to a person who lacks capacity to understand that person’s wishes and feelings to help them make a decision in that person’s best interests. However, the person identified as next of kin should not be asked to sign and/or consent to certain interventions (unless they have a legal basis for doing so). This is a mistake often made in many hospital and nursing or residential type accommodations, where family members are asked to sign care plans, end of life plans and other treatment options and provide consent which is not legally valid.

2.3.4 The leaflet then goes on to further explain the terms:

* Advance Decisions
* Lasting Powers of Attorney
* Court of Protection and Court Appointed Deputies

2.3.5 As far as the law is concerned next of kin has no legal meaning with the exception of children aged under 18. The next of kin of a child under 18 may be entitled to make decisions for or on behalf of a child if the person has parental responsibility for the child.

2.3.6 Next of kin is not the same as ‘nearest relative’ within the Mental Health Act

 1983.

2.3.7 However there are ways for a relative to be able to make care decisions on behalf of someone else. People in England and Wales can make a Lasting Power of Attorney (LPA) for health and welfare and/or property and financial affairs so that, if there is a time when they aren't able to make decisions about their care and treatment and/or property and financial affairs, an appointed person - an attorney - will be able to do this for them.

2.3.8 An LPA needs to be created while the person is still able to make this decision,(ie has capacity) and advance planning is necessary

 . They can also appoint more than one attorney.

2.3.9 If there is no LPA for health and welfare, professionals such as doctors and social workers will generally make decisions about a person's care if they cannot do this themselves. However in making these decisions, professionals should consult the person's family, so that they can still be involved in the decision-making process.

2.3.10 An appointee can apply for the right to deal with the benefits of someone who can’t manage their own affairs because they’re mentally incapable or severely disabled. Only one appointee can act on behalf of someone who is entitled to benefits (the claimant) from the Department for Work and Pensions (DWP).

 An appointee can be:

* an individual, eg a friend or relative
* an organisation or representative of an organisation, eg a solicitor or local council

3. Purpose and Terms of Reference

3.1 The purpose of a Safeguarding Adults Review (SAR) is neither to investigate nor to apportion blame. It is only relevant to commission one when professionals can learn lessons and adjust practice in the light of lessons learnt. It therefore requires outcomes that:

* Establish what lessons can be learnt from the particular circumstances of a case in which professionals and agencies work together to safeguard adults.
* Identify what those lessons are, how they should be acted upon and what is expected to change as a result.
* Review the effectiveness of procedures, both of individual organisations and multi-agency arrangements.
* Improve practice by acting on the findings (developing best practice across organisations).
* Improve inter-agency working to better safeguard adults.
* Make a difference for adults at risk of abuse and neglect

3.2 The Terms of Reference of this Safeguarding Adult review included:

3.2.1 Areas for consideration:

 The 6 Principles of Safeguarding:

* + **Empowerment** - People being supported and encouraged to make their own decisions and give informed consent;
	+ **Prevention** - It is better to take action before harm occurs;
	+ **Proportionality** - The least intrusive response appropriate to the risk presented;
	+ **Protection** - Support and representation for those in greatest need;
	+ **Partnership** - Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse; and
	+ **Accountability** - Accountability and transparency in safeguarding practice.

 And:

* To review and learn from the safeguarding alerts and actions taken on the case going back several years. Were there missed opportunities?
* To consider the understanding of the term ‘next of kin’ by Health and Social Care staff and any guidance on this for them.
* To consider if any action could have been taken earlier to prevent the situation resulting in the financial abuse allegations.
* To consider whether the Mental Capacity Act 2005 was used appropriately to determine capacity? Was the use of advocates considered?
* How was Mr V’s daughter involved at the different times allegations were made and after he died?
* To consider the concerns of Mr V’s daughter.

3.2.2 And specifically:

* To consider the overall lessons to be learnt to prevent similar situations arising;
* To consider the multi-agency aspects of the case;
* To understand if there missed opportunities to prevent the situation from continuing;
* To understand whether there were adequate and robust assessments;
* To review if the Mental Capacity Act 2005 was considered when appropriate;
* To understand if risk and the duty of care was considered when forming a protection care plan;
* Consider the arrangements for protecting users from financial abuse and whether current guidelines reflects best practise; and
* Consider whether recording systems made it more difficult in this case for staff to see the pattern of emerging/possible financial abuse.

3.3 The Purpose (outcome)

3.3.1 To help develop learning for Commissioners, Providers, Police and Health and Social Care staff on safeguarding actions in relation to financial abuse.

3.3.2 To understand better how next of kin status is determined, what it means and to clarify what rights and duties this status gives.

3.3.3 To offer insights into person centred practice.

4. The review process

4.1 The methodology applied for this SAR combined formal individual management reports and a chronology from each agency with discussion at multi-agency panel meetings.

4.2 The main focus of this review was on the 2 years preceding Mr V’s death. However where relevant, references are made to information prior to 2012.

4.3 The Independent Author and Chair met with agency authors at the beginning of the review to discuss the terms of reference.

4.4 The reports were reviewed and discussed in detail at meetings between the panel and authors.

4.4 The Independent Author and Chair was supported in the review by a panel. The panel members were from the SAB partner agencies and brought a further level of expertise and scrutiny to the individual agencies’ reports. The panel membership included:

* SAR Panel Chair
* Independent Overview Author
* The community day centre
* Senior Solicitor - Legal, LBTH
* Detective Chief Inspector, Public Protection & Safeguarding Tower Hamlets Borough
* Brokerage Manager, LBTH
* Joint Safeguarding Adults Strategy and Governance Manager (Interim), LBTH).
* Operational Director for Adults Care & Support, London Borough 1
* Head of Safeguarding Adults, Barts Health NHS Trust
* Delivery, Transformation and Independence Service Manager, LBTH
* Safeguarding Adults Board Coordinator, LBTH

4.5 Organisations that had significant involvement with Mr V prior to his death completed a chronology of events outlining their involvement.

4.6 Individual management reviews (IMRs) were requested from all of the organisations that had significant involvement with Mr V and were received from:

* The community day centre
* LBTH Adult Social Care
* Barts Health NHS Trust
* The residential care home
* Metropolitan Police

Further information was received from:

* Mr V’s daughter via a telephone call with the Independent Author
* The residential care home

However it is of note that getting the relevant information from the residential home proved difficult not least due to staff and ownership changes.

4.7 The panel met in March, May, August and November 2017 to consider the IMR reports. The IMR authors presented the reports to the panel, answered questions and contributed to discussions. The report was further updated following the Health and Care professions tribunal service decision, contact with Mr V’s daughter and review by the LBTH’s governance team.

4.8 Contact with Mr V’s daughter also proved problematic as no one agency seemed to have clear and accurate contact details despite her contact with various agencies at various times before and after Mr V’s death.

4.9 However when the author spoke to Mr V’s daughter she was concerned to know:

* How she could be removed as next-of-kin without anyone informing her?
* Why her father was treated in the way he was?
* Why she was ‘blocked’ out of his life?
* Why someone could take over as next-of-kin without any proof?
* Why the perpetrator hadn’t been prosecuted?

4.10 In the following pages the report tries answer these questions and the areas covered by the terms of reference.

5. Who was Mr V – a description

5.1 Mr V was a black man of African Caribbean heritage. He was born in Barbados and had lived in the East End of London for many years and had worked at a motorcar factory in Dagenham. He used to attend a local Christian Church.

5.2 Mr V had a daughter who at the time of his admission to the care home lived in New York USA.

5.3 Mr V was an active and independent person who, despite having suffered a stroke in 2006 that had left him with difficulty speaking, enjoyed the social side of the lunch club he attended at the day centre. He did not feel that he had care needs.

5.4 In later years when at the care home he would watch TV in the communal areas, but he had few visitors except for AA who would bring take-away food, snacks and arrange haircuts.

6. Narrative chronology of events concerning Mr V

6.1 Mr V suffered a stroke in 2006 that had led to him having difficulty with his speech. He was under the care of an urologist because he had a diagnosis of prostate cancer. It was thought he started attending a day centre at about the same time.

6.2 The Police had a note of concerns about suspected fraudulent bank loans over a six-month period in 2005. However after investigation no action was taken, as there was no evidence of any misadventure or fraudulent act.

 6.3 There was a reference to a note of a 2006 Safeguarding Adults investigation on a February 2008 LBTH review completed by a social worker. It was alleged that in 2006 a friend/carer was taking money out of his account. The police were reportedly involved but the carer was no longer visiting him. The social worker in 2008 checked the care records and confirmed an adult protection investigation took place in 2006 and that the person was no longer visiting Mr V. The 2008 review also noted that he received both a state and a personal pension.

6.4 In April 2006 the day centre advice worker wrote to AXA Sun Life stating that Mr V had two policies for funeral expenses and asking for one to be cancelled.

6.5 In 2007 the day centre noted that Mr V was worried about his bank account. He gave the day centre workers authorisation to claim benefits on his behalf and represent him. On 23/4/08 he visited his bank with the day centre worker, because he was worried about his bank account. The day centre record noted all his direct debits were explained, ‘also the loans he took out in 2005’.

