



Financial Abuse of People Lacking Mental Capacity

A Report to the Dawes Trust

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Summary

Introduction, aims and methods

Financial abuse is defined as harms that are perpetrated intentionally on victims by perpetrators to their financial benefit. Financial abuse of people lacking mental capacity is a complex phenomenon involving a wide range of possible victims and abusers who range from deliberate fraudsters to those who are misguided, ill-informed or incompetent in handling the victim's affairs.

Financial abuse of people lacking mental capacity is frequently hidden from public scrutiny and there is often little protection or redress for victims. This report addresses the nature, extent and contexts of such financial abuse and the relevant laws and safeguarding procedures.

The aims of the report and the methods used are summarised in the following Table.

Aims	Methods
Review recent knowledge regarding financial abuse of people lacking capacity.	Synthesis of findings from published sources - academic, professional and "grey", 1990-2016.
Estimate current scale and severity of problem.	Analysis of local and national statistics. Case study of a representative London Borough. Interviews with key personnel.
Characterise dynamics of financial abuse – motivations, justifications, & types of abuse.	Detailed analysis of a sample of Court of Protection cases
Make recommendations for research and policy.	Synthesis of all evidence gathered.

Previous findings

Since 1990 research on the abuse of adults has been carried out in a number of countries, but particularly in North America and Australia, as well as in the UK and Ireland. A survey of UK households, in 1992 indicated that financial abuse of older people was as common as the more widely recognised physical abuse.

In 2004, a major investigation into the prevalence of abuse in England and Wales, which included financial abuse, attempted to establish prevalence rates for older people, with capacity, living in the community. It concluded that around 0.7% of older adults in private households had experienced financial abuse by close family, friends or care-workers during the previous year.

Action on Elder Abuse, in 2007, suggested the 0.7% figure could be an underestimate, as the survey excluded two key vulnerable groups from its sampling – individuals living in residential care settings and those lacking mental capacity. Inadequate sampling of vulnerable groups lacking capacity is a continuing concern regarding the limitations of prevalence surveys. Prevalence has always been seen as an important research goal, because unless the scale of abuse can be ascertained, it is difficult to persuade policymakers of its significance. However, it is not clear how the obstacles to establishing prevalence can be overcome and additional ways need to be found in order to establish the case for action.

Since the 2004 England & Wales prevalence investigation, there has been little research in the UK on levels of financial abuse. During the 1990s and early 2000s research into financial abuse has continued overseas, especially in the United States. For example, the US National Elder Mistreatment Study in 2010 indicated rates of financial abuse experienced, but not reported, by older people of around 5.2%, mainly by family members. Researchers in Ireland in 2012 reported a lower but still significant prevalence of 1.3% for financial abuse, with adult children identified as the main abusers.

Current scale and severity

National sources

We found that official data collection in relation to financial abuse is undertaken neither systematically nor comprehensively, mirroring the fragmented way in which the prevention or containment of financial abuse is tackled generally – dealt with by different agencies, with different sanctions at their disposal. In particular, crime statistics do not help in forming a national picture of financial abuse of people lacking capacity because that particular form of abuse does not fit into the classificatory model for fraud used in compiling national crime figures.

However, although there are no useful statistics on overall prevalence of specific forms of financial abuse, there are statistics on aspects of the problem. Safeguarding individuals lacking capacity is a significant responsibility for local authorities and data on their safeguarding activities were an important source of information. From local authority returns (in the years 2013-15), it is clear that concerns about financial and material abuse constitute a substantial part of councils' safeguarding responsibilities. Such abuse was *third* most frequent in the list of categories for abuse related referrals across the country at around 20% of referrals, and was not greatly different in proportion from the first two categories (*viz.*, "neglect & omission" and "physical abuse") – all three of which are often interlinked. Given that financial abuse is generally regarded as an often hidden form of abuse, the fact that it comes to the attention of councils at all, is worthy of note. Around 40% of all cases were either substantiated or partially substantiated and 25% of those who were subjects of concluded referrals lacked capacity. However, we do not know from the statistics the extent to which redress was obtained or prosecutions pursued.

Voluntary sector organisations provide considerable support to individuals at risk of financial abuse and often encounter instances of actual or suspected abuse. One national voluntary organisation (Alzheimer's Society) found that in cases reported to its helpline, financial & material abuse constituted 26% of the total received, and ranked a close second to "neglect" (29%) out of seven categories of abuse. Nearly half of experienced Society staff interviewed suspected six or more 'money management' cases *annually* among persons they dealt with: but it is not clear that money management was code for abuse.

A case study of one London Borough

In the Borough used in the case study, Financial & Material (F&M) risk was the third most common type of abuse, at 20% of cases referred to the safeguarding authorities (after Neglect & Omission and Physical Abuse at 27% and 30% respectively) and this was consistent with the ranking across England as a whole. F&M cases constituted a fifth of all concluded safeguarding cases – similar to other boroughs in London but slightly above most other regions across England.

It is clear that financial abuse is an active risk facing certain sections of the population in the case study Borough, and it was present across age groups and ethnicities (although poor data makes it difficult to comment on ethnic composition in relation to concluded cases). Over half of the victims of F&M abuse were victimised in their own homes by a person whom they knew.

Over two thirds (69%) of those referred in relation to F&M risk lacked capacity, half being younger adults and the remainder being over the age of 65, including 2 individuals over 95 years. In terms of outcomes, in a third of concluded cases the F&M risk was substantiated or partly substantiated – but only a handful (5%) involved any police action.

Dynamics of financial abuse: Court of Protection case studies

Responding to concerns about the possible mismanagement of the financial affairs of individuals lacking capacity is one of the main responsibilities of the Office of the Public Guardian (OPG). We found that Lasting Powers of Attorney (LPAs) relating to financial & material affairs outnumber health and welfare LPAs substantially, and form the bulk of OPG investigations, along with cases subsequently referred to the Court of Protection (CoP) for revocation of LPA. Considerable sums of money and other assets may be involved. It is hard to judge how far fraud is a major trigger for the initial referrals received or the reasons for proceeding to full

investigation. A sample of 34 Court of Protection (CoP) cases was examined in detail and indicated the prominent role of intra-family disputes in the financial abuse of vulnerable people.

Most people named as attorneys in LPAs registered with the OPG are related by birth or marriage to the donors involved. The notion that family members are the best people to act as attorneys and be appointed as deputies (with close friends the best alternative) is embedded in court practice.

Analysis of the cases indicated that certain behaviours were associated with abuse and should be classified as *triggers* of suspicion while other behaviours were themselves abusive. Triggers included: failure to keep and provide accounts; care home arrears; and co-mingling of funds. Abusive behaviours included: gifting to self and others; incompetence; neglect and hoarding. The liability to pay for means-tested social care tempts families into illegal 'deprivation of assets', in which they unlawfully reduce their relative's funds, to avoid having to pay the full cost of social care.

Potential offenders may commit financial abuse of people lacking capacity 'because they can', but it is important to recognise the self-justifications that family members and carers give to feel more comfortable with themselves. These justifications include, 'entitlement' because of their status as a family member or because of the unpaid care work they are putting in or because they will inherit anyway and it is of more use to them now than later, or that the funds they 'deserve' may be eroded by care fees or death/inheritance tax duties to come.

In five cases, there were indications of police involvement but these mostly concerned incidents where disputatious family members had made allegations and counter allegations about financial abuse taking place – and these were not followed up by the police.

