Safeguarding Adult Review

"John"

Nikki Holmes

Research estimates that there are more than 944,000 people in the UK living with Dementia. This is a figure that is likely to only increase in future years, given that we have an aging population. [1]

Dementia is an umbrella term that describes symptoms ranging from memory loss, confusion and even noticeable personality changes.

As such, being diagnosed with Dementia is likely to impact a person's life in a multiplicity of ways; their decision making, their confidence, their relationships and even their ability to be safe to live independently.

Due to the cognitive impairments associated with dementia, such as memory loss, decision making, problem solving and language skills; those diagnosed may be at an increased risk of exploitation, abuse and harm. Those living with dementia may find it more difficult to seek support and report abuse. Therefore, it is imperative that practitioners working within the adult safeguarding arena, are aware of the intersect that often exists between dementia, and the increased risk of being exposed to harm.

One such example of harm that may disproportionality impact those with a dementia diagnosis, is financial abuse. Research such as that conducted with the Alzheimer's society [2]highlighted growing concerns relating to financial abuse and exploitation in the community, via rogue traders and sophisticated scams. Yet financial abuse can also be perpetrated by those closest to those living with dementia.

Research conducted in both a national and international context, has highlighted how adult sons and daughters are common perpetrators of financial abuse. For context, it is estimated that 50% of financial abuse in the UK is perpetrated by 'adult children'.

Financial abuse always has a profound impact on victims. But financial abuse that is perpetrated by family members who may conceal their abuse behind the care and support they simultaneously provide to their victims, is particularly insidious.

Concerningly, abuse of this nature may also remain undetected for many months or even years, as there remains a fragmented and misconstrued understanding of this issue; with some practitioners thinking that financial abuse was more likely to be a factor within institutions as opposed to familial environments. [3]

One additional factor that further adds to the complexity of this issue, is that is that financial abuse can start out as seemingly innocuous and legitimate transactions that can mount up to thousands of pounds over time, with the potential to plunge victims into debt and even poverty.

Therefore, this review acknowledges the challenge of preventing, identifying and responding to known or suspected financial abuse faced by practitioners, and aims to provide valuable learning and insights to support further developments in process and policy which provides greater levels of protections to some of the most vulnerable adults in our society.

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[1] Supporting people living with dementia to be involved in adult safeguarding enquiries. (2021), Department of Health and Social Care. University of Bath.

[2] Financial Abuse Evidence Review (2015), Age UK.

[3] Mihaljcic, T., and Lowndes, G. (2013) Individual and community attitudes toward financial elder abuse. Journal of elder abuse & neglect

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1.Introduction

1.1 Safeguarding Adults Reviews (SARs) were introduced in the Care Act (2014) to inform and facilitate learning following the death of an adult at risk of abuse or neglect, and where there are concerns that partner agencies could have worked more effectively to safeguard and protect the adult at the centre of the review.

1.2 The purpose of a SAR is not to allocate blame or responsibility to an individual or organisation, but to identify ways of improving how agencies work, singly and together, to help and protect adults with care and support needs who are at risk of abuse and neglect, including self-neglect, and are unable to protect themselves (Department of Health and Social Care, 2020)

1.3 This statutory SAR is focussed on the life of John, who at the time of being found deceased at his home, where he lived alone in February 2024, was 78 years old.

1.4. During the latter stages of John's life, he suffered from several chronic and co-morbid health conditions. His diagnoses included epilepsy, anxiety, Chronic Obstructive Pulmonary Disease (COPD), asthma, heart failure and deafness. In addition, he had also been diagnosed with Alzheimer's in August 2023.

1.5 During the period of John's life which is explored within the scope of this review, John was isolated from his wider family network and only in regular contact with his son. It is worthy to note that his son lived some geographical distance away from John and had his own health needs and a physical disability which made providing care for his father more challenging.

1.6 Despite his complex health presentations, John was a man, who until his death, remained fiercely independent, crediting his self-reliance and desire for independence on the time that he had spent in the Army during his youth.

1.7 Although John was in poor physical health, his death was one that was not anticipated nor expected.

1.8 It was also identified in the weeks preceding John's death, that there were some financial irregularities in relation to his bank account. This raised concerns that John had been subjected to financial abuse by his son, who, until a few months prior to his death, had the most contact with him.

1.9 These concerns, were perhaps exacerbated due to the fact that there was also some suggestion of John being actively alienated from his other children, and his extended family members. This prompted a police investigation, and subsequently, the commissioning of this review process.

1.10 The aforementioned police investigation was closed as No further Action (NFA) in July 2024. It was deemed that as John had died, and subsequently was unable to bear witness, the investigation would not progress nor meet the threshold for charge. However, it was deemed appropriate for the SAR process to continue, in order to extrapolate learning.

2. Governance and Methodology

2.1 John was born in Berkshire in 1945 and lived in Bexley at the time of his death. Therefore, this particular SAR was commissioned by Bexley Safeguarding Adults Board.

2.2 Terms of Reference for the review were developed and agreed by the commissioners of this review and the review panel. The full Terms of Reference that steered and underpinned this review process can be found in **Annex A.**

2.3 The review panel consists of representatives of partner agencies who had oversight and opportunity to scrutinise, challenge and quality assure the review process. The panel worked with and supported the review author whilst ensuring that the review was conducted in alignment with the agreed Terms of Reference.

2.4 The methodology and scope of the review was also agreed with review commissioners and members of the review panel. The methodology of this review was carefully considered to ensure that the recommendations arising from it will improve outcomes for vulnerable adults who have a shared lived experience to John.

2.5 Evidence to support the review process was provided by all agencies who had involvement and/or contact with John during the review scoping period. Each agency provided a chronology of their individual involvement, and an appraisal of their response and interventions.

2.6 This review focuses on **three key learning episodes** that have been identified as being particularly pertinent for the purposes of this review, and therefore this review does not encompass every chapter or facet of John's life. That said, events and information deemed as relevant that fall outside of the scope of these key episodes, have been analysed and included within this review where relevant, to provide further understanding, insights and context.

2.7 Strategic review panels consisting of senior managers from key agencies were convened to support in-depth analysis of the case alongside the use of chronologies and individual agency reports as a starting point for this analysis.

2.8 A Practitioner Learning Event was also held to support understanding of key events. The engagement of front-line practitioners and the managers that supervise them at this event was invaluable at informing the analysis and conclusions outlined in this review. All the practitioners involved in the review process demonstrated great candour and reflection. It was also observed that they had a palpable emotional connection to this case, and a clear commitment to learning. As such, the author of this review extends her thanks to them all for providing their honest, critical reflections.

2.9 A list of agencies who provided chronologies and contributed to both the strategic panel and the practitioner learning event can be found in **Appendix B.**

2.10 John's lived experience has been analysed by applying an evidence-based learning lens. This means that the learning from both research, national guidance, policy, and key findings from previously published SARs has been considered and referenced where pertinent to do so. This approach supports the identification of systemic barriers and challenges which impeded safe and effective practice.

2.11 This review is also strengths-based, and as such seeks to simultaneously identify areas of effective and/or innovative practice which should be further replicated across the system to strengthen existing safeguarding practice.

3. Review Author

An Independent author, Nikki Holmes, was commissioned to lead the review and author this final overview report. The author is an accredited Independent Reviewer, criminologist, and independent safeguarding consultant, with extensive expertise of working operationally and strategically within Children's and Young Adult Services. She has extensive experience in the field of Adult Safeguarding which includes knowledge of financial and domestic abuse.

4.Family Composition and Key Relationships

John was a white, British male. He was born in Berkshire and grew up in the Jack Wood area before moving to and settling in the Bexley area.

Although he lived alone at the time of his death, John had been married and divorced, and was the father of four children; three daughters and a son.

It is apparent that John had what appeared to have a complex relationship with his family, particularly with his three daughters which had cumulated in lengthy periods of estrangement. Whilst records suggested that he had a closer relationship with his only son, who until the few months before his death was documented as his Next of Kin, there is some evidence to suggest that his son may have played an active role in orchestrating the alienation of other family members, thus isolating John from his daughters for protracted periods of time.

During this review, John's son is referred to as Daniel. His daughter who played a pivotal role in providing care for him towards the final months of his life, is referred to as K.

5. Family Involvement

The involvement of family, friends and the people that knew the person at the centre of the review, is vitally important. In the case of John, talking to family and those connected to him required particular sensitivity.

Given the complex and somewhat fractured family dynamics, the review author and panel gave careful consideration to how best engage with the family in a way that does not cause any further distress or familial divide. Prior to John's death, in November 2023, John has requested to his GP that all contact regarding his care and support needs must be made with one of his daughters, K. It was determined that John had capacity when he made this request. As such, the decision was made to make initial contact with his nominated daughter to inform her of the review process.