6.6 Mr V was attending a club at the day centre 4 days a week for lunch at this time. The February 2008 review also noted that he was receiving home care, arranged by LBTH.

6.7 He had a review in March 2010 that stated that he was able to prepare a meal, carry out his own personal care and do his housework and shopping. It would appear the home care ended at some point before this review.

6.8 In March 2010 the day centre contacted LBTH to report a safeguarding concern regarding Mr V. A student (not AA) at the day centre had had a conversation with Mr V where he told them he gave a day centre worker money and they had asked him for money. This was investigated and the notes record that LBTH social services decided that no adult protection issues had been present but agreed a plan of action for the worker to be supported in supervision around appropriate practice.

6.9 In 2010 Mr V’s GP contacted LBTH adult social care requesting a carer. The GP had been contacted by the day centre that had made the initial request. A home visit was undertaken on 19 October 2010. Mr V said that he enjoyed visiting the day centre and had made friends and would like to continue to use the service. He reconfirmed the review findings of March 2010 in respect of care needs and that he was content with his current arrangements.

6.10 During this assessment it was recorded that Mr V told the care manager that his daughter had made unwanted telephone contact with him, asking for money. It as further recorded that Mr V said he had not had any contact with his daughter for a long time and was not interested in seeing her.

6.11 The review concluded that Mr V was independent and had good mobility; he was alert and orientated; his home was clean; the beds were made; and his clothes were well arranged; all essentials and cleaning materials were arranged in the appropriate place. On 21 October 2010 the manager reviewed the case and closed it.

6.12 On 16th February 2011 a social work student, AA, shadowed the day centre project manager on a home visit to Mr V who had reported issues with his electrical equipment.

6.13 In November 2011 Mr V was admitted to hospital with abdominal pain. The NHS record notes that Mr V was confused and would require supervision in the community either in a nursing or residential home.

6.14 A referral was made to the hospital social work team stating that while there was no current discharge plan for Mr V, he would need help with his personal care on discharge. It was noted that he was very confused on the ward. Mr V was visited on the ward by the social worker who noted that Mr V was confused and refusing medical treatment. Mr V was also being visited by the manager at the day centre.

6.15 It is recorded that the day centre manager told the social worker that Mr V had a daughter that he did not have any contact with, due to the daughter taking money from him without his agreement. However there are no further records that indicate this was investigated.

6.16 The social worker requested a psycho geriatric assessment and noted that Mr V had become increasingly confused and needed on-going support. The plan was to transfer his case to the long-term social work assessment team. It was noted that Mr V listened to the day centre manager who was happy to support him during any social worker assessment.

6.17 The day centre manager also informed the social worker that Mr V had previously had homecare but he did not engage with the service. The manager also highlighted that it was important that Mr V’s communication needs were understood and planned for. The manager also reiterated again that Mr V had no contact with his daughter due to possible financial abuse. The manager recommended that Mr V was discharged home with a personal budget and wished to be involved in the assessment process.

6.18 The decision was made to reallocate the case from the intake team to the hospital longer-term team.

6.19 The new social worker, SW1, met with Mr V and the day centre manager. SW1 noted that Mr V appeared less confused than previously described. He noted that he was able to engage in a conversation about his discharge plans and gave as an example that Mr V did not agree to allow access to his keys saying he did not trust people he did not know. While initially reluctant to have carers, Mr V agreed to have carers from the day centre rather than the reablement service.

6.20 SW1 recorded that Mr V spent a long time talking about losing some money and was anxious. This was seen as confusion, and the need for a psychiatric assessment was noted.

6.21 On 6/12/11 a social work assessment by the longer-term social work team was noted. Mr V was assessed as unable to undertake domestic work, needing assistance with washing and dressing, and that while he was able to mobilise independently, he was at risk of falls. It recorded that Mr V mentioned again that his daughter only wanted money from him and that he had given up any contact with her.

6.22 His eligible needs were assessed as:

* Need help with personal care - risk critical
* Unable to remember to take medication - risk critical
* Unable to undertake domestic work and shopping

6.23 A discussion between the social worker and Mr V’s psychiatrist was noted, stating that Mr V had mild cognitive and memory impairment. Also noted was a capacity assessment that stated he did not have capacity but his best interests would be achieved by being discharged home with reablement and if that didn’t work, to consider a residential placement. It is not clear from the recorded what decisions Mr V lacked capacity to make.

6.24 The day centre manager suggested that the day centre assisted in the introduction of reablement workers to Mr V. The social worker requested that the day centre arranged for keys to be cut for the reablement service. The social worker told the day centre manager that he had left money on the ward for the keys to be cut. The case recording implies that the social worker also left the front door key with the money.

6.25 Mr V was discharged on 19 December with a support worker from the day centre with him. There were further discussions about keys for the front door and access to them as they were security keys from the housing association.

6.26 The discharge summary from Barts and The London NHS Trust dated 19/12/11, noted: ‘discussed with old age psych – Mr V assessed and found not to have capacity’.

6.27 Mr V had been in hospital for nearly a month.

6.28 While the reablement service was providing support, the day centre manager contacted the social work team and gave a detailed update, which gave the impression that she was coordinating his care.

6.29 A mental capacity assessment form was completed by SW1. It noted that Mr V seemed to have capacity to manage and decide most of his daily needs including where he wanted to go and what he wanted to do. However his main difficulty was to express his needs. It recorded that there was short-term memory loss but that he seemed to understand the consequence of his decisions. There was a reference to the risk of financial abuse as he relied on other people to assist in cashing his pension.

6.30 There were further discussions about support over the Christmas and New Year period, specifically around Mr V having access to money for meals.

6.31 SW1 visited Mr V on 22 December 2011 and he noted that Mr V was able to walk with him to a local shop and that in his own environment he seemed much improved. He also noted that Mr V spoke highly about the good treatment he got from the day centre, and also about a day centre worker. SW1 noted that a worker (unclear from the note if it was the same worker Mr V referred to above) at the day centre had been involved in a previous allegation where they allowed Mr V to visit their home and allowed Mr V to give their children money. SW1 noted that he spoke to Mr V about his relationship with a day centre worker and that Mr V spoke highly of them and said that they were a good friend and very supportive. He further noted that he had no evidence to be concerned about the relationship between Mr V and the worker. SW1 noted that he undertook a capacity assessment during this home visit, but there was no record of the outcome of this assessment.

6.32 Mr V was admitted to hospital for one night on 5 January 2012 but he did not require any further support.

6.33 There were further notes about Mr V having insufficient money and not allowing the reablement service to provide care.

6.34 An independence plan with a start date of 11.1.12 and a refresh date of 27.1.12. Noted in the section headed relationships and behaviour:

 *Mr V lives on his own. He has one daughter however he has no contact with her as he says that she only wanted his money and when he didn't give it to her she just went away.*

 *Mr V reports that he has no other family.*

6.35 Further plans with a refresh date of 10/2/12, 20/2/12 also contained this information.

6.36 On 27/1/12 there was a full discussion with the day centre manager regarding the support available from the Friends and Neighbours Scheme (a local support scheme). It was also noted that reablement needed to start withdrawing support as no goals had been achieved. The day centre manager was concerned about Mr V’s personal hygiene deteriorating. Meals on wheels also discussed Mr V’s ability to access takeaway meals, which he preferred at the weekend.

6.37 A befriender at the Friends and Neighbours Scheme had been visiting Mr V for four years. The social worker asked if the scheme could support Mr V with an escort to the bank, Post office, hospital and GP appointments. This was agreed.

6.38 Another refreshed independence plan was completed around the 10/2/12.

6.39 A further independence plan was completed on 20/2/12. At Mr V’s request the reablement service was stopped. The independence plan was passed to the long-term support team.

6.40 On 1 March 2012 it was noted that the day centre worker had received the keys for Mr V’s flat.

6.41 On 30 April 2012 a home visit was undertaken with an Occupational Therapist and Day Centre staff to assess Mr V’s bathing needs. A potential risk to health was identified due to his reduced self-care ability.

6.42 On 17 May 2012 the Occupational Therapist called the Friends and Neighbours Scheme for an update and explained that the Occupational Therapy service was closing their involvement as Mr V had declined services. She told the Friends and Neighbours Scheme that the Day Centre was monitoring Mr V’s health and well-being but were unable to monitor his medication. The Friends and Neighbours Scheme appear to have agreed to check periodically whether Mr V’s medication and dosage box was up-to-date and agreed to alert the GP if there were any problems.

6.43 An Occupational Therapist assessment dated 30.5.12 noted:

 *Due to memory and communication difficulties, Mr V needs assistance to*

*access his finances. At present staff from the day centre have been assisting to take him to the bank to withdraw his money as and when he needs it. He usually withdraws enough money to get him by for 2-3 weeks. He informed the RO that he fully trusts both the centre manager and the day centre worker who usually assisted him to go to the bank.*

 Also:

 *Mr V lives on his own. He has one daughter but no contact with her and reports that he has no other family.*

All of Mr V’s utilities and other payments had been set up on direct debits.