The CoP and the OPG have powers of investigation, but their legal duty relates to whether the law protecting those lacking mental capacity is being breached and whether those given power under the Mental Capacity Act 2005 to act for such individuals contravene that authority and/or fail to act in the best interests of those for whom they act. The civil court is the main conduit for redress – or at least for the recovery of what has been taken. The police and the crown prosecution service play very little part. This mirrors the experience of safeguarding teams in local councils where the police, although represented on adult safeguarding boards (and sometimes chairing them), pursue very few cases of financial abuse that the safeguarding process reveals. The police report that they are unable to follow up cases because, too often, the required levels of proof are not met or other priorities imposed by higher authority (such as the Home Office) take precedence. Revocation of an LPA and the appointment of deputies are the main means of protective intervention for the donor. Little beyond that generally happens to abusers.

Conclusions

The abuse of people lacking capacity often takes place in isolation, by trusted carers, friends or family members. Such abuse occurs at a significant level and is a pressing social issue which needs further serious consideration in policy and practice terms.

Key recommendations

- Improve statistical information made available from all sources to practitioners and policymakers in order to provide a clearer picture of the scale of the problem.
- Encourage greater knowledge-sharing and training across sectors to improve the safeguarding response to the problem of financial abuse.
- Strengthen the service provided by the OPG to people becoming attorneys to ensure they fully understand the scope of their responsibilities and duties.
- Initiate a public debate on how the law can better deal with those who abuse their mentally incapacitated relatives under the guise of acting in their best interests.

THE NATURE AND SCALE OF THE FINANCIAL ABUSE OF PEOPLE LACKING MENTAL CAPACITY

Introduction to the Report

According to the available evidence, the phenomenon of financial abuse is complex and the range of its possible victims extensive, with the abusers involved ranging from the devious and greedy to those who are misguided, ill-informed or incompetent. It is associated with several domains of discourse – among them moral, legal, psycho-social and administrative. Where people lacking mental capacity are the targets of the abuse – and the subject of this research report – it is too often hidden from public scrutiny and for many of its victims there is often little protection or redress. The abuse may be associated with intra-family relationships of obligation, rights and thwarted expectations, it may be linked to (misplaced) moral resentment or the exploitation of trust where so-called friends (and/or professional advisers) take advantage of vulnerable adults. It frequently relates to the way in which the law deals with matters of capacity and the structures and procedures which agencies of government establish to safeguard potential victims from the risk of harm.

In exploring financial abuse in relation to individuals lacking capacity (in particular older people with dementia, individuals with traumatic brain injury, those with learning disabilities and people with mental health problems), this report addresses these issues within the research framework set out in our original proposal and the stage one report already submitted to the Dawes Trust.

Sequence of the report

In the first chapter, we first set out the issues and the research background to our study, reviewing policy development from the mid-1990s to the present day and the impact it has had on the wellbeing of individuals lacking mental capacity who may be at risk of financial abuse. We look briefly at the range of research undertaken in the UK and elsewhere relevant to the particular concerns of the research¹ and go on to discuss the theoretical background to the study. We also consider the issue of definitions, from the general to the specific and from the moral and conceptual to the strictly legal and behavioural. We then set out the aims and methods of the research against the background of these preliminary considerations.

The second chapter constructs a national picture of the problem based on an analysis of statistics where they exist and consultations with experts from a range of professions involved with the issues of financial abuse and mental capacity, drawn from the judiciary, the law, local authority safeguarding professions and voluntary sector organisations.

A case study of one London borough follows in the third chapter, involving the analysis of local statistics and presenting the findings from interviews with local professionals. The fourth chapter examines a sample of Court of Protection cases in detail. During the course of the research it became apparent that such cases constitute a rich source of data, especially in relation to the part played by intra-family disputes in the financial abuse of vulnerable people and so we devoted additional time to examining its significance.

In discussing overall findings, the final chapter considers how far our knowledge of the nature of financial abuse perpetrated on people lacking capacity has been expanded. Can financial abuse be usefully classified and defined, and if so does this aid our understanding of the phenomenon? What have we learnt about the way in which safeguarding works to protect those at risk? We also consider the case for giving prominence to the issue of financial abuse as it affects vulnerable people (particularly those lacking capacity) in the field of public policy. The report concludes with a series of recommendations for practical activity around prevention as well as areas for future research.

Dr Gillian Dalley
February 2017

¹ The knowledge review contained in the stage one report submitted to the Dawes Trust in February 2015 considers this research in more detail.

Chapter 1

**ABUSE, FINANCIAL ABUSE AND INDIVIDUALS
LACKING CAPACITY: THE ISSUES**



CHAPTER 1

ABUSE, FINANCIAL ABUSE AND INDIVIDUALS LACKING CAPACITY: THE ISSUES

The idea of abuse

Within the context of society's duty to protect its citizens from harm, financial abuse is a sub-set of the wider phenomenon of abuse, which itself refers to the harms that are perpetrated often intentionally on individuals by other individuals to their own benefit (whether material or psychological or both). Such behaviour is characterised by asymmetrical power relationships, almost always involving the abuser as the dominant actor. Initial ideas about abuse in recent times tended to focus on the physical abuse of children but, as awareness about it increased, other types of abuse came to be acknowledged.

Child abuse (first referred to as "battered baby syndrome") was the earliest form of abuse recognised in modern health, social and legal policy as a social problem – with reports published first in the United States in 1962 (Kempe et al 1962) and in the UK a year later (Griffiths and Moynihan 1963). A decade after that, the abuse of women in domestic settings (Dobash and Dobash 1979) gradually began to be recognised (women were identified as victims of domestic violence or as "battered women") and the Domestic Violence and Matrimonial Proceedings Act was passed in 1976 in the UK.

During the 1980s, the idea of abuse or "battering" began to be applied to other victim candidates – older people in particular. In the UK, alerts by geriatricians based on their clinical experience (Bennett 1990), and social workers (Eastman, 1984) were early indicators of professional concern and in 1993 the Department of Health and the Social Services Inspectorate (DH and SSI, 1993) published guidance to local councils on protecting older people from abuse in domestic settings. That same year a charity for older people, Action on Elder Abuse, was established and became the focus for widespread campaigning on the issue. The charity defined abuse as: "a single or repeated act, or lack of appropriate action, occurring within a relationship where there is an expectation of trust which causes harm or distress to an older person"².

This growing awareness of abuse as behaviour which could affect a range of different groups of people in a variety of ways and which, it was argued, ought to be regarded as a public policy issue, prompted research and policy responses in the UK and internationally.

The research response: the emergence of the financial abuse of adults as an issue

The research response to the abuse of adults was widespread, particularly in north America (both USA and Canada) (Pillimer and Finkelhor 1988; Podnieks 1990), and Australia (Boldy et al 2002) as well as the UK (Penhale, 1993; Ogg and Munn-Giddings 1993). Initially, as with child abuse, the focus was primarily on physical abuse but gradually, as understanding of the phenomenon grew, the notion of abuse became differentiated, to encompass abuse by neglect along with sexual, psychological and financial abuse. In relation to the latter, for example, in an omnibus survey of UK households, Ogg and Bennett (1992) found as many reports of financial abuse as of physical abuse of older people – although research into financial abuse specifically was generally slower to take off than investigation into other forms of abuse. Langan and Means (1996), the authors of an exploratory study of financial abuse in relation to people with dementia in the mid-1990s, noted that research on the topic in England had so far been sparse.

However, concern about the abuse of adults, including financial abuse, grew steadily and attracted the attention of policymakers, practitioners, charities and academics. The House of Commons Health Select Committee (House of Commons 2004) looked at abuse relating to older people, regarding financial abuse as a particular risk. The Law Society (2013) issued practice guidance, Solicitors for the Elderly (2010) produced a strategy for aiding recognition of abuse, and Action on Elder Abuse (2006), in the voluntary sector, issued briefings on the topic. In

² <http://elderabuse.org.uk/what-is-elder-abuse/> (n.b. this definition, referring to abuse in general, does not require the intention to harm or gain benefit but emphasises 'trust')

the early 2000s, the then Public Guardianship Office (PGO) gave access to researchers looking at patterns of financially abusive behaviour in cases which the Office had itself handled (Brown et al 2005).