His daughter was fully supportive of the review process and expressed a wish to contribute. It should be noted that she wished to express her gratitude towards her father's GP and in particular the candour they showed after his death, stating "*They really cared and the support they gave me after my dad's death was amazing. They know there are things that could have been done differently, but they held their hands up straight away and that means a lot.*"

Her valuable contribution to the review process illuminates the Machiavellian nature of financial abuse and its far-reaching consequences, not just on victims, but their families. At the

time of John's death, he was over ten thousand pound in debt, as a direct result of the money that had be syphoned from him, silently and insidiously, over the years.

The emotional and psychological impact of financial abuse should also not be overlooked. John's daughter shared how when the financial abuse had been identified, she visibly saw a shift in her father's demeanour;

"I always remember he started to sing again. He wasn't scared anymore. He had food in his cupboards, and was putting on weight. Although he was poorly, his health did improve a bit. It's just heartbreaking that so soon after what Danny did was uncovered, my dad died. But I am happy that I got to hear him sing again."

6. Chronology and Key Learning Episodes

6.1 This review focuses on **three** key episodes which are periods of John's life which have been identified as being significant to understand practitioner involvement and systemic strengths and areas of challenge.

6.2 Therefore, as above-mentioned, this review does not encompass every element of John's life but is representative rather, of the most key actions and activity, which have been considered as the most helpful to highlight, as part of the wider review and learning process.

7. Key Learning Episode 1: 8th June 2023- 5th July 2023.

This episode is focussed on the point of John's life where his son, who was providing the majority of his care at this time, began to raise concerns in relation to his father's safety and escalating health needs. This Key Learning Episode also seeks to examine and understand how effectively agencies were attuned to potential risk and indicators of harm, and their understanding of disguised compliance.

7.1 It is documented within GP records, that in March 2023, during a routine annual medical review, that John's son Daniel was recorded as his Next of Kin and emergency contact. Records show that Daniel presented as being invested in his father's care; frequently accompanying him to medical appointments, despite not living locally, and keeping in regular liaison with the GP and other professionals involved in his father's care via telephone and text.

7.2 In early June 2023, it was apparent that John's care and support needs were escalating due to a deterioration of his physical health. At this time, John appeared to be relatively isolated. He was not in contact with his three daughters or wider family members, and much of his day-to-day needs were being provided solely by his son, Daniel who lived an hour and a half away from his father.

7.3 In addition to the support that was provided by Daniel. John was also supported by carers, who, at the time of his death were attending to John in his home three times daily. He also received support from a social care assistant and practitioners from the Bexley Memory Team.

7.4 Daniel expressed particular concerns to John's GP in relation to the fact that John continued to drive despite his significant memory problems. He also informed the GP that he was worried that John was misusing his prescribed inhalers and asked for the contact details of Adult Social Care. There is no record of Daniel being provided with the contact details he

requested, or the GP contacting adult social care directly at this time to convey the concerns that had been raised.

7.5 Similarly, the concerns raised in relation to John's insistence on continuing to drive, despite potentially not being fit to do so, were not responded to. Daniel was advised to make contact with the Driving and Vehicle Licensing Agency (DVLA), but it is not clear if the DVLA were ever informed of the potential risk that John posed to himself and others by continuing to drive. In fact, all agencies appeared to have overlooked the potential harms associated with John continuing to have access to a vehicle and did not give adequate consideration of John's fitness to drive despite his complex, intersecting and worsening health conditions.

7.6 Records indicate that some of John's care and support needs were not always met, and that his complex medical needs were not consistently managed. One such example of this pertains to a GP record from the 9th June 2023, which highlighted that John had missed three appointments to discuss recent scan results which indicated the presence of Alzheimer's disease. Whilst the GP ensured that contact was promptly made with Daniel, there is no evidence of any consideration being given to the fact that John had been identified as being unfit to drive and so may have been completely reliant on his son to take him to appointments. Additionally, there is no evidence of consideration being given to the fact that Daniel lived a considerable geographical distance from his father and had his own presenting health needs and a physical disability which may have impacted his ability to meet the escalating needs of his father.

7.7 John was referred to the Bexley Memory service to be clinically assessed following scan results that indicated the presence of Alzheimer's. He was due to be assessed on the 28th June 2023, however prior to being assessed, John was admitted to hospital on June 23rd due to an exacerbation of his Chronic Obstructive Pulmonary Disease (COPD).

7.8 John was hospitalised for a period of four days, during which time it was noted that he had become agitated, stating that he wanted to be discharged home and that he wanted to see his newborn grandson. This did not appear to prompt a professionally curious conversation about John's wider familial network which may have assisted with identifying additional sources of support for John, as well as gaining an understanding of the complex familial dynamics and how this was adversely impacting him.

7.9 One other factor which may have impeded clinicians on the ward exploring John's wider support and familial network, was the fact that his son was recorded as his Next of Kin on his acute patient record. There is no evidence of John being consulted whilst hospitalised, to ascertain if his son was still his chosen Next of Kin or if he had nominated a Lasting Power of Attorney with whom information relating to his medical needs and care should be shared. Additionally, there was no exploration of if there was any other family member or trusted friend that he would like to be informed of, and involved with, his future care.

7.10 Whilst John remained under admission, Daniel contacted the hospital and expressed concerns about his father's self-neglect. It is not clear from records how this was explored with John or how these concerns were communicated with community health teams and Adult Social Care to prompt further exploration and assessment.

7.11 The Bexley Memory service had scheduled a further appointment with John to undertake his memory assessment, post discharge on 28th June 2023. The memory assessment was unable to be completed due to John presenting as *"stressed"*. The cause of his stress was attributed

to his recent hospital admission, and there appeared to be no further contextual exploration to establish if there were other factors that were leading to John feeling worried and anxious. Both John's son and GP were informed of the reasons why the assessment was not completed, and a further appointment scheduled for the following week.

7.12 Two practitioners from the Bexley Memory service visited John at home to carry out his re-scheduled memory assessment on the 5th July 2023. During this assessment, it was deemed by the assessor that John lacked Mental Capacity[4], and despite concerns relating to John's ability to consent to the assessment process, a decision was made to complete the memory assessment in his "*best interests*"[5] to ensure that he was able to receive the care and supported needed without undue delay.

7.13 There was evidence of the nurse practitioners undertaking the memory assessment considering the issue of self-neglect. There is a clear record of John presenting at this time as clean and appropriately dressed and his home uncluttered, clean and well kept. John's orderly home and physical presentation did not align with the concerns raised by his son to a social care assistant the day before the memory assessment took place. He shared that his father "*will not wash, change his clothes or eat meals, despite encouragement from his long-term carer.*"

7.14 It is not clear if the practitioners undertaking the memory assessment had been made aware of the concerns raised by the social work assistant which may explain why this disparity between the concerns raised by Daniel and his physical presentation at the time of assessment was not considered, further explored and triangulated with John's carer.

7.15 During the assessment, the issue of John's ability to continue to drive was addressed. It was recorded that at this point, John's demeanour changed from "*jovial and friendly*" to commenting that he would "*drive his car in a river if he was made to stop driving.*" Following the assessment, the comments made by John were shared with his son, who confirmed these concerns, stating that he thought his father could potentially act out this threat. However, this did not prompt an exploration as to why driving was so important to John, or exploration of the places to which he drove, or indeed if he felt his car and ability to drive was a way to escape risk or threat of harm.

7.16 The completed assessment and concerns identified relating to John's lack of Mental Capacity were shared promptly with a social work assistant within Bexley Social Services. Despite this information being shared, the Mental Capacity section within John's electronic social care record was not completed. This means that social work assistants who later visited John, may not have been aware or sighted on John's fluctuations in capacity, and how this may impact not only his ability to consent to treatment and make decisions, but also increase his vulnerability and susceptibility to abuse.

7.17 It is not evident, from records reviewed, if the concerns relating to John's reaction in response to being advised to cease driving were shared with the social work assistant, or if

[4] Mental Capacity refers to a person's ability to make decisions, understand information and communicate their decisions clearly. Capacity may fluctuate, for example a person with dementia may find decision making easier at certain times of the day.

[5] Principle 4 of the Mental Capacity Act sets out that if a person as been assessed as lacking capacity, then any action taken, or decision made for, or on behalf of that person, must be made in their best interests.

John's response, coupled with his son's concerns, was considered as a potential safeguarding concern.

8. Key Learning Episode 2: 6th July 2023 – 28th August 2023.

This episode explores agency activity following John's memory assessment and focuses specifically on the efficacy of information sharing, and the identification of risk.

8.1 Following John's memory assessment, there was some evidence of good joint-working between the Bexley Memory Service and the social work assistant who visited John at his home on July 10th 2023.

8.2 The role of the social work assistant differs to that of qualified social workers, and as such, the two roles should not be confused. In the context of John's case, the social work assistant's role was to explore the practical support that John needed to continue to live independently and safely at home, whilst offering advice, practical support and signposting.

