

**Safeguarding Adults Review – Executive Summary**

**Tower Hamlets Safeguarding Adults Board**

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

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Executive summary

Preamble

1.1 The purpose of all Safeguarding Adults Reviews is to keep the focus on learning and to prevent the reoccurrence of similar incidents/events. The final Safeguarding Adults Review report and those responsible for disseminating the learning from it should ensure that the recommendations can be translated into practice, not just for those involved but to a wider audience to support ‘prevention strategies’ and influence strategic plans.

1.2 It is not for a Safeguarding Adults Review to investigate how a death or serious incident happened. Neither is it the responsibility of the review to apportion blame.

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

Summary

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

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

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

Learning

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

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

3.3 Care planning did not make appropriate use of the Mental Capacity Act 2005, and workers did not undertake capacity assessments fully or at key moments in Mr V’s care and when one was undertaken the actions were not followed through.

3.4 The report also highlights further learning for health and social care agencies. In particular:

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

Recommendations

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

* The Making Safeguarding Personal programme
* Local safeguarding policies and procedures including PiPoT
* Information governance and information
* Next-of-kin
* Supervision
* Leadership behaviours
* Quality audits
* Mental Capacity assessments
* The casework recording system
* Working with relatives and family carers
* The use of an external organisation to assist social work staff in developing their practice
1. Section 14.121 Care and support statutory guidance

<https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance> [↑](#footnote-ref-1)