6.44 On 19/6/12 Mr V was admitted to The Royal London Hospital after he was found wandering in the street. The medical records note on that date: ‘assessed and lacking mental capacity to consent’. It does not record what he was unable to consent to. The ward completed a referral to the social work team. The social work duty officer noted that a social care review was outstanding. The duty worker noted: ‘I was provided with details of a friend of Mr V (AA) who may be able to provide information regarding Mr V’. The entry mentions that he may be the next of kin. The duty worker called AA but got no response.

6.45 On 25/6/12 the occupational therapy report noted that the Occupational Therapist had a conversation with a day centre worker. The occupational therapist referred to the day centre worker as the next of kin. The day centre worker said that Mr V came to the day centre four times a week; he made his own way but was known to become confused in unfamiliar environments. The day centre worker said that Mr V cannot manage independently but thought any alternative type of accommodation might add to his confusion.

6.46 On 26/6/12 the medical record notes that medical, speech and language and physiotherapy assessed Mr V and he was ‘as back to baseline’. There is doubt about his level of cognition in regard to concentration and reasoning. It was also noted that social services assessed Mr V as confused and declining services. A psychiatric review was requested, as was clarification of the reablement goals. The occupational therapist was also noted to have concerns about Mr V’s mental state and asked if a capacity assessment was required. On the 29/6/12 the medical records note that Mr V’s acute confusion has resolved but that he lacked capacity to decide on a discharge plan as he could not weigh up the risks.

6.47 The ward sister was noted to have informed the social worker that Mr V’s next of kin, AA, had been in touch with the ward and wanted to speak with him. The case record notes that the social worker called AA who informed him that he was the son in law of Mr V and that he was acting in his best interests as his relative. He was concerned that the care planning and discharge planning in the past have failed to meet Mr V’s needs. He went on to say that if the care plan failed he wished to discuss a ‘personal budget’. It was noted that AA said he and his other relatives would be willing to provide support.

6.48 AA suggested a discharge date when he would be able to take Mr V home and when reablement would be in place. The social worker agreed and asked the ward to liaise. Mr V was discharged on 5.7.12.

6.49 On 9/7/12 an Occupational Therapist telephoned AA who requested that Mr V receive a personal budget. The process was explained to AA.

6.50 On 31/7/12 a home visit was carried out and the worker noted AA as Mr V’s nephew. Also present were the day centre worker and an Occupational Therapist. It was noted that Mr V declined to participate in the review. However the review still recorded that Mr V declined reablement support and that he only accepted support from his nephew and a handful of staff at the day centre. It was noted that AA (as nephew) was requesting a personal budget as he was finding it difficult to care for Mr V. It was also noted that the additional support from the day centre had been voluntary as he was only a member of the lunch club.

6.51 It was noted that the London Ambulance Service made an out of hours call and were concerned that Mr V had no support and no food in the house. There was no further detail recorded.

6.52 On 28/8/12 Mr V was admitted to an emergency bed at the Royal London Hospital after being found wandering in the street. He was brought in by ambulance having been found by a passer by. The ambulance service took him home but found that he had no food in the house and no sign of carers. It was noted that they were ‘concerned about vulnerable adult, doubtful mental capacity.’ The medical record noted that there were no medical issues but a mental capacity assessment was completed and he was assessed as lacking mental capacity. The medical record stated his son in law and daughter were also present. It is recorded they told the doctor that they went to his house and he wasn’t there. They were angry and upset because he was supposed to have a care package but it had not happened.

6.53 On part B of the admission form AA was noted as ‘preferred contact/or next of kin’ and the relationship was recorded as son in law.

6.54 The social worker also noted that in 2010 that there had been a safeguarding episode relating to a day centre worker and Mr V. They further noted that the conclusion was that the day centre worker would no longer have close contact with Mr V.

6.55 On the same day (28/8/12) it was recorded that the social worker contacted AA who confirmed that he had been married to Mr V’s daughter. AA said he helped Mr V by visiting him, bringing him meals and sometimes buying toiletries and essential items. AA said he was concerned because Mr V takes his medication inappropriately (three doses in one go) and although he had asked the district nurse to assist this had not happened.

6.56 On 31/8/12 the medical records note that there was a consultant review that recorded that following a discussion with social services there was concern about financial abuse. That Mr V’s finances were being managed by a worker at the day centre and his ‘son-in-law’ (inverted comma from the record) is not his next of kin. The consultant and social care worker were in agreement that Mr V did not have capacity. They planned to appoint an IMCA. The planned discharge date was 5/9/2012 and it is further noted that re-housing and a court of protection order re finances will be completed as an outpatient. There is no evidence that any of these actions took place.

6.57 On 30/8/12 an assessment was started by a social worker (SW2) in the Hospital team. This was completed on 3/10/12. The assessment noted:

 *Mr V is in receipt of all Benefits due him. He is unable to manage his financial affairs due to confusion and poor memory. He will need help to manage his financial affairs.*

 *Mr V is supported by his son-in-law, AA (mobile number recorded).*

*Mr V has been assessed as needing to be cared for in a 24-hour Dementia Registered Care Home for his needs to be met safely. He is unsafe to live alone. He has been accepted by the Care Home (a registered Residential Home) for placement with additional support from a Day Centre to enable him to socialise with others.*

The nurses also noted a visit by the day centre worker and AA.

6.58 On 6/9/12 the social worker noted that Mr V’s finances were managed by the day centre worker. Mr V mentioned that the day centre worker invited him to her home to spend time with her children; Mr V was unable to say how recently that had happened.

6.59 The social worker also noted that Mr V talked about a former son-in-law whom he called George and said that he always wanted something.

6.60 On 19/9/12 it was noted that ‘Mr V’s son-in-law’ said that he was sorting out Mr V’s mail in order to get the documents requested as part of the assessment for Mr V to be considered for extra care housing.

6.61 On 25/9/12 the notes recorded a referral for a move to residential placement.

6.62 A telephone call was received from AA on 27/9/12. He had accompanied Mr V for his assessment at the residential placement. AA asked for clarification around medication for Mr V.

6.63 On 3/10/12 the longer-term team support social work assessment was noted as completed. There appeared to be two versions of this document. One taken from the LBTH social care record which records the Assessor’s view of current support arrangements and risks to independence:

 *The Multi-disciplinary team at Royal London Hospital recommends that his care needs will be best met in a Dementia Registered Care Home and also to continue the attendance at the Day Centre for socialisation. In my view, Mr V is at risk of wandering and unable to live independently as he is dependent for all his care needs. He needs to be placed in a Dementia Registered Care Home his needs to be met and reduce risks identified. He has been assessed and accepted by the Care Home for placement to ensure that all his care needs are met and reduce risks identified.*

And a copy of a document dated the same date and signed by the same worker, that was faxed to the care home on 18/10/12 that records within the same section:

*The multidisciplinary team at Royal London Hospital recommends that his care needs will be best met in an extra care sheltered housing scheme, continuous attendance at the day centre and an escort to be taken out to the local shops in the community. In my view, Mr V needs to be placed in an extra care sheltered housing scheme for his needs to be met and reduce risks identified. He has been assessed and accepted by XX extra care sheltered housing scheme for placement to ensure all his care needs are met and reduce risks identified.*

6.64 Around the same time the IMR noted a mental capacity form was completed by a LBTH out of hours worker. It concluded:

Q: Based on the above information, in your professional judgment, does the person have the capacity to make this decision? The box marked No was ticked.

*A: Mr V does not have insight into his needs and is a vulnerable adult. He is unable to manage his finances; carry out certain tasks (cooking, cleaning, etc) and has been found lost in the streets.*

6.65 On 5/10/12, while Mr V remained an in-patient, social worker SW2 raised a safeguarding adults concern about financial abuse of Mr V. Financial assessment for extra care sheltered housing had revealed £5000 being taken from Mr V’s account in one month. There was no evidence of an interim protection plan.

6.66 On 12/10/12 it was noted that the housing benefit form needed to be completed to ensure Mr V avoids rent arrears. Mr V remained in hospital.

6.67 On 18/10/12 the social worker SW2 wrote to the care home to refer Mr V and in that letter said:

*It is been agreed that his needs would be in an Extra Care Sheltered Accommodation with additional Day Centre Attendance.However we have been unable to place him at the extra care scheme due to an on-going suspected financial abuse and an Adult Safe Guarding investigation which needs to be concluded before he can be re-considered for Extra Care Sheltered Scheme.*

6.68 The Barts and The London NHS Trust – Discharge Summary Patient copy dated 22/10/12 further explains:

*Unfortunately access to Mr V’s bank account has been suspended whilst the financial services investigates the management of his money.* The Extra Care Accommodation *are unwilling to accept Mr V until he is able to pay for his residence. In the interim he is to be discharged to a care home.*

6.69 On 22/10/12 AA was contacted by a social worker to inform him that Mr V had been accepted at a care home rather than an extra-care resource, and that he would be discharged from hospital that day. AA said he would visit Mr V later that day and take some personal belongings to him.

6.70 A telephone call was received from AA on 26/10/12, who was concerned about the care at the care home. AA said that Mr V was not being stimulated enough and seemed to be deteriorating and more confused. AA was given advice about looking for another care home. It was agreed to review this ‘interim’ placement. The worker also told AA that the safeguarding investigation was on-going. AA said no one had contacted him.