8.3 For context, the use of social work assistants provided by One Bexley, to support those with care and support needs, where their care is not deemed as "complex" or there are no identified safeguarding risks, is embedded in Bexley. Therefore, the fact that it was deemed as appropriate for a social care assistant to maintain oversight of John's case, as opposed to a qualified social worker from Adult Social Care, was due to the perceived absence of any safeguarding risks and the fact that John's needs were not deemed as especially challenging. This is despite the concerns relating to John's driving, and the disparity between Daniel's concerns relating to his father's self-neglecting behaviour and practitioners being unconcerned about John's physical presentation and living conditions.

8.4 One example of good, strengths-based practice identified from the joint visit carried out by the Bexley Memory Service and the social care assistant, was consideration of a referral to local community social groups and the Bexley befriending service[6]. Although this offer or support was declined by John, the exploration of supporting him to build community connections is perhaps indicative of practitioners understanding of the impact of isolation on emotional and physical wellbeing. Exploring community-based support and the available local service offer is of particular importance for individuals such as John, who have limited support networks, or family that live a considerable geographical distance away.

8.5 Whilst there is a record of the practitioners from the Bexley memory service discussing John's case at their internal team meeting the day after the joint home visit with the social care assistant was undertaken, it is not clear if the outcome of the home visit was shared with external agencies such as John's GP. Furthermore, it is does not appear that the social care assistant discussed the outcome of the joint visit with their supervisor or team lead to ascertain if John's presenting circumstances required oversight from Adult Social Care.

8.6 John saw his GP again on the 27th June 2023 due to breathlessness and hyperventilating which was attributed to his COPD which was exacerbated by John continuing to smoke. It is

[6] Bexley's Aging Well strategy sets out the strategic vision to support the broughs aging population by connecting elderly populations with their local communities. The Bexley befriending service forms part of the local service offer that aims to mitigate the adverse impacts of loneliness and isolation that disproportionately impacts elderly cohorts.

documented that John shared with his GP that he doesn't know why but "he gets nervous and starts breathing faster". The GP also recorded in the patient record that an increase in prescribed medication (Mirtazipine) was advised to "*help with anxiety panic attacks*".

8.7 The nervousness, stress and anxiety that John had disclosed whilst hospitalised, during his memory assessment and to his GP did not appear to be explored through a wider contextual lens to determine if these feelings were stemming from his medical conditions or triggered by external factors. At the practitioner learning event, this point was acknowledged with one professional sharing "*Whilst anxiety and COPD do go hand in hand, it is important we think of other things and issues that may trigger anxiety. It is clear now that because of his health, we were all focused on his medical presentation, and not thinking about what else was potentially going on.*"

8.8 John's health continued to decline due to exacerbation of his COPD, resulting in a further hospital admission on the 27th July 2023. Whilst on the ward, a detailed assessment of John's capacity was completed, and it was determined via this assessment that John lacked capacity to consent to admission. However, a *best interest's*[7] decision was made to keep him under admission, despite his objections.

8.9 Records indicate that John was detained on the ward under Section 5(2) of the Mental Health Act (1983), enabling him to be detained on the ward for a maximum of 72 hours for treatment.

8.10 What is not clear from records reviewed, is the underpinning rationale to explain why it was decided to utilise the Mental Health Act to keep John under admission, rather than considering making an urgent application for a deprivation of liberty[8]. There is no evidence of clinicians undertaking a balanced assessment of the most appropriate options available to restrict John of his liberty in order to administer the medical treatment that he required at that time.

8.11 Given that there was no evidence of John posing a risk of harm to others, no psychiatric review being requested, and no evidence of there being specific concerns raised regarding John's mental health in addition to his dementia, the review questions the appropriateness of the use of the MHA to detain John of his liberty under these circumstances.

8.12 Additionally, it is not clear if clinicians considered how John's liberty would be legally restricted should it have been necessary to continue administering medical treatment and intervention post the 72 hours under which he could be legally detained under a short-term section. (S5(2) of the MCA).

8.13 It was also documented in John's hospital record that he was subject to deprivation of liberty safeguards (DoLS). Yet, there is no evidence of either an urgent or standard DoLS

[7] The Mental Capacity Act sets out that care and treatment can be provided if a person lacks capacity to consent to treatment, provided that the administering treatment is demonstrably in their best interests. Treatment and care must be provided in a way that is least restrictive and is considerate of that person's rights and freedoms.

[8] Deprivation of Liberty Safeguards (DoLs) are an amendment to the Mental Capacity Act (2005). They are procedures prescribed in law when it is necessary to deprive of their liberty a resident or patient who lacks capacity to consent to their care and treatment in order to keep them safe from harm.

authorisation[9] being made or indeed, being in place for him at this time. Whilst the care provided by clinicians was in John's best interest, the absence of the legal framework for the Deprivation of Liberty was absent and therefore this meant this his hospital record was inaccurate. Such inaccuracy increased the propensity of some treating clinicians making decisions in relation to his care, against his freedom of choice, wrongly believing that there were keeping him safe and that his rights were protected..

8.14 As John spent a total of eight days in hospital, it would appear, that in the absence of DoLS being sought, that after the initial 72 hours post admission, John was being deprived of his liberty without a legal framework.

8.15 Due to the concerns identified in relation to John's capacity to consent to treatment, coupled with his declining physical health, which meant that John was likely to require further treatment ward, it would have been both proportionate and prudent for the hospital to also consider the need to seek not only and urgent DoLs authorisation, but consider the potential need to seek either an extension of urgent authorisations (which are valid for 7 days) or simultaneously apply for a standard DoLs application. This would have ensured that clinicians would have had a clear legal framework in place to support them to navigate John's complex needs in a way that is least restrictive and lawful. [10]

8.16 This episode in John's care, also perhaps raises the question of the legal literacy of clinicians, and their ability to interpret relevant primary and secondary legislation, into their assessment, thinking and decision making. [11]

8.17. Whilst still under admission, the ward upon which John was receiving treatment received a phone call from one of his daughters, who was enquiring about her father's wellbeing. This prompted John's son to call the ward and instruct them that no information relating to his father should be shared with her. This did not prompt an exploratory and professionally curious conversation with John or his son, about why information should not be shared. This would have been a useful juncture to further explore John's wider support network and ascertain his preference relating to his nominated Next of Kin and if he had a Power of Attorney in place.[12]

8.18 Daniel contacted the social worker assistant team whilst his father was still an inpatient, seeking advice about moving his father from Bexley to the area where he lived. The decision to move John from Bexley was possibly prompted by the fact that his sister had made enquiries with the ward about her father. At this point, no one agency was aware of the complex and concerning familial dynamics which might increase John's vulnerability, and consequently Daniel's decision to move his father closer to home was seen as the actions of a caring and

[9] There are two types of DoLs authorisations; namely urgent and standard. Urgent authorisations are granted by the "managing authority" namely the hospital or care home where the person is being cared for and last for 7 days. Urgent authorisations are appropriate when depriving liberty is an urgent requirement in order to keep a person safe from harm. Standard authorisations are made by *managing authorities* to the relevant local authority who then assess the appropriateness of the deprivation of liberty within 21 days. Standard authorisations may remain in place for 12 months and will be subject to regular review during that time.

[10] Deprivation of Liberty Safeguards. Code of Practice.

[11] Managing and supervising legal literacy in social work. An evidence scope. Bray, S. Preston-Shoot, M. Research in Practice.

[12] A power of attorney is a legally binding document that appoints a person to be an "attorney" to make decisions on behalf of an individual that no longer is able to make or communicate their own decisions.

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loving son, as opposed to a direct ploy to isolate and exploit John. However, the review questions why John's views regarding relocation were not actively sought at the first appropriate opportunity.

8.19 John was discharged home on the 7th August 2023, and a discharge summary was promptly sent to his named GP. The summary received was focused solely on relaying details of John's medical complexity and treatment provided and made no mention of Daniel's explicit request to not give out information pertaining to John with any other family members. This meant that the GP was not sighted on family conflict and discord, which curtailed their opportunity to be professionally curious and consider potential safeguarding issues. **(Recommendation 1)**

8.20 John received a formal diagnosis of Alzheimer's from the Bexley Memory Service on the 22nd August 2023. The need for him to cease driving due to his declining cognitive ability was discussed with him again causing considerable distress. It was evident that John saw the inability to drive as a curtailment of his independence which he valued so dearly. It is recorded that John shared that if his driving license was rescinded, he "*would end his life*", but denied suicidal thoughts. The Bexley Memory Service made the GP aware and made a referral to the Home Treatment Team. Despite John expressing that he would end his life in the event that his license would be rescinded, this did not appear to prompt agencies to consider if it was appropriate for John's case to continue to be managed by the social care assistant team.