In 2004, a major investigation into the prevalence of abuse in England and Wales, which included financial abuse, funded by the Department of Health and the charity, Comic Relief, was conducted by researchers at King's College London and the National Centre for Social Research (O'Keeffe et al 2007). It attempted to establish prevalence rates for various types of abuse, including financial, of older people, with capacity, living in the community. While acknowledging methodological problems, it concluded that it was likely that 2.6% of older adults in private households experienced abuse by close family, friends or care-worker during the previous year (with 0.7% experiencing financial abuse, compared to 0.4% each for physical and psychological abuse).

Action on Elder Abuse (2007), however, suggested this could be an underestimate, citing its own data as showing a 5% general abuse prevalence rate. Moreover, the fact that the prevalence survey excluded two key groups from its sampling – individuals living in residential care settings and those lacking mental capacity – adds credence to the view that the King's College findings may have underestimated the prevalence of abuse (especially financial abuse) since care home residents are usually, by definition, people who may be vulnerable to abuse through general frailty and/or dementia, while mental impairment, independently, is an accepted risk factor for abuse. This underscores a continuing worry among researchers about the limitations of prevalence surveys. Prevalence has always been seen as an important research goal because unless the scale of abuse can be ascertained, it is difficult to persuade policymakers of its significance. However, it is not clear how these obstacles can be overcome and that additional ways need to be found in order to make a case for action.

Since the prevalence investigation, there has been little research in the UK, especially into financial abuse. Two major programmes of research relating to older people and ageing have been funded by the national research councils over the past twenty years but the study of abuse was not well represented. The first, 'Growing Older', comprised 24 separate projects, funded by the Economic and Social Research Council (ESRC) and ran between 1999 and 2004. The second, 'New Dynamics of Ageing' (35 projects), was jointly funded by the ESRC and the four other national research councils (MRC, AHRC, BBSRC and the EPSRC)³ and ran over a period of 8 years between 2005 and 2013. Of the 59 projects funded by these two programmes, only one investigated the issue of financial abuse (which was undertaken by members of the Brunel team undertaking this present project). The ESRC has, however, during the same period also funded a number of doctoral and other fellowships and projects including, for example, investigations of abuse of older people in care homes (Ash 2012) and the management of money within relationships (Price et al 2010). Additionally, a research and policy review undertaken by researchers at the London Metropolitan University (Sharp-Jeffs 2015) into financial abuse in intimate partner relationships draws attention to a small number of projects undertaken in the last decade on this little-known aspect of financial abuse.

It is worth noting that there has been growing research interest in the links between financial abuse and cyber-crime (and other scams) (Levi al 2015) – a criminal phenomenon which is growing rapidly much to the concern of the criminal justice system and the criminological research community. We have chosen not to focus on this aspect of financial abuse in our research. Our remit was to investigate the financial abuse of individuals lacking capacity and while it is not impossible for cybercrime to affect them, we have concentrated on abuse that involves the perpetrators they are most likely to encounter (people known to the individuals either as kin, friends, acquaintances and informal carers) rather than investigate their vulnerability to cybercrime.

Overseas research

During the 1990s and early 2000s, more research into financial abuse was undertaken overseas, especially in the United States, much of it concerned with trying to establish prevalence and policy responses (Choi and Mayer 2000; Dessin 2000; Kleinschmidt 1997; Maccolini, 1995). This concluded that elder abuse, especially financial, was a significant and much under-reported phenomenon (National Center on Elder Abuse 1998). However research into abuse was not without criticism. The National Academies inquiry (Bonnie and Wallace 2003) into the state of research on abuse, reporting in 2003, described it as "largely descriptive and pragmatic, taking existing concepts and definitions used in practice and in statutes as given rather than deriving them from theoretical premises or hypotheses. The atheoretical nature of the research is reflected in the tendency to lump

³ Medical Research Council, Arts and Humanities Research Council, Biotechnology and Biological Sciences Research Council, Engineering and Physical Sciences Research Council

all forms of mistreatment within a single category". Its report went on to try to rectify this problem and included a substantial report looking specifically at financial abuse (Hafemeister 2003), which also acknowledged the poverty of intellectual debate in the field. He argued for a more rigorous approach to developing concepts and definitions relating to financial abuse, based on its specific and distinguishing characteristics in contrast to other forms, and comparing and contrasting theorising in related fields (such as child abuse and domestic violence) as useful ways of advancing research in the subject – an approach updated more recently (Jackson and Hafemeister 2010).

Despite the methodological problems noted earlier, research has continued. The National Elder Mistreatment Study - a telephone survey of a representative sample of 5,777 American older people aged 60+ – attempted to establish rates of abuse experienced, but not reported, by older people (Acierno et al 2010). Respondents reported overall rates of abuse (emotional, physical, sexual) or neglect at around 10% in the past year with another 5.2% relating to financial abuse by a family member.

In Australia, a number of universities have run programmes of research into abuse including financial abuse. For example, Monash published a report on the prevalence of financial abuse in 2010 (Wainer, Darzins and Owada 2010), having also published a review of the range of evidence available on financial abuse specifically (Lowndes, Darzins, Wainer, Owada, Mihaljic 2009). Its researchers have, more recently, investigated community attitudes towards the problem (Mihaljic and Lowndes 2013) as have researchers at Flinders University (Bagshaw, Wendt, Zannettinob and Adamas 2013). Kinnear and Graycar (1999) at the Australian Institute of Criminology raised the question of whether the abuse of older people within the family was a crime or a product of family dynamics, or both.

Elsewhere, researchers in Ireland (Fealy et al 2012) have reviewed the literature on the financial abuse of older people and others have reported on a prevalence study which found a 1.3% frequency for financial abuse, with their (adult) children identified as the main abusers (Naughton et al 2012).

The links between abuse and mental capacity

As we have seen, abuse has been an issue of concern for several decades and a component of the policy development that has taken place during that time has been related to the specific form of abuse that we are concerned with in this report, namely, financial abuse. There is a second object of our concerns – the *victims* of financial abuse. In this research we are concerned with people lacking capacity and have looked at the consequences of this in relation to their vulnerability to abuse. We use the term vulnerability although we recognise that it is a contested term – one which is now avoided in social work discourse (with the term 'at risk' taking over)⁴ although it continues in its importance in law. Dunn et al (2008) examine the tension between the use of the two concepts (risk and vulnerability) and their relationship to another conceptual dyad – empowerment and protection. They also consider how these issues relate to another aspect of the capacity/lacking capacity debate, that is, autonomous, supported or substitute decision-making (Law Commission 1995). Too much reliance on the notion of vulnerability may lead, they argue, to unjustified intervention by the law – but adopting an 'at risk' approach may disempower and reduce "that person's life to a series of risk factors that fail, first, to place him/her at the heart of the decision to intervene, and, secondly, to engage adequately with the experiences through which that person ascribes meaning to his/her life. We therefore use the terms 'vulnerable' and 'at risk' bearing these cautions in mind" (p 234).

Policy background

Community care was probably the most influential governmental policy to have affected those lacking mental capacity during the last three decades of the twentieth century. Its introduction followed decisions made in the 1970s to close the long-stay psychiatric and old age institutions and replace them with plans for older people

⁴ See for example - "The use of the term 'vulnerable' is not popular as it may suggest that all people with care and support needs are vulnerable and attaches vulnerability to people rather than looking at the risks that face them. To rectify this, SCIE and others have used the term 'adult at risk' " - SCIE (2014) *Adult safeguarding for housing staff: Guidance for local authority social care staff*, Guide 53.

and those with mental health, physical and learning disabilities to live in community settings (Dalley 1996). It was formally enshrined in law in the NHS and Community Care Act 1990 and resulted from a mixture of pragmatic decisions made by a government persuaded by the economic case for hospital closure, changes in medical and social care practice relating to the care of older and disabled people, and revelations of a series of scandals in some of the institutions involved. Most importantly, from the perspective of this report, the new policy was accompanied by a profound change in the attitudes of disabled people themselves and their supporters which placed the accent on greater self-determination and life in the community rather than in institutions.