6.71 On 8/11/12 AA called the social work team again enquiring about the safeguarding investigation. He was informed that there had been no further feedback from the police. AA said that Mr V couldn’t pay for his lunch, as he had no access to his accounts. The social worker said that they would deal with it. On 10/11/12 AA visited Mr V and took him out to have a haircut.

6.72 The safeguarding investigation was allocated to the police Safeguarding Adults team on 23/10/2012. The police established that AA had been added to Mr V’s account in October 2012. Following a discussion between the investigating officer and the social worker, on 13/11/12 the police closed the case re financial abuse. This was noted in the police IMR as due to:

 ‘…*the fact that the information provided by Social Care did not provide enough evidence to pursue a criminal investigation into the missing funds. Specifically there were no details of what had happened, when or where. The victim’s lack of capacity was such that he could not even say whether the loss was a gift or the proceeds of a crime.’*

6.73 There was no evidence of any protection plan or discussion about a protection plan.

6.74 On 15/11/12 a social care action plan was presented for Mr V’s placement to the LBTH panel.

6.75 On 14/12/12 a social worker agreed for AA to deliver possessions and personal effects from his original accommodation to the care home. AA asked about terminating Mr V’s tenancy and said that he was having difficulty in accessing Mr V’s bank account. The social care report records that social work staff agreed to give AA access to the police report on him so he could use it to show the bank and access Mr V’s account. A senior practitioner advised AA about applying for appointeeship.

6.76 On 16/12/12 AA visited Mr V and brought him birthday cakes and presents.

6.77 On 17/12/12 Mr V’s daughter called the care home from New York (number recorded by staff) and asked if her father was receiving respite care or permanent care, she said she didn’t know what was happening in relation to her father’s care.

6.78 On 18/12/12 the care home recorded that FRIEND 1 ‘called up’ saying she had taken Mr V to the Church in the past. The note said the phone number for the First Response Team social worker was given to her.

6.79 On 22/12/12 AA visited Mr V with a ‘friend’ and brought him some new shoes.

6.80 On 8/1/13 AA called to see Mr V, and on 30/1/13 the care home staff noted AA’s wife called about optometrist appointments. On 6/2/13 AA called to raise concerns about Mr V’s self care and on 12/2/13 AA had a meeting with LBTH staff about Mr V refusing personal care.

6.81 The record noted on 7/2/13 that the case had not gone to the LBTH funding panel. On 20/2/13 the panel confirms the placement.

6.82 A telephone call was noted on 13/2/13 with AA regarding handing over Mr V’s house keys to the housing office. It was agreed that AA would arrange to pay all outstanding rent arrears on Mr V’s behalf. AA also asked about the user contribution that Mr V had to make towards the placement.

6.83 On 23/2/13 AA met with staff to discuss issues about Mr V’s eyesight and spectacles.

6.84 On 27/2/13 the LBTH finance section spoke to the social worker about Mr V’s placement. They were unaware of the placement being made in October and only became aware when it went to panel in February. There were significant arrears. The finance section wrote to AA with a detailed breakdown of the costs.

6.85 On 5/3/13 AA contacted the social work department about a letter he had received from LBTH finance. He was recorded as being concerned about the information he had received from the previous social worker and the bill which had been received from LBTH. An explanation was given to him.

6.86 He also mentioned Mr V’s attendance at the day centre and the contributions regarding that placement. The next day a further file note was recorded stating that AA had requested a fee waiver regarding paying for home care. The social worker told him that they would contact LBTH finance section to find out what could be done.

6.87 AA also questioned the financial assessment process saying that once Mr V had paid for the day centre, and his meals, he did not have enough spending money for the week. The officer explained the assessment process. It was also recorded that AA said that the costs were such that Mr V would have no money left for his funeral. The officer took this literally and said they would find out what arrangements for funerals were.

6.88 On 11/3/13 the financial assessment officer noted that AA had contacted them again regarding “his father in law’s” personal allowance. It was noted that AA did not dispute the income as set out in the letter that Mr V received but was concerned about Mr V’s ability to live on the allowed allowance. He was told that there couldn’t be a reassessment.

6.89 At the same time it was noted that a worker from the day centre said that Mr V’s needs had increased and that he was more confused than before. He had previously been a lunch club user not a day centre user. They would like him to become a Day Centre user.

6.90 On 12/3/13 AA contacted the social work department to challenge the financial arrangements. The discussion became detailed with reference to the ‘block purchase’ cost to LBTH for places at the care home and an additional amount being required by the care home for Mr V’s placement (top-up). AA was told that it was nothing to do with the social work department, it was a financial assessment matter, and that AA should speak to a manager regarding his concerns. The social care IMR noted that officers discussed that if AA was finding it difficult to manage Mr V's finances, then he could ask LBTH to look after them.

6.91 On 13/3/13 a home visit took place to see Mr V at the care home. The record noted that a review was completed with Mr V’s next of kin. AA was reported to be happy with the placement and wanted it to continue; however he didn’t agree with the client contribution. It was unclear whether Mr V was present at the review or not.

6.92 The care home notes recorded that ‘AA and Mrs AA’ visited Mr V on 13/04/13 and 30/4/13. They brought clothes for Mr V and asked about professional labelling so that Mr V’s name didn’t wash out. There was also a question about an up-to-date inventory of Mr V’s possessions. The Care home record noted on the 30/4/13 visit ‘AA and his wife (Mr V’s daughter)’.

6.93 In a letter dated 6 June 2013 from Barts Health NHS Trust, copied to AA and Mr V, the Haematology Registrar noted that she had a long conversation with Mr V’s next of kin, AA, about his condition; prognosis and treatment plan.

6.94 The same day the social worker received a telephone call from AA who informed the worker that Mr V needed palliative care and had a short-term prognosis. However it was also noted that AA was concerned that Mr V was going to be moved from the current placement where he was settled.

6.95 The record noted AA continuing to visit Mr V in June and December and again in January sometimes accompanied by a woman that the Care home notes referred to as Mrs AA. The Care home notes recorded that AA brings chocolate; milkshakes; snacks; and fast food takeaways for Mr V when he visits.

6.96 The Care home notes recorded on 25/7/13 that FRIEND 1 and ‘another lady’ came to visit Mr V. They also left a business card and said that Mr V’s daughter would like to know more about her Dad.

6.97 On the 26/7/13 the Care home notes recorded that a worker from the care home contacted AA and told him that 2 people had visited the day before and that they were asked to visit by Mr V’s daughter who told them that she had been prevented from speaking with him and that she wanted to find out what was going on with him. The note said the visitors asked lots of questions but the care home referred them to AA because the care home did not know who they were. It was further noted that AA ‘collected the details from the business card’. There was no record of anyone else being informed eg. LBTH

6.98 The Care home notes recorded further visits by AA with food and snacks on 22/12/13 and 21/1/14

6.99 The case notes recorded that Mr V died on 13th March 2014. The notes from the care home further recorded that he had moved to a hospice in Hackney a few hours earlier and died there.

6.100 On 18/3/14 a telephone call was received from FRIEND 1 who was concerned that Mr V’s daughter who lived in the USA might not be aware that he had died. She reported that she had provided the contact details of the daughter to the care home twice. She also said that the daughter had called the care home. FRIEND 1 explained that she was an advocate for Mr V until 2009 when she moved from the area. She continued to have contact with Mr V including visiting him. She said Mr V’s daughter would call him once in a while but had only called once in the last two years. She had never heard of AA who purported to be Mr V’s next of kin.

6.101 On the same day (18/3/14) after the call from FRIEND 1 the social worker contacted AA regarding the issue of next of kin. From the case note it was apparent that AA held a joint account with Mr V, which received Mr V’s benefits. AA confirmed that there was approximately £4000 in the account. He also discussed an insurance policy of about £1000 to help with the funeral. He confirmed that FRIEND 1 had called him some years ago and also confirmed that he was not the ex son-in-law. He said he had never met Mr V’s daughter and he was a friend who had been helping.

6.102 On further investigation the social worker noted that FRIEND 1 was referred to as an advocate when the sight and hearing team assessed Mr V prior to 2006.

6.103 The social worker also noted that FRIEND 1 said that Mr V did not have a good relationship with his daughter and that she called him only when she wanted money. Mr V’s daughter was now regarded as next of kin and it was noted that the team needed to try and find her contact details and inform her of Mr V’s death. The social worker also requested that the record of visitors to the care home be checked to see if FRIEND 1 or any other person visited Mr V while he was there.

6.104 On 19 March 2014 a telephone number in New York was identified for Mr V’s daughter. The duty officer also contacted the care home and staff confirmed that when they telephoned AA about Mr V’s death on the 14/3/14 he told them he would contact Mr V’s daughter in America and tell her. The care home said they had tried to contact AA since then to get details of the funeral arrangements but that they had been unable to do so.

6.105 The Duty worker called the telephone number for Mr V’s daughter and it is recorded that it: ‘goes through to the wrong person’.