8.21 Whilst exhibiting upset and distress in response to being advised to stop driving may be viewed as rational and valid, John's response to this advice and direction was particularly strong. Therefore, the review questions if professionals should have been more professionally curious, to ascertain why driving was so important to him, and to identify the places he was perhaps worried that he would no longer be able to visit. Importantly, there was no recognition of the fact that an inability to drive would mean that John was more isolated and alienated from his community, which may render him more at risk of abuse and exploitation.

8.22 At this appointment, it was also recorded that his son had contacted the Local Authority Housing team, to explore the possibility of relocating his father closer to him. This appeared to be taken at face value, and plausible given that John's health was in rapid decline; and his son who remained his main source of support at this time, lived some considerable distance away. However, this may have been an attempt by John's son to further alienate John and isolate him from other family members, such as his daughter who had recently enquired about John's wellbeing during his most recent hospitalisation. As this information had not been shared with other professionals involved in providing care for John in the community, they were not sighted on this information and overlooked the potential indicators of coercion and control.

8.23 This review has found consistent evidence of there being prompt assessment and joint working. For example, following the diagnostic appointment on the 22nd August, the Bexley Memory Service undertook a joint visit with the Home Treatment Team just two days later. During this appointment, it was noted that John had received a letter regarding an overdue bill for his care package, for which he was in receipt. Attending practitioners made immediate contact with the council and made them aware of John's Alzheimer's diagnosis. This debt was perhaps the first red flag of financial abuse. However, this appeared to be viewed through the lens of John struggling to independently manage his finances as opposed to a possible indicator of him being financially abused and exploited.

9. Key Learning Episode 3: 29th August to date of death.

This key episode is focussed on how agencies responded to concerns and familial complexities.

9.1 The first contact the police had with John was on the 30th August 2023, who visited him at home after being contacted by his son, who expressed concerns for his welfare. Concerns raised by Daniel, in response to John allegedly having told his son over the phone that he "*wanted to drive his car and kill himself*." When police attended, John appeared confused, about why Daniel had called the police, denied making that comment to his son, and informed them that he had a visit from social work assistants who had made comments about moving closer to his son, to which he responded he would "*top himself*" if he was relocated. John denied suicidal ideation or thoughts, stating this remark was "*flippant*".

9.2 The police response to this incident was robust. A Merlin report[13] was created due to concerns in relation to John's welfare and assessed by Bexley Adult Multi Agency Safeguarding Hub (MASH), resulting in a decision to refer the report to Adult Social Care.

9.3 Upon receipt of the report, Adult Social Care triaged the referral, and passed the information to the Memory Team that was continuing to support John and to the Complex Care Seniors team for information only. The fact that this referral did not lead to a formal assessment of John's escalating care and support needs, or a multi-agency discussion was a missed opportunity to identify new and emerging safeguarding risks.

9.4 John's response to the thought of being moved closer to his son seemed to be alarming and disproportionate, given that Daniel would often purport during conversations with professionals, that he enjoyed a close relationship with his father. This disparity was perhaps the strongest indicator of the relationship between John and Daniel being problematic and potentially abusive. A detailed formal assessment or multi-agency discussion would have provided a reflective forum whereby this may have been further discussed, debated, and explored.

9.5 The decision making at the "*front-door*" is perhaps also indicative of the fact that the intersect between the well-evidenced increased risk of suicidality following a diagnosis of dementia was not known or fully understood by practitioners completing the triage process. [14] **(Recommendation 2)**

9.6 Whilst a diagnosis of Alzheimer's does not automatically exclude a person from being able to drive, several concerns had been raised regarding John's ability to drive safely due to his cognitive decline and deafness. There is evidence that he either did not heed or understand professionals' concerns and continued to drive regardless. The GP received notification from the Queen Mary's Hospital respiratory unit, on the 1st September, informing them that John had driven himself to and from the hospital when acutely unwell, and refused to visit an Emergency Department for further tests despite them advising him to do so. It is not clear from records

[13] Officers working within the Metropolitan police service create Merlin reports to record and share concerns about children or missing persons and vulnerable adults with partner agencies. The purpose is to safeguard the public and assess any risks or harm to the individual

[14] Alothman D, Card T, Lewis S, Tyrrell E, Fogarty AW, Marshall CR. Risk of Suicide After Dementia Diagnosis. *JAMA Neurol.* 2022;79(11):1148–1154. doi:10.1001/jamaneurol.2022.3094

reviewed if this information was shared with Daniel, community health teams or indeed the DVLA by the GP.

9.7 When a person continues to drive against medical advice, their GP may provide their relevant medical information to the DVLA, without their consent, provided they have informed their patient that they have done so writing. This does not appear to have been considered by the GP at this time. This meant that the opportunity for the DVLA to undertake a formal assessment of John's fitness to drive was missed. **(Recommendation 3).**[15]

9.8 When consulting with John's daughter for the purpose of this review, she shared that despite Daniel raising concerns in relation to her father continuing to drive, she learnt that money had been taken from her father's account to purchase a used car to the value of approximately three thousand pounds and that this purchase had been made by Daniel. She felt that if professionals had been more professionally curious, they may have queried this which may have been an early indicator of financial abuse.

9.9 During this period of John's life, Daniel appeared to become increasingly concerned about information relating to John being shared with other family members. In mid-September he made contact with the GP explicitly instructing them not to share information with other family members. However, the reasoning behind this request was again not explored with Daniel, or most importantly with John.

9.10 Sadly, John's physical health continued to worsen, resulting in a further hospital admission on the 29th September 2023 due to his COPD and heart failure. Upon arrival to the Emergency Department where he was conveyed by ambulance, he disclosed; "*something happened with my son which is why I came to hospital, I can't remember*." It is acknowledged by the review, that upon arrival, John was acutely unwell and addressing his presenting medical needs was paramount. However, when settled and stable on the ward, this statement should have been explored with John so that clinicians could be satisfied that John had not been alluding to an incident that may have raised safeguarding concerns.

9.11 The day after admission, John's son raises a complaint with clinicians on the ward due to his belief that they were "*giving information to non-authorised people*". This is further evidence of Daniel being anxious about the interest in John's wellbeing being expressed by other family members.

9.12 Whilst John was under admission, Daniel also requested that a mental health referral was made. It is not evident from the records reviewed, if clinicians explored the factors that underpinned this request, or if a referral to mental health services was indeed made. Whilst treating clinicians did raise concerns in relation to John's lack of mental capacity, there is no evidence of any concerns being flagged in relation to his mental health, indicating an absence of mental illness. This was further evidence of the disparity between Daniel's "concerns" and the observations of professionals providing John's care.

9.13 Prior to discharge, due to John's declining health, a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)[16] was made by John's healthcare team. It was recorded that at the

[15] The law on driving and dementia. Alzheimers.co.org.uk

[16] A DNACPR decision provides clinicians and care professionals with clear guidance in relation to how to act if a person has a cardiac arrest or dies suddenly. .

time of undertaking the assessment, John appeared to lack capacity to understand and participate in the assessment.

9.14 In cases where a person lacks capacity to be involved in making decisions about life-sustaining treatment options, a doctor may make a medical decision in a person's best interests. However, in advance of doing so, clinicians should also check if their patient has a Lasting Power of Attorney or Advance Decision to Refuse treatment in place, and ask other professionals involved in the provision of care for their views to support decision making. These checks and balances do not appear to have been carried out, which meant there was a further missed opportunity to ensure that John's rights and wishes were represented by a person of his choice who has been bestowed the legal power to act on his behalf. **(Recommendation 4)**

9.15 Daniel was first informed of the DNACPR decision via a text sent from the GP following John's discharge from hospital on the 5th October 2023. The GP had booked a telephone appointment to discuss further. The General Medical Council set out clear guidance in relation to how discussions relating to future life-sustaining treatment should be approached with patients and those closet to them. The GMC are explicit that discussions should "*include a sensitive and careful explanation that the intention is to spare the patient treatment that will be of no benefit, not to withhold any other care or treatment the patient will need."*[17] The review, however, finds that contacting patients' relatives via text to inform them of a DNACPR decision lacks the level of sensitivity required. It is important to note that the GP practice contributing to this review acknowledges this and has identified this as key single agency learning.

9.16 The review also questions the appropriateness of utilising telephone appointments to discuss sensitive and highly emotive topics such as DNACPR decisions. John was audibly present in the background of the call, and it was documented that he *did* want to be resuscitated in the event of cardiac arrest. Whilst this was recorded by the GP, no face-to-face appointment was held with John to further understand his views and wishes and to ensure he understood the rationale behind the DNACPR decision that was made.

9.17 Daniel continued to raise concerns about his father's inability to cope alone at home, whilst continuing to advocate the need for his father to be located closer to him. There is clear evidence of the social care assistant being proactive in responding to Daniel's concerns and seeking solutions to ensure that John's care and support was increased to align with his escalating needs.