Older people and dementia

At the same time, however, an awareness began to grow that poor and sometimes cruel care – along with other forms of abuse – could occur anywhere, not just in institutional care. Within this increasingly large group, older people with dementia were perhaps the single largest sub-group regarded as being at risk.

At the end of the 1990s, the government published statutory guidance (though not law) in *No Secrets* for councils in England (Department of Health 2000). That document, key official guidance up till 2014, defined abuse as “a violation of an individual’s human and civil rights by any other person or persons” and in respect of financial exploitation in particular, as “theft, fraud, exploitation, pressure in connection with wills, property or inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits” (Department of Health 2000: Section 2.7). In a general comment, Brammer (2015) notes that the tone and conceptual basis of the guidance is “located in a rights discourse and clearly influenced by the timely introduction of the Human Rights Act 1998” (p 3).

Learning disabilities

While *No Secrets* applied to all vulnerable adults, concern about the safeguarding of *younger* adults lacking capacity was less apparent during the period leading up to its publication and beyond. In the case of people with learning disabilities, the aim was to provide them with opportunities to be independent and enable them to live “ordinary” lives in the community rather than institutions (Towell 1988)⁵. The government white paper, *Valuing People*, published in 2001, made little direct comment on the issue of abuse and the duty to protect. Its approach to abuse and protection was to regard the issues as part of the government’s wider approach to protecting all vulnerable people, stating that people with learning disabilities deserved “at least the same level of support and protection from abuse and harm as other citizens” (p.93).

Mental health problems

In relation to people with mental health problems (other than those with dementia), there seemed to be as much concern about the need to prevent *them* from committing harm to other people through the application of the new Care Programme Approach (CPA) as there was to protect *them* from the risk of abuse by *others*. The National Service Framework for Mental Health (Department of Health 1999) outlined the role of the enhanced CPA as:

“an assessment of the nature of any risk posed; and the arrangements for the management of this risk to the service user and to others, carers and the wider public, including the circumstances in which defined contingency action should be taken.”

This might partly have been prompted by the occurrence of attacks on practitioners or members of the public during the 1990s, committed by people with mental health problems which were well publicised in the media (always ready to run alarming headlines) – notably, in relation to the deaths of Isabel Schwarz and Jonathan Zito (Health Education Authority 1997). These tended to exacerbate underlying worries about the risk posed to others in situations where people with mental health problems were left unsupervised in the community (Killaspy 2006) – although it may have been an indication of the relative lack of concern about the rights of people with mental health problems as a whole existing at that time.

⁵ This approach is currently reflected in: Warren, S and Giles, J (2013) *Ordinary life: the way forward*, Paradigm, which notes that people with learning disabilities should be enabled to take risks like other people and that there needs to be a change in the pervasive “belief expressed by some people that ‘community’ is a dangerous place and that the desire to ‘police check’ everyone that comes into the life of a person with learning disabilities” (p12).

Traumatic brain injury

For people with traumatic brain injury (TBI), most policy attention over the years has been given to improving prospects for post-trauma rehabilitation rather than taking steps to ensure they are protected from abuse. More recently, recognition of some of the sorts of risk that may face people with TBI has begun to develop. A paper in 2010 noted the lack of attention paid to the needs of people with TBI and stressed how important it was for health and social care professionals to inform themselves of the issues and problems faced by sufferers (Mantell 2010). It acknowledged the scarcity of information about and understanding of TBI and pointed out that those with TBI and its physical and cognitive consequences were likely to face various sorts of problems especially in relation to family and other social relationships. Abuse – financial abuse especially – was a significant risk:

“The poor memory and awareness associated with TBI mean that people with a TBI are particularly vulnerable to such [financial] abuse. Impulsivity can make them extremely susceptible to cold callers and they can build up debt on credit cards and catalogue accounts.”

It also noted that in the case of some of those with TBI, substantial sums of money may have been awarded to them as a result of accidents – making them particularly vulnerable to financial exploitation.

The Mental Capacity Act 2005

The mid-2000s saw a major development in the way in which the issues of vulnerability, risk and protection across all client groups were to be handled and this has had a significant impact on the way in which the law affects individuals in all four client categories which are the subject of this research. After a decade of discussion, starting with the report from the Law Commission on mentally incapacitated adults (Law Commission 1995), followed by the publication of *No Secrets* (the key guidance document on adult protection issues) in 2000, and an investigation and report by the House of Commons Health Select Committee into elder abuse in 2004, which drew specific attention to the risks of financial abuse, new legislation was enacted. The Mental Capacity Act 2005 gave new protections to vulnerable people, rethinking the concept of ‘capacity’ and establishing the Office of the Public Guardian (OPG) – replacing the old PGO (Public Guardianship Office) – and the re-structured Court of Protection. Under the Act, and key to the new approach, lack of capacity is seen as associated with an impairment or disturbance of mind, and lack of capacity may vary according to the situation under consideration, which means that it must be assessed each time a relevant decision needs to be made. Assessments cannot be made on a once and for all basis but must be specific to the issue about which a decision is to be made. Individuals should be supported wherever possible to make their own decisions, and where this is deemed not possible, ‘best interests’ considerations must always be central to the substituted decisions that are made.

In response to the advent of the Act, new structures for safeguarding adults were put in place at local (council) level with the establishment of adult safeguarding teams responding to referrals from a wide range of other professionals and members of the public – in short, whoever they are and wherever they come from. A consultation (Department of Health 2009) on a review of *No Secrets* nine years after its publication found widespread support among relevant agencies and professions (including the police, councils, housing authorities, the NHS, the Care Quality Commission) for the “direction of travel” and also support for adult safeguarding and adult safeguarding boards to be put on a statutory basis. It reported concern about terminology – suggesting the term ‘people at risk’ as a replacement for ‘vulnerable people’ and also noted that as far as was known there had been few prosecutions to date as the outcome of existing adult safeguarding processes.

Statutory provision for safeguarding adults from the risk of financial (and wider) abuse is now embedded in the Care Act 2014. An important aspect of the legislation is its emphasis on the responsibility of local councils for the “wellbeing” of their residents, whether or not they are recipients of a council’s own social care and support services. Section 42 of the Act states:

“Abuse includes financial abuse; and for that purpose financial abuse includes—
(a) having money or other property stolen,
(b) being defrauded,
(c) being put under pressure in relation to money or other property, and
(d) having money or other property misused.”

The prominence of financial abuse as a specific component of the Act reflects its growing significance as a public policy issue.

Research: the link between financial abuse and safeguarding

While research into financial abuse directly has been modest, particularly in the UK, a range of social research focusing on safeguarding developments, both in general and in relation to adults with cognitive or physical impairments, *has* involved consideration of financial abuse, as a risk experienced by some of them. This interest has partly stemmed from the tension between two policy goals; personalisation and protection. The development of the concept of 'personalisation' (essentially about giving choice and control to disabled people over their own lives through providing money which they can spend as they choose rather than being provided with direct services) became a cornerstone of social care policy during the 2000s (Department of Health 2005). As it did so, it also became clear that the policy carried the associated risk of abuse in certain circumstances of vulnerability. Reporting on research for a charity supporting people with learning disabilities (the Ann Craft Trust) which had revealed the high level of bullying that many people with learning disabilities experience (Fyson and Kitson 2010), the researchers concluded:

“Practitioners need to be aware that one person’s freedom may be another person’s abandonment to abuse and one person’s safeguarding may be another person’s restriction of freedom. An awareness and embrace of human rights should lie at the heart of all social work practice. True respect for the human rights of people with learning disabilities demands that we accept the need to work with complexities and contradictions, rather than adhering rigidly to abstract principles.”