6.106 The social worker contacted AA who agreed to send copies of bank account statements and the notes record he confirmed that he was not the son-in-law and said he had never told anyone that he was. The staff member said that they would need to ascertain the amount of the remaining funds in Mr V’s account and find Mr V’s daughter. The social worker told AA not to contact the daughter as the local authority needed to inform her of her father’s death.

6.107 On 31/3/2014 FRIEND 1 again gave the phone number she had originally given. She also said that Mr V had told her in the past that he had a son in the Caribbean, and that he used to have a small telephone book with all the phone numbers in it.

6.108 A further duty worker (student) had a discussion with AA on the same day. The following points were recorded:

* + AA said Mr V never had a telephone or address book that he had seen;
	+ That AA had found some footage on his mobile phone of him talking to Mr V on his birthday where Mr V said not to contact his daughter because he did not want to talk to her and she would only want his money;
	+ AA said that Mr V had never mentioned any other relatives to him;
	+ AA said that no money other than Mr V’s had been paid into the joint account. AA said a previous social worker had advised him to apply for power of attorney but that AA had thought it would be easier just to have a joint account.
	+ AA confirmed that he had been made the appointee for Mr V. The staff member asked for evidence and he confirmed that he would send it as soon as he could find it.
	+ AA made a number of points about Mr V’s contribution to the care home.
	+ AA was asked about particular withdrawals from the joint account, particularly a number of withdrawals for £300 at a time. The worker asked what the money was spent on, and AA said he would buy Mr V clothes; food; or take Mr V out for the day. The duty officer asked AA if he could remember when he last purchased anything for Mr V and he could not remember.

6.109 On 2/4/14 LBTH called AA and asked him to pick up the death certificate and also that he stop all payments in and out of the joint bank account and to inform the pension authorities that Mr V had died. AA complained about a lack of support when Mr V was admitted to the care home and said no one gave him advice or told him what to do.

6.110 AA again said he was advised by the previous hospital social worker to have a joint account. He said the bank believed Mr V had capacity to make that decision.

6.111 The notes record that the social worker told AA that LBTH should have applied to the court of protection if LBTH had known that Mr V had no family. But because the record showed that AA was his son-in-law maybe that was why it was not applied for. It was agreed AA would contact the bank to stop all payments, and the social worker told AA he should contact the pension authorities as he was the appointee.

6.112 AA agreed to pick up the death certificate and wanted to arrange the funeral. The social worker agreed to take legal advice, as it had not been possible to contact Mr V’s daughter at that time. AA also agreed to provide the contact details of the life insurance company and the social worker agreed to look into whether a claim should be completed or not.

6.113 On 2/4/14 a student social worker visited the care home. The student social worker was told that a woman had called (leaving her name) and said that she worked for Hackney Council (bereavement officer) and that she would be coming to inspect Mr V‘s room.

6.114 The student social worker asked the day centre staff to review their files to establish if there were details of contact between Mr V and his daughter. They noted that his daughter called him on 17/12/12 and said she was very annoyed that her father had moved to the care home and that she had not been notified. She had asked to speak to her father but it was recorded that Mr V had become confused and did not believe he was talking to his daughter. The worker at the day centre said it was also noted that AA never had any contact with the day centre, but then seemed to go on to say that AA was a student social worker who was on placement at the day centre in 2011.

6.115 The case record noted that when the student social worker visited the day centre, they provided an envelope of information on AA and said that the student social worker could come back and view the complete file.

6.116 In the social work notes it was recorded that AA called the student social worker’s practice teacher to say he was frustrated about the current position. He confirmed that he had requested the duplicate bank statements but said he was not sure how long it would take to get copies. AA also referred to the bereavement officer from Hackney and asked why the care home and LBTH were not allowing the bereavement officer to audit Mr V’s bedroom.

6.117 On 7/4/14 a safeguarding ‘contact’ was made. This related to the joint bank account and the allegation that AA had purported to be Mr V’s son-in-law. The record also noted that Mr V was confused and lacked capacity when he was placed in the care home in October 2012.

6.118 The referral also noted that AA sent the bank statements to the longer-term support social worker, which showed sums of £300 being withdrawn on ‘many occasions’ and AA could not account for what he spent the money on.

6.119 It was also noted that a discussion had been had with the LBTH internal audit team.

6.120 The referral identified four areas of concern:

* AA was added to Mr V’s bank account;
* AA had been subject to a previous safeguarding alert;
* AA had allegedly declared himself as next of kin and son-in-law;
* There was an outstanding sum to LBTH in relation to Mr V’s resident contribution of approximately £5000; and
* There was a concern that the bank account might have been depleted prior to the original financial assessment.

6.121 The safeguarding referral was made and signed off by the manager.

6.122 The Hackney bereavement service was contacted and was requested to put their visit on hold. The care home was contacted and informed that no one should enter Mr V’s room until the visited.

6.123 A meeting took place with LBTH anti-fraud auditors. The agreed outcome was to start a police investigation.

6.124 On 8/4/14 a social worker called the Police team within the multi-agency safeguarding hub (MASH) and was informed that the case was being allocated to a police officer. On 9/4/14 Mr V’s account was frozen.

6.125 On 10/4/14 a social worker called AA to inform him that the safeguarding process had been started and that somebody would be contacting him. He asked if the Hackney bereavement service had the insurance details. He was informed that he did not need to arrange the funeral. AA said he needed access to Mr V’s room at the care home to get a suit for Mr V for the funeral.

6.126 Also on 10/4/14 a safeguarding strategy meeting took place with the police, the LBTH income and finance team, social worker and senior practitioner. It was agreed the police would start their investigation. The care home was informed not to allow AA into Mr V’s room.

6.127 On receipt of the allegations by police a block was placed on Mr V’s account. The strategy meeting held on 10/04/14 indicated a clear need for further investigation. An action plan was set; requiring a search of Mr V’s bedroom, work to ascertain the nature of the relationship, engagement with the bank, obtaining production orders and suspect interview. The Police investigation was to run alongside a joint agency investigation into AA’s professional conduct.

6.128 The notes record that the bedroom search was completed with a ‘negative result’.

6.129 On 14/4/14 information was received from the day centre about the placement start and end dates for AA’s placement at the centre. The induction date was 14/2/11 and AA’s final report was completed on 17/8/11. The social worker giving the information from the day centre confirmed that they had not seen AA at the centre since they began work there in August 2012. The worker said that she had also spoken to another care worker at the day centre who knew AA at the time of his placement and confirmed that he had not visited since that time.

6.130 On 22/4/14 a strategy discussion was noted to have taken place. It was apparent at this meeting that Mr V’s body remained at the hospice. The meeting agreed for the Hackney bereavement service to start funeral arrangements. The social worker was charged with contacting AA regarding the life insurance documents. It was noted it had not been possible to ascertain whether AA had involvement with any other residents since he completed his social work practice in 2011. The next day, 23/4/14, the chronology of events and other documents were sent to the police.

6.131 On 8/5/14 the Hackney bereavement service wrote to terminate Mr V’s placement at the care home.

6.132 On 12 May LBTH emailed the police to get an update. It was noted that AA visited the care home 14 times, the last visit being on 21 January 2014.

6.133 The social work team called the police on 22/5/14 and was told investigations were continuing.

6.134 On 30 May AA was allowed to collect Mr V’s clothes. The funeral took place on 10 June 2014 nearly 3 months after Mr V’s death.

6.135 The social care case notes record a number of attempts during June, July and August 2014 to obtain further updates from the police. There was no outcome to these attempts, and these contacts are not recorded in the police records.

6.136 The police investigation was subject to some delay due to workload pressures and a period of sickness. On 28/10/2014 the officer in the case noted that whilst on sick leave her desk had been ‘cleared and filed’, and she was now unable to locate any of the financial documents that had been passed to the police.

6.137 On the same day the police contacted the social work team and confirmed that they had been unable to locate any documents that had been passed to them previously by LBTH and requested copies. It was however noted that the officer in the case had established on 04/06/14 that AA had no registered Enduring Power of Attorney (EPA), Lasting Power of Attorney (LPA), nor was he a Court of Protection appointed deputy for Mr V.

6.138 The social work record notes an email to the police on 29/10/14 to update them with the contact details of Mr V’s daughter and also notes that the police asked if LBTH could alert London Borough 1 where AA was currently employed as a social worker, now that it had been established that AA did not have any legal authority to access the account of Mr V.

6.139 The police IMR notes that on the same day that the police officer obtained details for Mr V’s daughter, they made contact with her. Mr V’s daughter confirmed that AA was not the next of kin of her father, and was not related in any manner. The social care IMR further notes a telephone call with the police officer on 30/10/14 where the police officer was recorded to have said that they hadn’t contacted Mr V’s daughter at that stage - this is not reflected in the Police CRIS report. The social care IMR also notes that the police officer also said they could not advise LBTH on what actions they should take regarding AA and his current employment or his registration.

6.140 A safeguarding strategy meeting was noted as planned for 12/11/14 with the police, the social worker, finance and HR. HR did not attend and recommended the ‘long-term social work team management’ and the service manager make a decision on the next steps in notifying HCPC and London Borough 1.