9.18 The social care assistant promptly requested an increase to John's care package, which was granted, enabling him to receive an uplift in care and support from his existing care agency three times a week commencing from the end of October 2023. Interestingly, despite requesting and initially agreeing to the additional help and support, Daniel objected to the introduction of a new carer in addition to John's regular carer with whom he had a good rapport. During conversations with John's daughter for the purpose of this review process, she flagged this as an indicator of abuse, which again had been overlooked, stating that she is aware that her father's main carer was also being "*coerced and used*" to financially exploit her father, hence why Daniel was concerned about the presence of a new carer who may spot the signs of financial exploitation, coercion and control. It should be noted that there is

[17] Treatment and care towards the end of life: good practice in decision making. The General Medical Council.

no suggestion that the carer is involved in any criminal wrongdoing, but rather was potentially also a victim.

9.19 It was noted that during one carer's visit on the 16th October 2023, that the carer was unable to carry out John's food shopping as he had no money available for food and "*sometimes runs out*". This observation did not prompt any further exploration of why John was running out of money or the impact that the lack of access to nutritious food would have on his fragile health. This information, whilst documented, was not shared with any professional or agency connected with John, which curtailed a multi-agency lens being applied.

9.20 This was perhaps the biggest red flag of financial abuse, and thus, an immediate referral to Adult Social Care would have been a proportionate and necessary response to allow for additional enquiries to be carried out. The fact that a referral was not considered nor made, highlights that financial abuse and exploitation was not considered. **(Recommendation 5)**

9.21 John's GP first became aware of the existence of his daughters and wider family members at the end of October 2023, during a home visit to treat a leg wound. During the visit, John received a call from one of his daughters, T, who spoke via phone to the GP. During this brief conversation she explained that Daniel had been withholding information from the rest of the family and she was unsure of if Lasting Power of Attorney was in place.

9.22 The GP also received contact from John's daughter K, in November 2023. She informed the GP that she had become the main carer for her father as she lives locally and had recently resumed contact with him after 16 years estrangement. It is also recorded that K shared that Daniel had actively prevented her from seeing her father. Again, this did not prompt any professionally curious conversations about John's family dynamics or consideration of who, if anyone, was able to act as John's legal proxy.

9.23 Initiating an exploratory conversation considering the information received, may have helped avoid the situation that occurred towards the end of November 2023, which involved prescriptions for John's medication being rejected by the dispensing pharmacy due to multiple prescriptions being requested and issued to various family members. In response to this, the GP placed a note on the system, to state that no information was to be provided to anyone other than Daniel.

9.24 Despite evidence of familial fracture, conflict and evidence of intentional and purposeful alienation and isolation of John, a referral to Adult Social Care was not considered. The decision to continue to share information, with Daniel led to John being further isolated, allowing Daniel to continue to financially exploit his father away from the gaze of concerned family members.

9.25 Whilst the opportunity for multi-agency assessment of John's case and circumstances was missed; positively, the GP did consult John, asking him during a scheduled home visit on the 24th November 2024, who he would like to have contacted about his care. It was clearly documented that during the conversation, John appeared to be capacitous, and was clear that he wanted his daughter K, to be contacted and recorded as his Next of Kin. Providing space to listen to John and capture his voice is an example of person-centred practice.

9.26 During the aforementioned home visit made by the GP, it was documented that John was still presenting as "*anxious and panicky*". There was no contextual exploration or deeper enquiry into what was triggering these feelings; instead, these feelings were attributed to be

symptomatic of his diagnosed complex medical conditions. John's daughter K, shared with the review that her father was often living in a perpetual state of anxiety, as Danny would frequently let himself into his property with a key, and demand money from his father. It is entirely feasible that John's anxiety at this time, was associated with the fact that his daughters were now overseeing his care, and he was anxious about Daniel's reaction to this.

9.27 Although John's wishes were captured in relation to him requesting that his daughter K is recorded as his Next of Kin, it is not clear if this information was shared with other agencies, which meant that there was a risk that information relating to John was still likely to be shared with Daniel, against his wishes. **(Recommendation 6)**

9.28 The review also concludes that given the complexity of family dynamics coupled with John's fluctuating capacity, it would have been advantageous and proportionate for agencies to consider the role of an Independent Mental Capacity Advocate (IMCA).[18] Even though John had voiced that he wanted K to be his first point of contact and listed as his Next of Kin, there was at this point, still no Lasting Power of Attorney nominated and in place. Furthermore, the tensions between family members were likely to be a huge source of stress to John, and there was evidence of the complex dynamics having an impact on the quality of care he had received. As such, an independent advocate would have been well placed to ensure that John's needs remained paramount and were not obscured by ongoing familial discord. **(Recommendation 7).**[19]

9.29 John's allocated Social Care Assistant first became aware of concerns relating to money being appropriated from John's bank account at the end of November 2023, when K informed them that John had informed her that Daniel had taken a sum of eight hundred pounds from his account. At this point, only Daniel and one of his carers had access to his bank account. The Social Care Assistant sought permission from John to view his bank statements, and identified some anomalies; namely PayPal transactions. John stated he was unable to remember telling K that Daniel had taken money from his account and was observed to become anxious. This did not prompt a safeguarding referral to the MASH, despite there being clear indications of financial abuse being present. Concerningly, during this visit, the issue of Lasting Power of Attorney was discussed, and John had shared that he wished K and Daniel to become Lasting Power of Attorney for wellbeing and finances. Given the concerns raised, this should have prompted further exploration to ensure that John was not nominating Daniel to maintain control of his finances as a result of coercion and control.

9.30 The fact that a safeguarding referral was not made at this point, despite evidence of anomalous transactions is an indicator that social care assistants do not have a sufficient or shared understanding of how seemingly day-to-day transactions may signify exploitation and abuse or why concerns of this nature should result in a referral to prompt further analysis and multi-agency assessment of risk. **(Recommendation 5).**

9.31 The lack of proactivity and further professional enquiry into the concerns flagged to the Social Care Assistant resulted in further funds being taken from John's account. K made further contact with the Social Care Assistant team to inform them that further transactions had been made, and that those transactions now totalled over two and a half thousand pounds. In

[18] IMCA's were introduced as part of the Mental Capacity Act (2005). Their role was to provide independent representation of those that do not have the support of family members or trusted friends.

[19] Smith L, Morton D, van Rooyen D. Family dynamics in dementia care: A phenomenological exploration of the experiences of family caregivers of relatives with dementia. (2022).

addition, the key code to allow her entry to her father's home had also been changed; suggesting that Daniel had perhaps made further attempts to isolate his father. K was advised to call the police and the bank, to cancel her father's cards. Whilst the review understands the rationale behind instructing K to contact her father's bank, given the ability to answer questions that the social care assistant may be unable to, placing onus and responsibility on K to make contact with the police is questionable, and a direct negation of the agencies safeguarding responsibilities.

9.32 The information shared by K with the Social Care Assistants Team was not shared with the GP, meaning that the formal review of John's Personalised Care and Support Plan[20] (which was carried out in December 2023) did not identify the presence of safeguarding concerns or vulnerability factors. This curtailed the opportunity for the GP to provide additional support to John and meant that his personalised care and support plan was not reflective of his level of vulnerability.

9.33 The GP only became aware of the concerns of financial abuse in mid-January 2024 when K informed them of the concerns that she had identified. There is evidence of the GP being proactive in documenting the information they had been furnished with, and making an immediate referral to Bexley's Single Point of Access. However, there appears to have been no multi-agency activity result from this referral prior to John's death.

9.34 K was provided with a financial assessment form by the social care assistant to complete due to receiving unpaid invoices from her father's care agency; further evidence of the mismanagement of John's finances by Daniel. Upon completing the form, and submitting copies of her father's bank statements, further potentially fraudulent transactions were identified. K contacted the police, who attended John's home on the 20th January 2024, one month before his death. It was recorded that John was *unable to account* for what had taken place. Subsequently, a fraud investigation commenced. However, due to John's death and therefore inability to bear witness, the investigation was not further actioned and did not result in an arrest or charge. Despite this, due to the evidence of fraud, Daniel was successfully placed on the National Fraud database.

9.35 Given that financial abuse rarely occurs in isolation and commonly co-exists with other forms of abuse[21], and was committed in a domestic context by John's son, it would have been beneficial for the attending police officers to carry out a Domestic Abuse Risk Assessment (DARA) in order to determine if John had been exposed to any other form of abuse and harm. This does not appear to have been considered. **(Recommendation 8).**

9.36 John sadly died suddenly at his home on the 16th February 2024.

[20] A Personalised Care and Support Plan is a record of an individual's need and preferences about their future care and support needs.

[21] Research and evidence suggests that up to 95% of domestic abuse cases involve financial abuse

10.1 Analysis by Theme (Terms of Reference)

Information deduced from the provided individual agency reports, discussions which took place at both strategic panels and at the practitioner learning event, helped to identify key learning themes.