Just as the implementation of community care policy in the 1990s led to more people living in the community who needed to be protected from abuse, so too did the increasing focus on 'personalising' care, with its greater autonomy and control granted to the individuals concerned, result in the recognition of the importance of safeguarding and the development of ways of mitigating the risks. The report by Fyson and Kitson (2010) stated:

“The personalisation agenda supports choice and control, but it also gives rise to new opportunities for financial abuse the potential for individual budgets to lead to increased negative risks, including financial abuse. It increases the risk of opportunistic abuse and grooming a person for access to income and savings” (p1)

One consequence of the personalisation programme has been a growing body of research that reveals the significance of financial abuse as one of the risks facing those who may become the subjects of adult safeguarding policies. Much of this research focuses on the impact of policy and organisational changes in respect of social care services and the new (post-Care Act) architecture of safeguarding (Manthorpe and Samsi 2013). The conceptual and ethical tension between personalisation and protection may have affected implementation (Mitchell and Glendinning 2007). How, for example, does a service provider offer choice and control to people at risk at the same time as underwriting their safety?

Research investigating this dilemma has involved other topics, including: social workers' experience of multi-agency working in adult protection (Pinkney et al 2008; Perkins et al 2007; Preston-Shoot and Wigley 2002); changes to the organisation of safeguarding within a sample of local councils in the light of personalisation policy (Manthorpe et al 2015); the analysis of safeguarding referrals to local councils in one English region (Thacker 2011); how well the balance between protection and paternalism is managed in Scotland (Preston-Shoot and Cornish 2014); differences between professions in their views of various forms of abuse (including financial) (Trainor 2015); effective working between police and adult social care services (Shearlock and Cambridge 2009); and the financial abuse (specifically) of people with dementia (Manthorpe, Samsi and Rapaport 2014).

This research: aims and methods

As noted, the aim of our research was to throw light on the nature and prevalence of the financial abuse of people lacking mental capacity. In our initial response to the research specification we argued that it would be impossible within the parameters of cost and time to undertake a prevalence study for several reasons – particularly the technical and ethical problems of trying to identify people in this position and capture their experiences directly in the research (see Appendix 1). Our proposal therefore focused on the importance of seeking information that would enhance our knowledge of the issue in alternative ways.

Initial investigation (a knowledge review and consultation with experts) suggested that there is awareness of the general issue among professionals (social, health and voluntary sector advice workers, lawyers and the police) working in various ways with people who may be at risk, but this is only slowly coming to public attention. And although there is some public awareness, professionals feel that, at a practical level, financial abuse often

remains hidden and awareness of the full scale of the problem is limited. This initial exploration also suggested that a deeper examination of the problem might reveal how attempts to tackle it at a professional or organisational level may be unintentionally hampered by a range of factors yet to be fully identified. These, we hypothesised, might include:

- fragmentation in the organisational responses to alleged abuse;
- structural gaps between the agencies involved;
- over-reliance on prescribed routines and processes;
- differences according to both profession and agency in the understanding of mental capacity;
- differing perceptions of the nature and causes of financial abuse of individuals lacking capacity;
- contrasts in professional knowledge and consequent understanding of the causes of the problems and their possible remedies; and
- failure actually to protect those lacking mental capacity at risk of financial abuse, even after suspicion was aroused.

Taking these factors into account, our research proposition argued that the successful containment of the problem of the financial abuse of adults lacking capacity, often in informal settings, is constrained by the particular nature and structure of and motivation behind policies, procedures and processes (official and lay) to prevent or contain its occurrence or to react to it when it happens.

In pursuing this proposition our aims were to:

- construct a typology of financial abuse as it relates to our four groups;
- place it against an exploration of the policy and research background;
- describe and explain the constraints which operate to limit its effective ‘containment’;
- present a more detailed picture of ‘safeguarding in one London borough’;
- make recommendations, based on the findings of our research, for developing interventions designed to counter those constraints where possible; and
- identify further issues for research.

We planned to use a mix of methods to achieve our aims:

- expansion of the knowledge review conducted as a preliminary to the research;
- collection and analysis of relevant statistics (national and local);
- surveys of relevant professional groups;
- a study (rapid appraisal) of one geographical area;
- interviews with key informants (national and local; professional and lay; senior, middle-ranking; front-line);
- attendance at professional and lay meetings and seminars where appropriate.

Establishing a theoretical framework for the current research

Our initial task was to establish a theoretical framework for shaping our approach and informing our analysis from two complementary perspectives:

- the nature of financial abuse in respect of adults lacking mental capacity; and
- the organisational issues which might have an impact on policy implementation.

Abuse in respect of adults lacking mental capacity

While there is now a growing body of literature on abuse across a range of issues and a range of sources, critics argue – especially in the case of financial abuse – that it is under-defined and under-theorised. A number of researchers have attempted to develop a generally applicable model of financial abuse which possesses robust explanatory power across a range of issues and settings. In doing this for abuse in general, Henderson, Varble and Buchanan (2003) have included financial abuse as one of four categories of abuse (the others being physical, psychological & verbal and neglect) on which to base their attempt to classify the causal variables that account for the abuse of older people. They refer to the predominant theories of “transgenerational violence, social exchange theory, exhausted caregiver (excessive demands), external stress and ageism [n.b. their concern is with *elder* abuse]” and also go on to explore a range of risk factors associated with both victims and perpetrators, and context (such as financial difficulties, family conflict and inadequate social support).

Some have proposed the adoption of specific frameworks – for example, an ecological approach in which a complex of nested, interconnected systems operate, which Rabiner and colleagues (Rabiner, O’Keeffe and Brown 2004) label the “aetiology of financial exploitation” which focuses on power relationships within families where financial, cognitive and physical factors have an impact. Others have looked at situational action theory which explains how the intersection between environmental factors and personal factors, where opportunity provided by environmental factors (temptations) and moral rule-breaking, leads to abuse (Wikström 2006 – as described by Goergan and Beaulieu (2010)).

Conrad et al (2011) set out a conceptual model of financial exploitation based on an exercise which involved developing a “concept map” generated by experts from various fields which could be used “to develop a hierarchical concept model for elder financial exploitation screening and triage” in an exercise that is reminiscent of the consensus conference model and/or Delphi techniques used in the UK in health services research in the past where experts get together to reach agreement on particular topics (Bunn et al 2016; Adler and Ziglio 1996). In this study, Conrad and colleagues drew on the work of other researchers into financial abuse to generate an inventory or pool of descriptors, risk factors, concepts and models thrown up by previous research and tested them by various means (see below⁶) gradually eliminating those where there could be no consensus until a final agreement is reached. On this basis, they drew up a hierarchy of types of exploitation: theft and scams at the top end (severe); through abuse of trust involving trickery and lies; spending victim’s resources on self; coercion and exploitation, including co-mingling of funds; and at the bottom (least severe), money management problems linked to trusted others involved in individual’s financial affairs.

However, the salience and validity of such “severity indicators” for this research is questionable. In their hierarchy, Conrad et al place abuse by external actors at the most severe end of the scale and abuse by trusted others at the lowest end. In financial abuse relating to people lacking mental capacity, cross-cutting or contingent factors – such as the restriction of individuals to domestic settings, an inability to make financial transactions themselves or the limited range of social relationships (with greater dependency on family members) available to them – may play a more significant part in determining the type and severity of different sorts of financial abuse, factors which they do not fully acknowledge. In this respect, factors related to the risk of abuse by an individual known to and trusted by victims would be placed higher up the scale of severity.