6.141 On 10/11/14 an email was received by the hospice from Mr V’s daughter. She was requesting information about what had happened to her father; why she was removed as next of kin; who AA was and why he was treated as next of kin? She ends by saying ‘…this is killing me how my Dad was treated and I was not informed.’

6.142 An email sent from the hospice to Mr V’s daughter was noted on the adult social care record. It confirmed that she had sent a copy of her birth certificate as proof of her relationship to Mr V. She was given information about the LBH bereavement service and the social worker by the hospice.

6.143 On 12/11/14 a safeguarding strategy meeting took place. On 17/11/14 legal advice was requested and the LBTH corporate fraud and governance manager indicated they needed to be updated and involved.

6.144 On 20 November the safeguarding adults manager contacted London Borough 1 to inform them of concerns regarding AA. No information was provided to the regulator at that point.

6.145 On 21/11/14 it was noted that the safeguarding investigation was completed.

6.146 Following further police investigations the case was passed to the Crown Prosecution Service who later in 2015 determined that it was not possible to prove whether Mr V had capacity to consent to AA accessing his money, and the offence of fraud could not be proved.

6.147 Following further contact with Mr V’s daughter in 2018 the police reviewed evidence but were still unable to proceed further as no new evidence was available.

6.148 On 1st December 2016, the interim Adult Safeguarding Joint Strategy and Governance Manager made checks to ensure that the Health Care Professions Council had been informed, which they had been by London Borough 1.

7. Analysis

7.1 Relationship between AA and Mr V

7.1.1 In February 2011 AA commenced his first social work placement arranged through his college at a voluntary sector community day centre. This was located in the London Borough of Tower Hamlets. Whilst working at the placement he met and got to know Mr V. During this time, he visited Mr V’s flat with his on site practice educator. This was in order to help Mr V who was experiencing problems with his electricity. As a result AA gave Mr V his telephone number in order that he had someone to contact at any time. He then started to visit Mr V on a regular basis. These visits continued even after his placement had concluded. It is recorded that AA would assist Mr V to go to local shops, make sure he had enough food and Mr V would call him at weekends for assistance.

7.1.2 Mr V was a service user of adult social care services and AA was a student social worker and as such all the professional codes of practice applied. It was inappropriate for AA to give Mr V a personal telephone contact. If AA did not mention this contact to the placement and his site practice educator that may indicate he knew it was inappropriate, and if he did mention it, it calls into question the professional judgment of the placement and educator, likewise, the college where he was studying.

7.1.3 AA continued to maintain his relationship with Mr V and from the care home notes was the only person who visited on a regular basis and undertook personal shopping and brought him food.

7.1.4 AA also continued to maintain contact with the statutory authorities, and was encouraged to be a point of contact – often being asked to manage tasks around discharges, or payments.

7.1.5 There was little evidence that the care and support needed by, or provided to, Mr V was person centred nor holistically coordinated. From time to time AA raised concerns about Mr V’s care; his medical needs e.g. ophthalmologist, palliative care. But from the reports there was no sense that other than AA and some Day Centre staff any professional had a care coordinating role.

7.2 Next of Kin

7.2.1 Mr V was admitted to Barts Hospital in November 2011 and to Royal London Hospital (RLH) in June 2012. AA’s details do not appear in either the Long Term Support Team social work assessment for the 21/11/2011 or the contact sheet completed on 21/06/12.

7.2.2 However, while in July 2012 a file entry refers to AA as Mr V’s nephew between 2012 and Mr V’s death (March 2014), the professionals who were involved with Mr V started to document that AA was Mr V’s son-in-law. For example in an entry in Mr V’s electronic case noted dated 06/07/12, the following was recorded by the social worker:

 *Tel call made to service user’s son-in-law AA following message left to make contact.*

7.2.3 The care home also referred to a woman who visited Mr V as Mrs AA or AA’s wife. There was seemingly no curiosity as to whether this was therefore Mr V’s daughter. It is also recorded that day centre staff are referred to as being present at the same time as AA is present e.g. para 7.2.3 below and para 6.57 on 30/8/12: *The nurses also noted a visit by the day centre worker and AA*.

7.2.4 On 28/08/12 Mr V was again admitted to RLH. He had been found wandering. He was confused and was lacking capacity. On 31/8/12 the medical records noted that there was a Consultant review that recorded that following a discussion with social services there was concern about financial abuse. That Mr V’s finances were being managed by a worker at the day centre and his ‘son-in-law’ (inverted comma from the record) is not his next of kin. The consultant and social care worker were in agreement that Mr V did not have capacity. They planned to appoint an IMCA. It was further noted that re- housing and a court of protection order re finances will be done as an outpatient. There is no evidence any of these actions took place.

7.2.5 In an entry in the social care case notes dated 31/08/2012 made by a social worker it was recorded:

 *On 19/08 AA (formerly married to his daughter) and a BB (day centre officer) visited him...*

 *Phone call to AA, who confirmed he had been married to Mr V's daughter. AA said he helps Mr V by visiting him, bringing meals to him, sometimes buying toiletries or essential items.*

7.2.6 A case note entry on 19/09/2012 made by social worker SW2 states:

 *Received telephone call from AA, son-in-law, who reported that it will take a day or two to sort out Mr V’s mail to be able to get documents asked for as part of his assessment to be considered for Extra Care Sheltered Scheme...*

7.2.7 A further case note entry made on 27/09/2012 by Social worker SW2 states:

 *Received telephone call from AA who reported that he accompanied Mr V to extra care for his assessment.*

7.2.8 A Long term Support Social Work Assessment form was completed by social worker SW2. Under relationships it states:

 *Mr V is supported by his son-in law, AA.*

 And under informal support arrangements it states:

 *Mr V has a son-in-law, AA who visits and assists with other support needs and will continue to visit and support him when he moves to Care Homes.*

7.2.9 On 13/03/13 the LBTH social worker completed a long-term assessment, and recorded in case notes:

 *Review completed with AA - next of kin.*

7.2.10 Two LBTH social workers had contact with AA following Mr V’s admission to the RLH. They both recorded in the electronic case notes and on referral documentation that AA was Mr V’s son-in-law. They both believed AA when he allegedly told them he was the son-in-law.

7.2.11 When interviewed by the police AA denied having ever said he was Mr V’s son in law. He had been referred to as such by others, but he said he had at no point told them this.

7.2.12 It was evidenced that professionals officially recorded that AA was Mr V’s son-in-law in a significant number of documented communications over a 3-year period. These were different individuals and while it may be accepted that in some cases this might have been an assumption based on previous documentation, there is evidence that AA’s behaviour reinforced this perception.

7.2.13 The social care record notes that AA accepted that he had signed a document, which set out that he was the son-in law, but he had strongly denied that he ever verbally stated that he was anything other than a friend.

7.2.14 On balance, the conclusion has to be drawn that AA deliberately deceived social workers as to his relationship with Mr V.

7.3 Safeguarding issues

7.3.1 There had been a history of safeguarding concerns going back to 2006.

7.3.2 In various case notes there were references to Mr V saying that his daughter only wanted money from him. His daughter denies this and there was no record of this being further discussed with Mr V, his daughter, nor it being investigated.

7.3.3 In 2010 there was a referral from the day centre about a member of their staff that was concluded with LBTH agreeing a plan of action for the worker to be supported in supervision around appropriate practice.

7.3.4 On 5/10/12 social worker SW2 raised a safeguarding adults concern about financial abuse of Mr V. The financial assessment for extra care sheltered housing had revealed £5000 being taken from Mr V’s account in one month.

7.3.5 AA told staff that following Mr V’s admission to hospital and his subsequent move to the care home, Mr V asked him to make his personal account a joint account. He stated that he took Mr V to the bank and he signed the joint account agreement. This change took place in October 2012.

7.3.6 On 08/10/2012 SW2 completed a Safeguarding Referral Outcomes (SAR1). Under Potential Danger it states:

 *There is a higher risk of potential financial abuse continuing if people who have had access to Mr V's finances are not investigated and changes made to stop the potential abuse of his finances.*

7.3.7 Under events that increase risk it states:

*Mr V is confused and unable to remember or indicate what the money was used for. People who have access to Mr V's accounts are 1 (name removed) 2 AA, son-in-law, these are potential suspects.*

7.3.7 Under details of referral strategy discussion it states:

 *Interviewed AA, son-in-law, on 8th October. AA was simply asked if he could account for the £5000 that had gone from Mr V account, and he simply stated he didn’t know. AA provided the statement that led to concern.*

7.3.8 Following discussion with the police, no further action was taken.

7.3.9 AA was the only individual who accessed the account. It was recorded that he used it to purchase items for Mr V and pay for trips. The regular amounts of £300 taken out from cash points AA said were used for this purpose, and the unused cash Mr V kept in a locker.

7.3.10 AA was not related to Mr V, nor Mr V’s appointee. However Mr V’s account was amended to a joint account, this may or may not have been at the request of Mr V although the bank would have needed to see Mr V in person to action this request. While there was varying evidence that Mr V lacked capacity (as tested under the Mental Capacity Act) he would have been seen as a vulnerable adult in receipt of social care services and as a social worker AA should have fully understood the consequences of his actions and refused such a request or at least sought advice. Given Mr V was not related to AA the use of an advocate to support decision making for Mr V should have been considered.