The entirety of this review considers the factors that led practitioners to act as they did. In addition, the agreed key themes have been analysed.

The key themes of this review can be summarised as:

- **Factors that impeded practitioners and agencies' ability to identify potential indicators of risk and harm.**
- **Agency's recognition and understanding of the concept of disguised compliance.**
- **Agency's recognition and response to domestic abuse in the context of financial abuse.**
- **Agency's understanding of the interface between domestic abuse and dementia.**
- **The efficacy and reliability of information sharing.**

Each theme will be considered in turn below, with any learning clearly identified and a focus on the factors that led to practitioners acting in the way that they did.

10.2 Factors that impeded practitioners and agencies' ability to identify potential indicators of risk and harm.

10.2.1 The balance of independence with the provision of safe, effective care.

Safeguarding adults is a complex area of practice. The Care Act (2014) sets out the responsibilities of local authorities and partner agencies, clearly defining their roles in supporting adults with care and support needs who may be at risk of abuse and neglect. However, the act requires practitioners to walk somewhat of a tightrope; requiring them to protect adults from abuse and neglect whilst simultaneously "*having regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances.*" [22]

This balance and decision making may present as additionally challenging in cases such as John's *where* the capacity for decision making is dynamic and influenced by a range of factors such as the presence of dementia and cognitive decline.

This review found consistent evidence of practitioners placing paramountcy on respecting John's wish to remain independent, despite his rapidly declining health. Whilst empowering individuals to live their lives in the way they would like is central to The Care Act, enabling choice and control must be carefully balanced with the prevention of harm. In this case,

[22] The Care Act (2014)

professionals, despite the presence of "*red flags*", did not identify the presence of risk, perhaps due to mistakenly assuming that John's fierce independence, somehow reduced his vulnerability and the likelihood of harm.

In addition to John's desire for independence which influenced the way in which practitioners viewed risk, the general consensus and view of panel members and practitioners involved in this review process is that John's medical complexity obscured their view of factors that increased his vulnerability and the risk of being abused, exploited and harmed. The focus was very much on preventing the worsening of John's physical health, and the recognition that his health needs could render him more vulnerable to exploitation and harm, notably absent.

One pertinent example of this was the fact that his stress and anxiety which was observed and noted on several occasions was viewed as a symptom of his medical conditions, and not considered as an indication of the abuse that John was subjected to.

10.2.2 The intersect between dementia and financial abuse

A lack of consistent understanding of the intersect that can be found between dementia, reduced cognitive function and financial abuse was also a factor in this case. There is a body of evidence and research that sadly highlights how those with dementia are at an increased risk of being victimised in the context of financial abuse, and how that abuse may be perpetrated by close family members and those providing care in the community.

This may be due to those with dementia not being able to remember what has happened to them and being less able to manage their money independently. This may be further exacerbated by technological advancements such as mobile banking and chip and pin.

It is common for those with dementia to be seen as less credible when they do disclose worries or concerns. However, given the well-established relationship between dementia and financial (and elder) abuse, it is imperative that all practitioners, working in all sectors and levels, are cognisant of the increased risk of abuse faced by this cohort, and appropriately trained to respond consistently and proactively to any concerns identified, disclosed and shared. **(Recommendation 9)**

10.2.3 Legal literacy

The absence of legal literacy is a common theme in Safeguarding Adults Reviews (Braye et al., 2015a, 2015b; Braye and Preston-Shoot, 2017; Preston-Shoot, 2017**)**. Similarly, this review found some challenges in relation to practitioners understanding of terms such as *Next of Kin*, and what powers this affords a person in terms of being able to make decisions regarding a relative's care. Whilst a nominated Next of Kin, (normally a close blood relative, spouse or civil partner), can receive information in relation to a relative's medical care and treatment, the term Next of Kin has no legal definition in law. This means that nominated Next of Kins do not have any legal right or powers in relation to decision making regarding care and treatment.

This lack of legal literacy means that practitioners appeared to assume that Daniel, as John's Next of Kin, had the power to make decisions on his behalf and in his best interests, when in fact, he did not have the legal proxy to do so. One example of this, was when Daniel was insistent that John should be re-located away from Bexley so he was closer to where he lived. Given John's dementia diagnosis and declining capacity, there was a risk that this request would have been supported by professionals who mistakenly believed that Daniel had the

power to make such decisions for his father. This would have potentially increased John's vulnerability to abuse.

It also is apparent, that professionals are not consistently aware of the role of the Independent Mental Capacity Advocates and the important role they play in ensuring the needs, wishes and voice of those like John are heard, respected and responded to. For much of the scope of this review, John did not have a formally appointed LPA in place. This, coupled with the complex family dynamics meant that seeking the support of a IMCA would have been entirely appropriate.

The review also found evidence of some legislative confusion, leading to the potential inappropriate use of the Mental-Health Act (1983) to detain John in hospital for treatment when the use of DoLS would have been more appropriate. It is recognised however, that understanding the legal landscape is complex, and it is not uncommon for practitioners and clinicians to lack confidence in relation to legal knowledge.

One other example of a lack of legal literacy is the fact that at various points in John's life, his capacity was simply assumed, as opposed to formally tested. This increases the risk of assumptions being made about a person's decision-making ability which could mean that their wishes, views and rights are not upheld.

It is perhaps therefore, not enough to know the principles of core legislation such as the Mental Capacity Act. Training needs to equip practitioners with the skills and knowledge to appropriately apply the relevant legislation and procedural knowledge in a wide range of scenarios. (Hubbard, 2018). However, training alone is not sufficient to increase and sustain practitioner levels of legal literacy. The use of formal supervision and establishment of complex case management forums are also important. **(Recommendation 10)**[23]

10.3 Recognising and responding to disguised compliance (Disguised engagement).

Disguised compliance is a term that is most frequently used within the context of children's safeguarding and refers to parents and caregivers' apparent co-operation with safeguarding professionals in order to allay concerns and prevent the likelihood of further agency investigation or engagement. [24]

However, disguised compliance (also referred to as disguised engagement) also has relevance to those working to protect and safeguard adults. Those providing care for adult relatives may also appear to be co-operative with agencies in an attempt to keep them at arm's length. Subsequently, it is essential that practitioners are aware of this concept and are sufficiently professionally curious in order to avoid situations where risk is masked and factors that increase the propensity of harm remain overlooked and unaddressed.

Identifying actions and behaviour that may be indicative of disguised engagement presents particular difficultly. This was certainly the case in relation to John's son who presented as invested in his father's care and would frequently initiate contact with agencies and professionals.

[23] The importance of legal literacy in adult social care. Research in Practice. (Nov 2022).
[24] Reder, P., Duncan, S & Gray, M (1993) Beyond blame: child abuse tragedies revisited.

Practitioners involved in this review, recognised that they did not consider that disguised engagement may be a presenting factor and that they took John's son "*at face value*." One practitioner who met John's son described him as "*engaged and charming*" and reflected that "*because he was recorded as John's next of kin, and how he presented we just saw no red flags.*" It was also noted that John's son had his own physical disability; he was an amputee as a consequence of serving in the military, and this may also have been a factor that fed into practitioner bias and led to the formation of the view that he was unlikely to pose threat or harm.

Although it is acknowledged that John's son presented plausibly as a loving and caring son who wanted the best for his father, this review highlighted the presence of multiple red flags that did not prompt further reflection nor enquiry. This perhaps indicates that practitioners lacked awareness of the fact that vulnerable elderly individuals such as John, are open to abuse by family members who may isolate them so as to actively exploit them via fraud and theft.

The use of genograms[25] would have been helpful in John's case, to further understand the complex familial dynamics which may have led to Daniel's involvement being viewed through an altogether different lens. Practitioners contributing to the review process shared that current systems do not enable them to utilise genograms and eco-maps, despite some practitioners historically being able to. One practitioner shared "*not being able to create a genogram is absolutely a lost function. They were so useful at visually representing who was who, in a person's life*."

The efficacy of using genograms to promote an understanding of both children and adults is well documented in evidence and research. Genograms play a critical role in establishing the context and nature of relationships a person has with family members. In the case of John, utilising a genogram may have supported practitioners to identify the presence of a wider familial network, that would have prevented him from being actively alienated, isolated and estranged from his daughters. **(Recommendation 11).**

Given that identifying and responding to disguised compliance presents such challenge and complexity, a multi-agency approach is required in order to identify concerns and patterns of behaviour that may be indicated, when viewed through an accumulative lens, such as the presence of false reassurance and disguised engagement. This was lacking in the case of John. Many of the agencies involved in this review process held information that, in silo, did not necessarily indicate the presence of risk, but when combined with other concerns and sources of information, presented a picture of concern.