Another line of theorising has also focused on the position of the victim. Goergan and Beaulieu (2013) in a paper on criminological theory focus on the victimisation involved in financial abuse and argue that ‘vulnerability’, and the power relations involved in the abuse, are the key variables to investigate. Associated with the notion of vulnerability is that of trust. They cite other researchers who have made the point that trust is “a person’s readiness or willingness to be vulnerable to the actions of a trusted person, this readiness being based upon positive expectations regarding the actions of the trustee”.

We think this is a significant proposition and relevant to the position in which adults lacking capacity are sometimes placed. Dixon and colleagues (2010), reflecting on the King’s College/NatCen survey in 2004, regard trust as an important variable, pointing out that the notion of trust within the family may be a disputed concept – with rational choice theorists arguing that trust is well-embedded within the family while others, including feminist theorists, see the family as the site for potential conflict around notions of trust. They note that their survey generated interesting evidence that the presence of trust was not always guaranteed and that the motivation of some relatives was not always beyond reproach. Similarly, the Brunel University scoping study on trust, risk and relationships for the Joseph Rowntree Foundation (Dalley et al 2012) found reports of similar variation in attitudes and practice.

Since the 1980s, studies (Gilhooly 1984; Land and Rose 1985; Carretero et al 2009) have investigated the notion of caregiver burden (which is included in Henderson et al’s list of causal variables noted earlier). Rather than looking at the victim, their starting point has been with the informal carer (usually female) and her wellbeing, with an implicit expectation that caring responsibilities will take their toll - emotionally and/or economically. Theories around ‘stress’ and the ‘burden of caring’ have sometimes been cited as providing explanations of abusive behaviour within families where certain members may carry responsibility for caring for dependent relatives (or in formal caring contexts such as care homes where understaffing or lack of leadership may be

⁶ including brainstorming, statement analysis and synthesis, unstructured sorting of statements, multidimensional scaling and cluster analysis, and the generation of numerous interpretable maps and data displays” (from Conrad et al, *ibid*)

precipitating factors leading to physical abuse or neglect). Murphy et al (1997) report women carers of ageing parents feeling resentful, although there is no mention of abusive behaviour linked to this (the question was not raised in the study). Whether or not this resentment leads to abuse (particularly financial abuse) is possible, though not evidenced.

Others suggest that rather than concentrating on the abuse event and the risk factors associated with it, understanding might be gained by seeing intra-family abuse as the process of taking advantage of opportunities offered family members being responsible for managing the assets of an older relative – using a version of ‘routine activities theory’ (RAT) (Setterlund et al 2007; Goergan and Beaulieu 2010). It centres on three factors – the person under threat, the absence of protection by a “capable guardian” and the presence of a likely offender.⁷

It seems clear that the financial abuse of adults lacking capacity, where it occurs, is likely to take place within the family setting even if only because this is the setting where they are most likely to be located – hence our interest in theory which relates to the dynamics of family life. In this respect, perhaps the most apposite theoretical framework for us was the one outlined by Parrott and Bengston (1999) using social exchange theory linked to the notion of intergenerational solidarity. Help, support and normative expectations about familial obligations infuse constructs of family solidarity across generations over time, with solidarity itself being a multi-faceted construct – affectual, associational, structural, normative, economic and functional. It can account for the willingness of some family members and, importantly for us, the reluctance of others to fulfil normative obligations of help and support conditioned by events that have happened over the life course of the family. As Dixon et al say, citing Biggs and Powell (2001), “moral and normative ideas about trust in families conflict with the descriptions of ‘the family’ as a site of inter-generational stress, conflict and violence, as are common in accounts of elder mistreatment” (Dixon et al 2010).

In line with this approach we can then ask what happens when conventional notions of family solidarity are absent or have broken down. Research shows that a large proportion of financial abuse affecting older people takes place within the family, perpetrated by family members – almost two thirds (60%) of officially substantiated cases of financial abuse in one example were found to have been perpetrated by adult children (MetLife Mature Market Institute et al 2009). Attitudes and expectations of inheritance may also be relevant (Finch and Wallis 1994; Rowlingson and Mackay 2005). Finch and Wallis suggested that the issue of inheritance could be subversive in family relationships. Rowlingson and Mackay found that around a third of people think they are likely to inherit from their relatives – threats to this may prompt abuse. Likewise earlier histories of intra-family violence and disputes (Chin and Giles 2013; Golding et al 20013; Sharp-Jeffs 2015) may be implicated in abuse in later years. As Gibson and Qualls (2012) state: “long-standing dynamics shape attributions and responses”.

A family dynamics perspective of this sort which recognises the need to look within the family for possible explanations of behaviour – particularly when it comes to analysing cases of intra-family financial abuse – seems to offer a productive way forward. However, none of the above elements on its own is a sufficient condition for financial abuse to occur.

Organisational theory

We hypothesised that successful implementation of policy (in this case safeguarding) may be constrained by factors at play within the organisations charged with the duty of implementation and external to the policy in question. We have drawn on a body of literature dealing with this proposition from various angles – how issues become social problems, the impetus for policy change, and the forces which may impede progress. Early rationalist models of organisations and organisational behaviour (see Butler 1986) tended to see organisations uncritically – and optimistically – as operating purposively in line with clear agreement about goals and objectives, themselves based on informed planning and decision-making (and indeed this line of thinking still underpins much of modern government policy-making).

Many agreed policies however fail to achieve some or all of their goals: they may be modified, undermined or disregarded. Some labelled this uncertainty and variability as “incrementalism” or “muddling through”

⁶ http://www.citynmb.com/index.asp?SEC=3FD273E8-4654-4359-9AE1-9C86F704AF44&DE=7FE7466C-E018-411A-B5D5-368D05B6712C&Type=B_BASIC

(Braybrooke and Lindblom 1963) with scope for action being limited by what has gone before with change often only possible at the margins. Linked to this was the notion of “satisficing” - doing what is necessary in relation to immediate requirements (March and Simon 1958). Discretionary resource allocation (of time, services or money) can be a powerful tool in the hands of professionals with implications for policy outcomes (Adler and Asquith 1981).

Recently, in keeping with this line of thinking, Ash (2013) has written about the dilemmas facing social workers in making safeguarding decisions, taking as her starting point Lipsky’s notion of the “street-level bureaucrat” and his “contention that policy is, in reality, made by front line workers in public sector agencies” (1980). She describes the challenges faced by social workers handling possible cases of abuse in having to make decisions about what action to take (that is, put policy into practice). Against a background of research evidence that safeguarding practice varies according to local authority and that thresholds for action are inconsistent, Ash’s own research examines the dilemmas facing workers placed in the decision-making position. She talks about a “cognitive mask” coming down, veiling the evidence before their eyes, which might lead them to decide not to raise a safeguarding alert contrary to the evidence in front of them. For a variety of reasons – which she describes – policy intention is subverted. Similarly, Scourfield (2015)’s study of care home reviews uses Lipsky’s approach describing how policy is “mediated at the point of delivery” by where not only practitioners but managers too are able to exercise discretion even in the face of clear procedural rules.

Other contemporary researchers have described other influences or constraints on the ability of front-line workers to make decisions which to the external eye might appear to be unambiguous: a study of social workers in Wales (Pinkney et al 2008) describes how a number of barriers exist which thwart the good intentions of front-line staff – such as poor information sharing, ideological differences (the medical vs the social model in perceptions of disability), blockages in the flow of knowledge and information from the top of the organisation to the front-line or periphery, lack of resources and too much reliance on good will. Inter-professional differences in screening and making referrals were explored in another study (Trainor 2015) showing that differing professional attitudes had a bearing on perceptions of the seriousness of a case, leading them to adopt different thresholds for determining action. Another study looked at differences in styles of information-sharing between professionals which revealed four types “ideal, over-open, over-cautious and chaotic” of sharing which had a bearing on outcomes. Similarly, differences in professional culture in a range of collaborating agencies were found to be the cause of contrasting views and associated problems (Richardson and Asthana 2006).