7.3.11 At no point was there evidence that protection plans were put in place. There was no evidence that professionals took either a holistic or long-term view of safeguarding referrals and events around Mr V. Events were seen in isolation, no connections were made, and a lack of professional curiosity about Mr V and his life was evidenced.

7.3.12 Even after Mr V’s death, when the true relationship with AA became clear, there was not a timely investigation into the circumstances. Even though Mr V died in March 2014 and the first safeguarding referral / contact made in April 2014, the police did not conclude their investigation until 2015 and LBTH did not make contact with London Borough 1 until November 2014.

7.3.13 It was also apparent that LBTH Legal officers ‘advised ASC to setup an IMR to run alongside the investigation conducted by Police and London Borough 1.’ (26.11.14) Those involved in the strategy discussions were in agreement that an IMR should be undertaken to review the circumstances of the case; the necessity of this was again confirmed on 10.1.15. However this did not happen.

7.3.14 While there was evidence that LBTH Senior Management did respond to minimise harm in this case once they were made fully aware of the circumstances, the lack of an IMR, as proposed in 2014, delayed the identification of systems or practice needing change to prevent similar failings or future abuse.

7.3.15 While many local authorities commissioned Serious Case reviews for adults prior to the implementation of The Care Act, it was that Act that created a duty to commission Safeguarding Adult Reviews in 2015. This SAR was finally commissioned in late 2016.

7.4 LBTH social work practice

7.4.1 Analysis suggests that this case demonstrated a problematic culture within adult social care, rather than just the poor actions of a few individuals. Staff from a number of teams failed to listen to or provide a personalised service to Mr V.

7.4.2 The records evidence that involvement lacked continuity, that concerns were not followed through, and that connections were not made. The IMR’s noted that some social work staff seemed to assume that without criminal court level evidence no safeguarding could be undertaken – not even a plan to support and protect someone could be put in place.

 7.4.3 The majority of staff were grateful to, and not challenging of AA – they involved him in the interests of completing key tasks, suggesting that through-put was more important in the culture of the organisation than quality of safeguarding or personalisation.

7.4.4 This was in marked contrast with the practice of a student social worker who was challenging of AA and proactively sought out and obtained the key information which uncovered the issues around AA and his next of kin status, even though AA tried to undermine her by contacting her practice teacher. This suggests that her good practice was different to the prevailing culture.

7.4.5 Clearly, few staff had read the case record when they were working with Mr V. A number of staff took no action when they had read the case record, disregarding what it showed them about safeguarding risks. Some staff failed to take safeguarding action even when information suggesting significant risk was placed directly before them in the course of their work.

7.4.6 It was concerning that it was assumed that Mr V lacked capacity after his second discharge from hospital. It was open to all the staff who worked with him to ensure that a mental capacity assessment was undertaken and to maximise attempts to involve Mr V in care planning and day-to-day decision making. However, staff oriented themselves towards AA to make the decisions, even when there was evidence before them that he posed a risk of financial abuse.

7.4.7 When AA presented at the hospital allegedly claiming to be Mr V’s son-in-law, the social worker did not conduct any checks on his identity.

7.4.8 Time was not taken to get to know Mr V. by any of those who made social care assessments or developed social care plans with Mr V. While his speech made it hard to understand him, he had been in contact with the hospital, social care, faith and voluntary care organisations for some years. No contact seems to have been made with housing workers or his GP, nor the Friends as made with the Friends and Neighbours worker to find out more about his history and Mr V as a person. There seemed to be gratefulness from social work staff that AA would take on a range of tasks. Even after Mr V had died and there was substantial suspicion about financial abuse AA was still being asked to undertake practical tasks. It was hard to say if this was due to a lack of focus by workers, or they were genuinely hard pressed – in any case there seems to have been a significant lack of management and supervisory oversight.

7.4.9 Even with the inappropriate involvement of AA, Mr V spent significant a mounts of time in hospital with very little positive outcome. It is concerning to consider what would have happened if there had been no one at all to undertake practical tasks for Mr V.

7.4.10 No staff working with Mr V ever questioned where his daughter was or, with the exception of the student social worker, sought to find out about her, despite the fact that AA described himself as a son-in-law and sometimes visited with a woman referred to as his wife.

7.4.11 From all the IMRs there was no evidence that a protection plan was ever put in place. Despite there being a number of safeguarding concerns over a number of years, albeit with no convictions or further action being taken, not even interim protection plans seem to have been put in place.

7.4.12 The safeguarding investigation, initiated after Mr V’s death because the LBTH student social worker had made the proactive checks that her colleagues had failed to make, which evidenced that AA had met Mr V as a student social worker and the existence of a daughter in the USA, was a process which was heavily delayed. The lead social worker provided AA with information about the investigation and sought to negotiate with him, encouraging him to continue with administrative tasks in relation to Mr V’s death.

7.4.13 The LBTH adult social care IMR noted:

 *The lead social worker was passive and unconfident in this safeguarding investigation, allowing the perspective of a (LBTH) fraud investigator who necessarily lacked the understanding that a safeguarding investigation can work in a person-centred way with a lower burden of proof than criminal proceedings to dominate the approach. The lead social worker failed to advise that the social work regulatory body should be informed about AA, leaving other service users at risk. Even when police encouraged him to act in this regard he failed to do so, calling more multi-agency meetings. The lead social worker failed to escalate matters via senior management or the safeguarding adults board when police failed to respond to him, leading to a very substantial delay before the London Borough 1 were informed about the risks posed by AA.*

7.4.14 A significant number of staff from different teams failed to meet required safeguarding standards even when they were able to access clear evidence of risk that Mr V had been financially abused.

7.4.15 There were particular concerns regarding leadership from senior social workers. The ASC IMR found that there was a case note recorded by the senior social worker agreeing the release of a copy of the confidential police report to AA, to enable AA to once again access Mr V's bank account. While the IMR noted that this had been released to AA there is no evidence on the file as to who undertook this task, AA regained control of Mr V’s monies shortly afterwards. The same senior practitioner failed to take any investigative action when there was delay in sending Mr V’s case to the funding panel, leading to a delay in identifying that a substantial amount of money was in arrears in relation to Mr V’s residential placement.

7.4.16 The IMR noted that:

 *The hospital social work manager took no investigative action when Mr V informed her that he had returned home from hospital with no support package in place, simply recording that he was “fine”.*

7.4.17 Given that the recording of Mental Capacity Act assessments were often unclear and in one episode clearly not acted upon, and that professional conversation and attention did not centred on Mr V’s wishes, it is evident that services provided did not adequately consider Mr V’s needs.

7.5 Professional standards and practice[[7]](#footnote-7)

7.5.1 It was clear that some social workers were unable to:

* undertake assessments of risk, need and capacity and respond appropriately;
* understand the need to protect, safeguard, promote and prioritise the wellbeing of adults at risk;
* manage and weigh up competing or conflicting values or interests to make reasoned professional judgements;
* exercise authority as a social worker within the appropriate legal and ethical frameworks and boundaries;
* understand the need to respect and so far as possible uphold, the rights, dignity, values and autonomy of every service user and carer;
* recognise the power dynamics in relationships with service users and carers, and be able to manage those dynamics appropriately;
* recognise that they are personally responsible for, and must be able to justify, their decisions and recommendations;
* make informed judgements on complex issues using the information available;
* work effectively whilst holding alternative competing explanations in mind;
* make and receive referrals appropriately;
* use interpersonal skills and appropriate forms of verbal and non-verbal communication with service users;
* understand the need to provide service users and carers with the information necessary to enable them to make informed decisions or to understand the decisions made;
* understand how communication skills affect the assessment of and engagement with service users and carers;
* understand how the means of communication should be modified to address and take account of a range of factors including age, capacity, learning ability and physical ability;
* work with service users and carers to enable them to assess and make informed decisions about their needs, circumstances, risks, preferred options and resources
* contribute effectively to work undertaken as part of a multi-disciplinary team;
* gather, analyse, critically evaluate and use information and knowledge to make recommendations or modify their practice;
* select and use appropriate assessment tools; and
* draw on appropriate knowledge and skills to inform practice.

7.5.2 There was a lack of evidence of:

* awareness of the impact of culture, equality and diversity on practice;
* practice being undertaken in a non-discriminatory manner;
* an understanding of the importance of and the ability to maintain confidentiality;
* the ability of social work staff to reflect on and review practice; and
* being able to assure the quality of their practice

7.5.3 The evidence suggests there was a systemic failure to understand in relation to social work practice:

* social work theory;
* social work models and interventions; and
* the development and application of relevant law and social policy;

7.6 Good practice

7.6.1 The discovery of the key information that AA had met Mr V as a student social worker was researched and uncovered by a student social worker on placement with the service.

7.7 Learning

7.7.1 The importance of professional curiosity in the work with Mr V, the need to spend getting to know him, his strengths and the outcomes he wanted.

7.7.2 The importance of professional curiosity in practice - the ability to consider alternative interpretations for how a person might be open to abuse or neglect.

