

7 Recommendations

- Statutory partners will provide assurance to the SAB that findings and recommendations from the review are considered as part of the safeguarding procedures and processes review. The following will be considered: -
 - The definition and use of multi-agency strategy discussions.
 - The process for providing feedback to referring agencies who raise safeguarding concerns.
 - The Team around the Adult (TAA) model.
 - The importance of keeping GPs and other health professionals informed of meetings.
- Stockport Council working in collaboration with PCFT and NHS Stockport Clinical Commissioning Group, to review their joint guidance covering the arrangements for responding to safeguarding concerns.
- Statutory partners should report to the SAB on steps taken to develop a multi-agency financial abuse toolkit which provides comprehensive guidance for professionals on best practice in identifying and investigating indications of possible financial abuse.
- The SAB should bring to the attention of the Safer Stockport Partnership the findings from this review in respect of the identification and response to financial abuse, with a recommendation that consideration be given to approaching the Financial Conduct Authority (FCA) to explore the potential mutual benefits of supporting the FCA's work on strengthening the national arrangements to protect vulnerable adults from the risk of financial abuse.
- Partner agencies provide assurance to the SAB on actions taken to ensure agencies who are providing services to people with care and support needs, particularly those with dementia, have robust systems in place to:-
 - ensure their records contain up to date contact details for family members and agree arrangements on who else should be notified of appointments.
 - follow up any missed appointments, including exploration of any contributory factors which need to be considered when planning future contact.

6 Learning Points It is important to record the rationale for concluding that a person has capacity in relation to the management of their financial affairs.

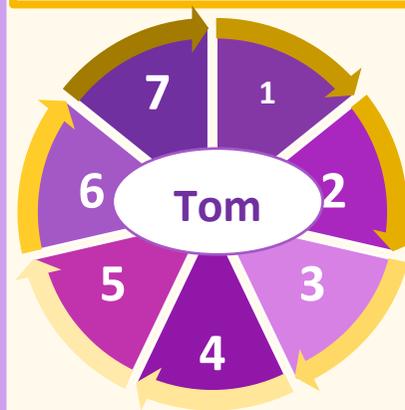
Most agencies identified learning, and included planned actions, to develop their staff skills in identifying possible indicators of abuse. The issues identified within the Individual Management Reviews (IMRS related to professionals: -

- not recognising the possibility of financial exploitation from the information supplied about the pooling of resources.
- not showing professional curiosity to probe the information provided by brother about his intention to apply for powers of attorney or accepting at face value his assertion that he already had obtained power of attorney without asking for verification of this.
- accepting at face value the assurances provided by Tom that he was happy with the financial arrangements, and not carrying out further visits to build a relationship and explore the situation further.

5 Review Process - It was originally anticipated that the review of this case would be carried out either as a Safeguarding Adults Review (SAR) or a Domestic Homicide Review (DHR) depending on the outcome of the police investigation. However, considering the outcome of the police investigation, it was agreed, after consultation with the Safeguarding Adult Board Independent Chair that the status of the review should be a Local Learning Review (LLR) which would be carried out using the standard SAR process.

1 Background

Tom was 63 years old who was diagnosed in 2018 with dementia. He lived alone with daily support from his brother including oversight of his medication and help in managing Tom's finances. Tom would also attend the Wellspring daily for his lunch, he was always well groomed and smartly dressed in combat dress; possibly a legacy from, and his pride in serving his country during his previous career as a Royal Marine.



2 Incident - Tom was a long-standing tenant with Stockport Homes for over 20 years. Several team members were involved at various points, particularly during the last 5 years of his life, in providing support in relation to the management of the tenancy or claims for welfare benefits. Ten days before Tom's death, safeguarding concerns were raised by his bank with Adult Social Care (ASC) and the police that Tom might be a victim of financial abuse by his brother who was taking Tom to the bank almost every day to withdraw large amounts of money from his account. An immediate police investigation concluded that there was no evidence of an offence having taken place. However, the police did have concerns about the brother's financial arrangements and a safeguarding concern was made to ASC, who forwarded information to Pennine Care NHS Foundation Trust (PCFT) for an allocated social worker to visit Tom to assess his capacity around managing his finances, and explore whether his brother was a suitable person to be a carer for Tom and whether both were receiving the financial and care support they were entitled to. This referral was passed to the appropriate Community Mental Health Team (CMHT) for further enquiries to be made but Tom died before the planned visit could be made.

4 Concerns

- Tom had been a potential victim of financial abuse. Initial concerns stemmed from the brother's significant interest in Tom's financial affairs and lack of response from Tom to attempts to contact him by Stockport Homes, and a subsequent text reply from his brother to say no further help was required.
- Tom's ability to manage and maintain his tenancy.
- Medication management and his inability to self-medicate.
- Lack of food in the house and Tom's alcohol misuse.
- Tom suffered with memory difficulties and was treated for Alzheimer's disease given the family history.
- Tom was considered to have capacity in relation to his support needs and finances, although no capacity assessment was conducted to support this rationale.
- Tom's brother was managing his finances due to his stage 3 dementia.
- The building society made a referral to ASC to report their concern that the brother may be exploiting Tom financially.
- Was Tom's brother working in his best interest? The building society's understanding was that there was a power of attorney in place but that this had not been registered with them.
- Concerns had increased when both brothers went into the branch to withdraw £2000. Both brothers had been attending the bank daily, seeking to withdraw £500 for the purchase of a car. After 2 withdrawals of £500 had been made, further requests were declined because of concerns about Tom being vulnerable due to his dementia.

3 Cause of Death - An investigation was carried out by the police because the circumstances of Tom's death were suspicious as he was found with significant injuries to his head and mouth. Following the review of all the evidence, which included further examination of issues relating to the management of Tom's finances, the decision was made that no charges would be brought against the brother. A post-mortem was initially unable to confirm the cause of death, this led to the pathologist identifying three main potential medical causes for Tom's death: -

- head injury
- epilepsy
- cardiac arrhythmia

The pathologist concluded that, on balance, the most likely medical cause of death was cardiac arrhythmia, also known as irregular heartbeat, where the heartbeat is too slow, or too fast. The head and facial injuries were believed to be historic.



7 Minute Briefing

Safeguarding Adults in Stockport