One way to perhaps mitigate the risk of overlooking risk indicators that may be masked by disguised compliance, is by developing a strong systemic culture of professional curiosity. Professional curiosity was lacking in professional practice examined as part of this review, and therefore, there is a need to ensure that professionals are reliably exploring every potential indictor of abuse and neglect and seeking to understand what life is like for the person in front of them, by exploring their routines, feelings and their perception of the world around them.

10.4 Agencies recognition and response to Domestic abuse in the context of financial abuse.

The Care Act (2014), defines financial abuse as *a violation of an individual's rights relating to their financial affairs or assets.* The term financial abuse is broad, encompassing acts of theft

[25] A genogram is a way that practitioners can visually map a basic picture of who their client/patient is and the role that family members and play in their lives.

and fraud, internet scamming, coercion, and the misappropriation of property, possessions or benefits. [26]

Financial abuse is also a legally recognised form of domestic abuse and is referred to as "economic abuse" under the current iteration of the Domestic Abuse Act (2021). The Domestic Abuse Act defines economic abuse as "*any behaviour that has a substantial adverse effect on ability to a) acquire, use or maintain money or other property or b) obtain goods and services.*"[27]

Whilst anyone can be victim of financial abuse, evidence and research consistently shows that individuals who have dementia or reduced cognitive function are more likely to be victimised. Furthermore, the risk of financial abuse increases with age and isolation. Despite John exemplifying all the factors known to increase risk, the increased likelihood of financial abuse was not considered by all those involved in providing his care.

Insidiously, financial abuse is most often perpetrated by a person acting in a trusted capacity, such as a friend, neighbour, care worker or close family member. This presents a set of complex challenges for professionals for two reasons. Firstly, victims may not be aware that they are being coerced, exploited and abused, and secondly professionals may be also reticent to challenge family members in fear of getting it wrong and causing irreparable upset and distress.

It is imperative that professionals are aware of the impact that coercive control has on the behaviour of victims, who may find it difficult to articulate the abuse and harm they have been subjected to, partly because they fear the consequences of doing so.

In addition, it should be recognised that financial abuse seldom occurs in silo and is likely to co-exist with other typologies of abuse and harm. As such, it is insufficient to simply respond to concerns flagged in relation to financial abuse; instead, other enquiries and assessments should be undertaken in order to identify other forms of abuse which may have been overlooked.

In John's case, the link between financial abuse and domestic abuse appears to have been ill-considered, evidenced by the lack of appropriate risk assessments, for example, a DARA, being carried out. It is vital that factors such as age and gender do not cloud any professional's view of the intersect between domestic abuse and financial abuse and extortion.

10.5 Agencies understanding of the interface between domestic abuse and dementia.

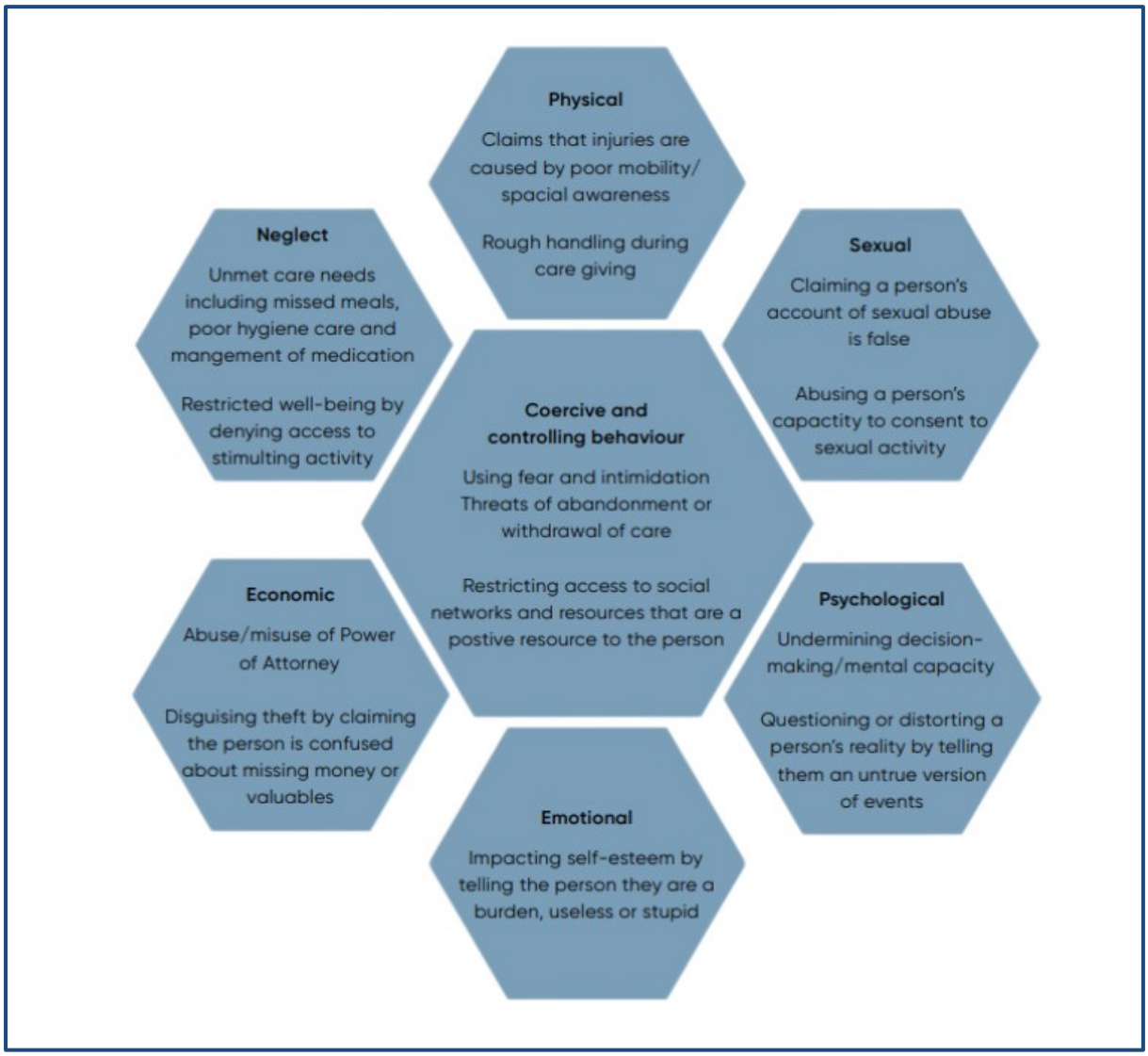
Anyone, of any age may be subjected to domestic abuse, and yet this is an issue that is often still viewed through a gendered and too-narrow lens. This is evidenced perhaps, by the fact that many risk assessment tools and specialist services have been designed to meet the needs of women experiencing abuse perpetrated by intimate partners. [28]

[26] The Care Act (2014) Section 42(3).
[27] The Domestic Abuse Act (2021) section 1(4).
[28] 7 Wydall, S. and Zerk, R. 2017. Domestic abuse and older people: Factors influencing help-seeking, Journal of Adult Protection,

In John's case, It did not appear that any one professional or agency considered that John could be a victim of domestic abuse, perpetrated by his son, and the absence of professional curiosity and wider contextual analysis of John's familial relationships, meant that D's behaviour was not considered as potentially indicative of coercive control.

The co-existence of dementia and domestic abuse is well established, although arguably still too poorly understood, and presents a complex area of practice. Therefore, it is essential that practitioners are well supported to understand how dementia presents as an ideal opportunity for perpetrators to exercise greater power and control over their victims, in a multiplicity of ways and the reasons and factors that may obscure the identification of vulnerability and risk. **(Recommendation 12)**

Figure 1:



Source: *Domestic abuse and the co-existance with dementia. Aberystwyth Univesity*

Furthermore, John's case perhaps was illustrative of how some perpetrators will purposely target a person's dementia, by undermining their mental capacity and autonomy, making decisions for them under the guise of those decisions being in their best interests, or purposely isolating them from their wider familial support networks and community connections. **(Recommendation 9).**

It is also not unusual for those that perpetrate abuse to have been nominated as a victim's attorney. As in the case of John, D was seeking Lasting Power of Attorney although this was not granted prior to his death. Given the issues of practitioner's legal literacy explored within this review, it is essential that practitioners across all sectors understand how to flag concerns and start the process of removing attorneys where there is evidence that they have abused their position of trust. **(Recommendation 10).**

10.6 The efficacy and reliability of information sharing.

It was observed during the scoping period that **opportunities for all key agencies to be involved in collaborative forums that allowed opportunity for reflection and shared discussion, were absent**, and consequently, no agency had a full, comprehensive understanding of John's lived experience and the risk and abuse he was subjected to.

This was likely the result of **insufficient information sharing**, which the review attributes to **systemic lack of understanding of the risk indictors of financial abuse**, and elder abuse.