Differences in outlook, knowledge base and professional ideology all seem to play a part in professional decision-making within and between different agencies. Much of our research involved just such a range of professionals and agencies. Councils, professionals, health and social care agencies and the law, are all key agents in governmental attempts to establish a policy that will protect a particularly vulnerable section of the population. A theoretical framework which offers explanations of why policy implementation is often hard to achieve, as referenced above, seems an appropriate one to adopt.

Definition of terms: financial abuse and mental capacity

Having considered the theoretical framework in which we have chosen to situate our research we also have to consider our definition of the terms ‘financial abuse’ and ‘mental capacity’ or at least bring some clarity in their usage⁸.

Financial abuse

As noted earlier, definitions of the term ‘financial abuse’ have varied from the general to the very specific, and from the strictly legal and behavioural to the moral and conceptual (or a mixture of both) and may be descriptive or explanatory. Thus it is possible to adopt a strictly law-based definition of financial abuse such as those laid down in the Care Act 2014 or the No Secrets guidance and in documents published by various specialist bodies, such as the Law Society (2013); or a definition based on behavioural criteria, as in the King’s College prevalence survey (Dixon 2010); or definitions based on moral and conceptual criteria such as the abuse of trust and improper behaviour (Setterlund et al 2007; World Health Organisation) – hence the following definitions from 6 different sources:

⁸ Law Society (2013) *Financial abuse: practice note*.
<http://www.lawsociety.org.uk/support-services/advice/practice-notes/financial-abuse/>

Financial abuse:

- Abuse includes financial abuse and for that purpose financial abuse includes—
 - (a) having money or other property stolen,
 - (b) being defrauded,
 - (c) being put under pressure in relation to money or other property, and
 - (d) having money or other property misused

(Section 42 The Care Act 2014)
- It includes: theft, fraud, exploitation, pressure in connection with wills, property or inheritance, or financial transactions, or the misuse or misappropriation of property, possessions or benefits
- (No Secrets: Department of Health 2000)
- One or more instance of financial abuse during the last 12 months, as with:
 - Stolen money, possessions or property.
 - Attempted to steal money, possessions or property.
 - Made you give money, possessions or property.
 - Tried to make you give money, possessions or property.
 - Used fraud to take money, possessions or property.
 - Tried to use fraud to take money, possessions or property.
 - Taken or kept power of attorney.
 - Tried to take or keep power of attorney.

(Behavioural definition King's College survey)
- 'The illegal or improper use of a person's finances or property by another person with whom they have a relationship implying trust.'
- (Setterlund et al 2007)
- It is another name for stealing or defrauding someone of goods and/or property. It is always a crime but not always prosecuted. Sometimes the issue is straightforward, for example, a careworker stealing from an older person's purse but at other times it is more difficult to address. This is because very often the perpetrators can be someone's son or daughter or age prejudice means that other people assume that it is not happening or that the older person is to blame.
- (Action on Elder Abuse)
- a single or repeated act or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person'
- (World Health Organization and the International Network for the Prevention of Elder Abuse 2002)

Each of these definitions is appropriate in particular situations but not wholly applicable to every circumstance. Dixon et al (2010) have commented on the difficulty in defining [elder] abuse and conclude that definitions may need to be "provisional, flexible and pragmatic, particular to specific research and policy purposes" (although they still think it is necessary to work towards a comprehensive definition). The same applies to financial abuse.

We are of the view that financial abuse⁹ is a complex subject both inherently and contextually.

It may take place:

- within the family, between and within generations;
- by friends, neighbours, acquaintances;
- by paid workers;
- by strangers in person, by mail, by phone or on-line.

It can take place in:

- domestic settings, such as in a person's own home, an extended family home, a relative or friend's home;
- care facilities (hospitals, supported living accommodation, care homes);
- the public domain (shops, banks, offices).

It can be designated or regarded as one or more of the following:

⁹ Besides debate over the *definition* of the term financial abuse there is also one about *usage* - should it be financial abuse or financial mis/maltreatment or exploitation – see Gilhooly et al (2016) Financial abuse through the lens of the Bystander intervention, *Public Policy & Aging Report*, 26, 1, 5-11.

- a criminal act;
- an issue for safeguarding people at risk;
- one part in a mosaic of various sorts of abuse and neglect.

It may be explained as being the outcome of the:

- criminality and/or the moral failings of individuals, exercised opportunistically *or* systematically;
- interplay of family dynamics (where there has been a breakdown of filial/family respect and obligation or where earlier abusive relationships have persisted);
- loss of a sense of community and the spirit of neighbourliness.

Society may deal with it:

- within a legal framework (Mental Capacity Act 2005, Court of the Protection, Office of the Public Guardian, the Fraud Act 2006)
- by developing a safeguarding policy structure within a framework of personalisation, empowerment – and protection; and
- by preventive action (trading standards campaigns, police surveillance, staff training, voluntary sector activity, mass communications, financial services' voluntary schemes to protect customers – sometimes despite themselves and their formal legal obligations to their customers' wishes).

This listing covers a large spread of social, conceptual and legal terrain and it seems clear that it would be difficult to construct a single conceptual and definitional category that would be able to capture the phenomenon of financial abuse in all its complexity – as well as being able to apply it to every case. Does financial abuse always involve abuse of trust? Is it always a criminal act? Is it always fraudulent? Is it sometimes excusable (some experts argue that small acts of abuse can be overlooked if the person abused values the benefits of friendship over the abusive behaviour, especially if the alternative seems to them to be loneliness).

Different disciplines inevitably adopt different theoretical and analytical approaches and even where analysts have tried to construct an overarching definition to meet all eventualities, problems are encountered. An example – when researchers at Monash University in Victoria, Australia (Wainer, Darzins and Owada 2010) tried to find a comprehensive definition based on the WHO definition of “illegal and improper use”, they ran into difficulties. What was the difference between this and fraud? Surely it also involved “illegal or unethical behaviour from a trust relationship” which is a “type of criminal behaviour that breaches boundaries of trust”. Other definitions, they also commented, could include instances of financial decisions being made by another person “that restrict the life of the other or are not in their best interest”.

This reflects conclusions drawn by Goergen and Beaulieu (2013) who refer to the “necessity of analysing EA/MOA [Elder Abuse/Mistreatment of Older Adults] by type instead of as a whole”, challenging their attempts to look at all elder abuse wholly through the prism of age. Instead, as an example, they focus on the concept and characteristics of vulnerability independent of age. Other researchers adopt a classificatory approach – developing typologies, taxonomies or aetiologies of abuse or lists (as in the legislation or codes of practice).

Our research, in trying to take account of these differences of approach, does not seek to make a once and for all, over-arching definition applicable to all circumstances. In doing so it has been selective and restrictive – in line with the original research specification. Thus our definition is not age-bound, but it is status-bound (it relates to acts of abuse against people *lacking capacity* in certain circumstances irrespective of age); it has an ethical dimension (acknowledging that concepts of trust and obligation are central in intra-family abuse); it is context-driven (likely for the most part to take place within the domestic domain, and within family relationships) rather than wholly abstract; it is theory-driven but not allied to any one approach (psychological, sociological, criminological theories may all have a contribution to make).

Mental capacity and lack of capacity

We have adopted the definitions and terminology of the Mental Capacity Act 2005. Rather than defining ‘mental capacity’ as a once-and-for-all determination, the Act focuses on a person’s ‘capacity’ or ‘lack of capacity’ in respect of decision-making in particular instances. We follow that approach, spelling out in some detail what the Act and the accompanying code of practice lays down.

The Mental Capacity Act 2005 states the following:

A person who lacks capacity is defined under section 2(1) MCA 2005 thus:

“a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or the brain.”