7.7.3 The importance of maintaining a professional questioning approach to information received and to question assumptions and stereotypes.

7.7.4 Ensuring that the service user is at the centre of all practice. Ensuring that Making Safeguarding Personal (2014), with its focus on person centred rather than process driven safeguarding, is implemented. It is recognised however that Mr V’s care and support was delivered before this programme came into force.

7.7.5 The importance of ensuring consistency in assessment and care planning, and when not possible to maintain consistent staffing, ensure that case records are reviewed and new workers have time to familiarise themselves with the person they are working with. That the casework recording systems need to enable practice focussed social work.

7.7.6 That safeguarding practice must be consistent; is completed with an outcome and has sufficient senior oversight. Making sure that local safeguarding policies and procedures are followed by all agencies.

7.7.7 Where a Local Authority is requesting another service to respond to a safeguarding concern - e.g the police - the Local Authority must maintain oversight and provide scrutiny for how that task is carried out, assuring the adequacy of the outcomes achieved for the person(s).

7.7.8 The need for a better understanding of the concept of Next-of-kin.

7.7.9 That Leadership behaviours need to promote good quality, practice focussed, supervision.

7.7.10 The need for a better understanding of Mental Capacity assessments, the nature of assessing for specific decisions and how these can be used to support and safeguard people.

7.7.11 For all agencies to develop policies around allegations made against People in Positions of Trust (PiPoT).

8. Conclusions

8.1 The safeguarding events in Mr V’s life were poorly examined. Neither oversight nor connections were made between the events and no protection plans were ever put in place. This evidenced a lack of person-centred social work; professional curiosity; and good quality supervisory oversight.

8.2 No one who assessed Mr V, or who was involved in planning his care and support, got to know him well. Mr V’s care and support was not improved by meaningful communications between assessors and the care givers at the day centre, the community support service nor at the care home. These services did know him but there is little evidence that the services that were assessing and commissioning Mr V’s support made use of this knowledge.

8.3 Mr V had no one to champion his support and care needs and while he had received advocacy in the past and it had been requested on his behalf once during the timescale of this report, it wasn’t followed through and he didn’t received the support of an advocate. He had a history of allegations of being taken advantage of and allegations of financial abuse. He said his daughter only wanted money when she spoke to him. However there was no evidence that anyone spoke to Mr V’s daughter. Even though her presence was identified on case notes and people who visited Mr V referred to her, no contact was made with her.

8.4 If AA was Mr V’s son-in-law he must have been married to Mr V’s daughter. There was no professional curiously to discover if the daughter referred to in case files, was the same person AA alleged he had been married to. There was no professional curiosity to try and locate the daughter, who in any case would have been a ‘closer’ relative than the (ex) son-in-law.

8.5 A worker at the care home had even recorded AA as visiting with ‘Mrs AA’. No connection was made. When Mr V was visited by friends in 2013 the care home noted they asked lots of questions and said his daughter wanted to know why she was being prevented from speaking to Mr V. The care home worker passed this information to AA, but there was no evidence this was passed on to, or picked up by, LBTH adults social care workers.

8.6 There was even limited contact with Mr V’s daughter after Mr V’s death. Unlike AA she was asked to send a copy of her birth certificate to confirm her identity, which the record noted she did, and she was then given details of relevant email contacts.

8.7 During his life Mr V did get support from the day centre and enjoyed going to a club there, but even in this ‘safe place’ there were questions about him being financially abused by a staff member and any on-going relationship staff had with AA. This was also where he met AA who befriended him and over a number of years took significant amounts of Mr V’s money without being able to clearly account for how it was spent.

8.8 No one professional or service had a good overview of whom Mr V was, what he was able to do and what he needed support to do. No one really found out what he wanted. A variety of workers, who seemingly had not looked at his case notes, came into, and then out of his life.

8.9 Mr V was admitted to hospital from time to time and on the last occasion stayed there for nearly two months while various workers drew up plans.

8.10 But when Mr V came into contact with statutory services he came across a lack of professional interest and curiosity into his situation; background; history and needs. Workers didn’t speak to care partners to find out more about him. The neighbourhood scheme: Friends and Neighbours had been involved with Mr V for a number of years but weren’t proactively involved. Mr V had even had an advocate in the past, but no one considered if he needed one at the time of his assessments. Information about his family: who they were; where they lived; the quality of the relationships had all been recorded but was often accepted at face value, not investigated or perhaps not read or ignored.

8.11 Staff did not understand the term ‘next of kin’, and did not know anything about who was supporting and helping Mr V. Instead of asking Mr V who he wanted to help and support him and find a legal and open way to meet his wishes, assumptions were made about AA that in part made it easier for him to financially abuse Mr V.

8.12 Professional staff did not see through safeguarding concerns to a conclusion, lacked rigour in their practice, and lacked a concern for Mr V and his outcomes. They didn’t assess his capacity frequently enough nor at appropriate times to ensure the decisions that needed to be made involved him as far as was possible.

8.13 It is impossible to say if Mr V knew AA was taking money from him and if he did, what his view was. Mr V had concerns about his daughter only wanting his money, but AA was the only person visiting Mr V and he was dependant on him for arranging haircuts, take away food and a range of day to day purchases.

8.14 Mr V was denied the opportunity by the statutory agencies to make his own decisions about who managed his money and his affairs. He was denied the opportunity to make ‘good’ or ‘poor’ decisions about whom he trusted. He was not given the information he needed, nor involved in the decisions about his life and the way he wanted to live it that he was statutorily entitled too.

8.15 There is learning here for all the agencies involved. It is particularly important that when workers are placed in different organisations (e.g. social workers working within the hospital environments) they have the same access to professional support and oversight. Agencies did not sufficiently communicate with each other to understand Mr V’s needs and aspirations and did not follow through on plans made which may be offered some protection to Mr V.

9. Recommendations

9.1 For LBTH to continue to implement the Making Safeguarding Personal initiative and to audit against these outcomes.

9.2 To ensure adult social work staff working for LBTH, including those based in health teams, have a good and up-to-date understanding of local safeguarding policies and procedures particularly in relation to financial abuse.

9.3 For LBTH and health partners to offer staff guidance on next-of-kin and how to work with people to determine who their main carer is and who they want involved in different aspects of their lives. This may include the production of documentary evidence to show how the person who purports to be the next of kin is related to the service user.

9.4 For LBTH and health and social care providers to ensure there is regular and sufficient supervision available to all social work staff at the right quality and level to enable all workers and managers to escalate and follow through agreed actions.

9.5 For the Safeguarding Adults Board to ensure partner agencies review their SAR referral processes to make sure they are timely and effective, and understand that the SAR panel should be used for advice and consultation when considering whether the criteria for a SAR referral is met.

9.6 For LBTH and health partners to ensure quality case audits, including safeguarding audits, are undertaken on a regular basis and reported to the Safeguarding Board. To consider the use of multi-agency audits and peer supported audits.

9.7 For LBTH and health and social care providers to have systems in place that assure relevant managers and clinicians that their staff are capable of making good quality mental capacity assessments that meet the statutory requirements of being decision specific.

9.8 For LBTH to review the casework recording system to ensure it facilitates easy access to past casework entries and supports workers to review case histories.

9.9 For LBTH and health and social care providers to ensure that staff are confident in working with relatives and family carers, are aware of the potential complexity, conflict and tensions that can arise between family members and have the practice tools to enable them to ensure that the service users’ voice and wishes are at the centre of their practice.

9.10 For LBTH and health and social care providers to ensure that when communication is difficult for people using services e.g. due to stroke, dementia or other difficulties, plans are put in place to enable meaning communication ensuing that the service user and their views are at the centre of care planning.

9.11 For all agencies to develop policies around allegations made against People in Positions of Trust (PiPoT) and the Safeguarding Adults Board to assure itself that these are in place by developing a Board policy.

9.12 To consider the use of an external organisation to assist social work staff in developing their practice around person-centred social work.

1. Section 14.121 Care and support statutory guidance

<https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance> [↑](#footnote-ref-1)
2. <https://www.nmc.org.uk/globalassets/sitedocuments/ftpoutcomes/2017/february-2017/reasons-dabi-cccsh-51640-20170219-22.pdf> [↑](#footnote-ref-2)
3. <https://www.hcpts-uk.org/hearings/listing/201711131000-final_hearing-sw89947> [↑](#footnote-ref-3)
4. paragraph 89 <https://www.hcpts-uk.org/hearings/listing/201711131000-final_hearing-sw89947> [↑](#footnote-ref-4)
5. The Alzheimer’s Society web site: <https://www.alzheimers.org.uk/info/20125/augsept_2015/457/being_someones_next_of_kin_doesnt_have_the_meaning_in_law_that_we_might_think> [↑](#footnote-ref-5)
6. The Bournemouth University and National Mental Capacity Forum’s booklet: Next of Kin: Understanding decision making authorities

<http://www.ncpqsw.com/publications/nok/> [↑](#footnote-ref-6)
7. Taken from the HCPC: Standards of proficiency – Social workers in England [↑](#footnote-ref-7)