This was particularly apparent in the social worker assistant team who, despite documenting clear evidence that suggested the presence of abuse, did not appropriately act on this information. Social Care Assistants in Bexley are not allocated safeguarding cases, and as such, are not in receipt of level three safeguarding adults training. **The review questions how practitioners, without the knowledge and skills that are learned via the delivery of level three training, are able to identify accurately and consistently, when cases have escalated into the safeguarding area, and therefore in need of social worker intervention**. As John's case illustrated, risks were not identified or escalated appropriately leading to John being exposed to ongoing financial abuse. **(Recommendation 13).**

Despite evidence of some proactive joint-working, **there appeared to be lack of an identified "lead professional"** to serve as a key point of contact for all other agencies and professionals, which perhaps contributed to no agency ever holding "all pieces of the puzzle" and being able to build a complete, contextual picture which reliably illuminated the full extent of risk.

11. Conclusion

Writing, this review elicited feelings of great sadness given that it is focused on the abuse, coercion and control of a frail, vulnerable man by his own son; A person that posed as someone who has invested in, and concerned with, his father's welfare. But as shocking as John's story may be, is not unusual. It is estimated that 16% of adults in the UK (equating to approximately 8.7 million people) have been subjected to economic abuse at some point in their lives. [29]

Despite front-line professionals being well placed to identify the indicators and red flags of financial abuse, as in John's case, it often remains undetected for years. As the author of the review, it was clear that there were multiple indictors that suggested that John was indeed the victim of financial abuse and domestic abuse; the deliberate isolation and alienation of him from other family members, his anxiety which was noted, yet insufficiently explored by professionals on several occasions, his escalating care and support needs, the lack of available money to purchase basic provisions such as food, the debt, and later the anomalies on his bank statements, totalling thousands of pounds.

Yet, despite the number of agencies involved in delivering John's care, the abuse was not identified, and only came to notice when his daughter K alerted them to John, who in turn alerted her to monies going missing. Consequently, the harm to which John was exposed, was never fully recognised, leaving him exposed to enduring harm and trauma in the final years of his life.

Therefore, this review has been focused on understanding *why,* despite the multiple indicators of financial abuse being in plain sight, professionals did not spot the signs.

It is necessary and fair to acknowledge that financial abuse can be challenging to identify, particularly when the victim lacks capacity or may not even recognise that they are being abused. In cases such as this, where the abuse is orchestrated by a close family member, an additional layer of complexity enters the equation; victims may be less likely or willing to disclose their abuse, and perhaps we, as professionals are more inclined to overlook abuse perpetrated by close family members, seeing it as "unfathomable".

This is why it is essential that professionals across all sectors are unconstrained in their view of who is likely to be a victim, and importantly, by whom it is likely to be perpetrated.

Information sharing is also key to assist with the prompt identifation of financial abuse. Despite the expansive network of professionals and agencies supporting John, no one agency had a full, complete picture of John's circumstances or a sufficient understanding of his familial dynamics, which may have assisted with the identification of risk and increased vulnerability. This was undoubtedly due to the absence of information sharing, perhaps hindered by

[29] The Fairness Group (2016).

practitioners underestimating the pertinence of the information and observations to which they had been privy.

Professional curiosity and "*disguised compliance*" were, as in the case of many reviews of this kind, factors that led to the late identification and response to concerns. It is evident that John's medical complexity and declining health obscured him from being understood in a full, holistic, contextual context. In turn, this ultimately led to the full range of risk and the extent of his vulnerability also not being known whilst John was alive.

As the author of this review, I did not get to meet John, as my role was to write the final chapter of his story after his death. That said, from the conversation I had with his daughter, I obtained a sense that John was a man with a strong moral compass; with a strong sense of right and wrong. Perhaps I deduced this from her telling me that despite D's actions, he was adamant that following his death, his money and belongings were still to be split fairly four ways, to reflect the fact that he had four children. I therefore, cannot help but feel that John would want this part of his life, to promote learning, to prevent harm coming to others in the way that it came to him.

Recommendations

Recommendation 1: All health professionals should be encouraged to review the London Care Record for patients with care and support needs, so that both acute and community staff can have an awareness of each other's involvement in the provision and oversight of care.

Recommendation 2: Bexley Safeguarding Adult Board should review the current training offer to ensure that practitioners who have interface with patients with dementia are cognisant of the increased risk of suicidality and diagnosis, and aware of where to signpost to seek appropriate support.

Recommendation 3: Assurances should be sought to ensure that GPs are aware of the need to inform the DVLA (and consider raising a safeguarding alert) when a patient's fitness to drive safely has been identified, and there is evidence to suggest that they and others are at risk due to their continuation to drive.

Recommendation 4: The Southeast London Integrated Care Board should consider the adoption and roll out of the ReSPECT programme to ensure that patients who lack capacity (or who have an immediate foreseeable risk of loss of capacity) have a summary of personalised recommendations in place to ensure that their wishes are upheld in the event of a clinical emergency.

Recommendation 5: Bexley Safeguarding Adults Board should review their current training offer, and further develop it as required to ensure that practitioners working at all levels and across all sectors have a sufficient understanding of the risk indicators of financial abuse.

Recommendation 6: Bexley Safeguarding Adults Board should ensure that there are appropriate processes in place to ensure that when a person has lost capacity having previously appointed an attorney for Health and Welfare, that information is shared with relevant agencies in the best interests of the person concerned.

Recommendation 7: Bexley Safeguarding Adults Board should ensure that practitioners from all relevant sectors understand the role of Independent Mental Capacity Advocates and seek assurance that referrals to them are being made in line with the MCA, particularly when there are familial disputes around the best interests of a person, safeguarding concerns or the person is unsupported and facing difficult decisions.

Recommendation 8: The police should ensure that due to the intersect that commonly exists with financial abuse and other forms of abuse such as domestic abuse, that when identified, the completion of a DARA is considered to support the prompt identification of other forms of abuse that may have been overlooked by other agencies.

Recommendation 9: It is recommended that Bexley Safeguarding Adults Board should consider the development of a toolkit which provides practitioners across all

sectors (including commissioned care agencies) with information and access to resources to improve their understanding of the relationship between dementia, elder abuse, domestic abuse and financial abuse.

Recommendation 10: Agencies should review, and where appropriate, update their offer or commission an appropriate provider to ensure that clinicians and practitioners are able to develop appropriate legal literacy skills and are able to apply complex legal and procedural knowledge in practice. Agencies should also ensure that their supervision offer consistently provides an opportunity to examine and discuss complex cases to further develop legal literacy skills.

Recommendation 11: The Southeast London ICB and Adult Social Care should explore with their respective providers of their electronic patient record systems, if there is scope for systems to be upgraded to allow for the use of electronic genograms.

Recommendation 12: Bexley Domestic Abuse services should consider the learning from this review and consider if the current iteration of the Domestic Abuse strategy requires further strengthening to support the understanding of the relationship between domestic abuse and dementia.

Recommendation 13: Adult social care should ensure that all social work assistants, are in receipt of level three safeguarding adult training, to equip them with the knowledge and skills to be able to identify safeguarding risks, that they may otherwise overlook.

Appendix A: Terms of Reference

Scope of the Review - The multi-agency review should consider the period between June 2023 – to Date of Death. In addition, relevant contextual information that pre-dates the scoping period should be considered.

Terms of Reference

1) Were opportunities missed to identify potential indicators of harm and risk?

2) What was the efficacy of intra and inter-agency information sharing?

3) How well does the system recognise and respond to domestic abuse in the context of financial abuse and within familial contexts?

4) How well do practitioners recognise the interface that exists between dementia and financial abuse?

5) Understand how well practitioners understand and apply the principles of the Mental Capacity Act.

6) Determine the efficacy and reliability of risk assessment processes.

7) How effectively do practitioners understand and recognise disguised compliance?

8)Identify areas of single and multi-agency good practice.

Key Learning Episodes

Key Learning Episode 1:
08/06/23 - 05/07/23 (Concern raised by son - diagnosis of dementia).

Key Learning Episode 2:

06/07/23 -29/08/23 - (assessment and information sharing)

Key Learning Episode 3:
30/08/23 – Date of Death. Agency response to concerns to familial complexities

Appendix B: List of Contributors

Role	Agency
Bexley SAB Practice Review & Learning Manager	
Bexley SAB Partnership Officer	
Deputy Director, Adult Social Care	London Borough of Bexley
Head of Safeguarding Adult Service	London Borough of Bexley
Designated Nurse, Safeguarding Lead	SEL Integrated Care Board, Bexley
Lead GP	SEL Integrated Care Board, Bexley
Safeguarding Lead SE BCU	Metropolitan Police Services
Safeguarding Lead	Lewisham and Greenwich NHS Trust
Safeguarding and Prevent Lead	Oxleas NHS Foundation Trust
Safeguarding Lead	Dartford and Gravesham NHS Trust
Registered Manager	Cameleon Care
GP	Bexley Medical Group
Quality Assurance Team Manager, Adult Social Care	London Borough of Bexley