It is based on the following principles:

- A person must be assumed to have capacity unless it is established that he lacks capacity.
- A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
- A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
- An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.

It goes on to state:

- For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.
- It does not matter whether the impairment or disturbance is permanent or temporary.
- A lack of capacity cannot be established merely by reference to—
 - a person’s age or appearance, or
 - a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about his capacity.

(Part 1. The Mental Capacity Act 2005)

In this way the Act makes specific statements about how lack of capacity is to be defined and the situations in which individuals can make decisions, but even so it may not be always straightforward for non-lawyers to grasp its finer points. Professionals dealing with assessing capacity in the course of their work as social workers, police officers, bank staff or health workers, for example, not to mention lay persons, such as family members, may have an incomplete understanding, or employ conflicting definitions of what it is and what it means. Such a view is confirmed by the House of Lords (2014) report scrutinising the operation of the Mental Capacity Act since its enactment in 2005. It found evidence of a widespread lack of awareness and understanding of the Act’s core principles and that cultures of paternalism were still widespread. The ethos of empowerment, central to the Act, was not being delivered. It concluded that the “presumption of capacity in particular is widely misunderstood” and called for the establishment of “central ownership” to combat the Act’s current patchy implementation.

To assist better understanding of the scope and intention of the Act, the code of practice published in 2007 provides comprehensive guidance to professionals likely to be involved in assessments and we have taken this into account. It sets out the process for assessment – which must be a two-stage process – which determines whether or not the person truly have the capacity to make an informed and fully understood decision.

The Mental Capacity Act 2005 code of practices sets it out thus:

Assessing capacity

Anyone assessing someone’s capacity to make a decision for themselves should use the two-stage test of capacity.

- Does the person have an impairment of the mind or brain, or is there some sort of disturbance affecting the way their mind or brain works? (It doesn’t matter whether the impairment or disturbance is temporary or permanent.)
- If so, does that impairment or disturbance mean that the person is unable to make the decision in question at the time it needs to be made?

Assessing ability to make a decision

- Does the person have a general understanding of what decision they need to make and why they need to make it?

- Does the person have a general understanding of the likely consequences of making, or not making, this decision?
- Is the person able to understand, retain, use and weigh up the information relevant to this decision?
- Can the person communicate their decision (by talking, using sign language or any other means)?
Would the services of a professional (such as a speech and language therapist) be helpful?
(From: Mental Capacity Act 2005 Code of Practice)

It also clarifies what the Act means in relation to a person's capacity to make a decision:

A person is unable to make a decision if they cannot:

- understand information about the decision to be made (the Act calls this 'relevant information')
- retain that information in their mind
- use or weigh that information as part of the decision-making process, or
- communicate their decision (by talking, using sign language or any other means).

(From: Chapter 4)

In day-to-day life, those affected by the assessment and decision-making processes need to know and understand how this all works in practice. Unlike the Mental Health Act 1983, there is no provision in the Act for detaining or "sectioning" an individual (although members of the public sometimes assume there is) on the decision being made by an approved mental health professional (AMHP), or relative, and two doctors, one of whom must have had specific training. Assessment under the Mental Capacity Act 2005 is much more open, consultative and fluid.

The Alzheimer's Society describes it thus:

Who can assess capacity?

Generally, whoever is there when the decision is being made will assess the person's capacity. However, this will vary depending on the decision that needs to be made:

- For everyday decisions, including what someone will eat or wear, whoever is there at the time can assess capacity, which is likely to be the person's family, carer or care worker.
- For more complex decisions, such as where someone will live, or decisions about treatment, a professional will make the judgment - for example, a social worker or the person's GP. This should be done in consultation with those closest to the person, such as their carer and relative.

*From: Alzheimer's Society website*¹⁰

While it may be relatively straightforward for researchers to accept and adopt these clear definitions of terms and concepts – and in this case as we have seen there are clear legal descriptors available – it may be more complicated in the 'real' world of day-to-day practice. The evidence from the House of Lords scrutiny report is that many practitioners are not fully informed of the scope of the Act and its application. Moreover, the scope for professional and lay people having different definitions and not realising it is one which we, as researchers, need to bear in mind in the course of analysis and explanation.

We felt that it was important to set out our position at the end of this first chapter on both our definition and usage of the term financial abuse and our understanding of the way in which the concepts of 'capacity' and 'lacking capacity' apply in the context of our report. Our aim was to investigate and understand how they are operationalised in the 'real worlds' of both professional practice and lay experience. It was thus essential to spell this out in some detail at the outset.

¹⁰ https://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=354

Conclusion

Our research project aimed to learn more about the financial abuse of adults lacking capacity. This introductory chapter has set out our overall approach to the study, in terms of the research and policy background in which it is placed along with the theoretical framework which we have adopted for anchoring our data, its analysis and findings.

Chapter 2

FINANCIAL ABUSE: NATIONAL QUANTITATIVE AND QUALITATIVE DATA



CHAPTER 2

FINANCIAL ABUSE: NATIONAL QUANTITATIVE AND QUALITATIVE DATA

Introduction

Financial abuse, especially of people lacking capacity, is hard to quantify. The reasons for this are several – it may be hidden within families or other informal relationships; perhaps committed by people in positions of dominance near at hand who can control, take advantage and prevent its divulgence all at the same time; or it may be conducted over the phone or on-line and never be obvious to any person other than the victim, if at all. Counting up instances of these multiple types of abuse is clearly problematic – made much worse when the victims are individuals who lack mental capacity and thus often unable to provide convincing evidence of its occurrence (even if aware of it, and able and willing to report). Thus, the very conditions that make them exploitable also make it less likely that anyone will be aware of it or do anything about it.

This chapter, while acknowledging these hindrances, attempts to set out what can be reliably stated about the extent of known financial abuse. It looks at national and local official statistics as well as those produced by charitable organisations on a national basis, where available. It then goes on to report on the views and experience of experts who through their work in relevant fields (the law, health care, social care, gerontology), have encountered abuse and have views about the current processes for identifying and countering it.

PART 1

Statistics on financial abuse

While there are no reliable statistics on overall prevalence in relation to the specific form of financial abuse that we are concerned with, there are various sources of statistics on aspects of the problem which may be relevant. We identified five possible sources of relevant financial abuse data. These relate to:

- the alerts reported to local councils of concerns about abuse perpetrated or suspected of being perpetrated;
- reports of possible breaches of the duties (which may amount to abuse) of attorneys appointed under Lasting Powers of Attorney, registered with the Office of the Public Guardian (OPG), or by deputies appointed where no LPA exists once a person has lost capacity and supervised by the OPG;
- cases heard by the Court of Protection of breaches of duties (which may amount to abuse) by attorneys or deputies and where revocation of the powers is applied for or where the LPA is contested;
- crime statistics, from the Home Office and National Fraud Intelligence Bureau, particularly any statistics available which relate to the criminal offence of fraud under the Fraud Act 2006, given that this is the offence most closely associated to financial abuse in many of the situations described to us; and
- voluntary sector organisations, mostly supporting people lacking mental capacity and their families, which might compile statistics from case records and requests for help and advice.

HSCIC data

Local authorities acting in their safeguarding role are the most important and accessible source of data on financial abuse. In recent years they have begun to record statistics of the abuse-related referrals which they receive annually. These referrals are made under the responsibilities local authorities hold with regard to 'safeguarding adults at risk'. Referrals relate to a wide range of concerns, of which financial abuse is one. Local authorities are required to submit safeguarding adults returns (SARs) annually to the Health and Social Care Information Centre (HSCIC) [and now renamed NHS Digital]¹¹. Returns for the year (2013-14) were the first to be gathered in this form, replacing the previous Abuse of Vulnerable Adults (AVA) returns. The second year's data

¹¹ The data are submitted to the HSCIC through the Omnibus system, a secure online tool which also runs a series of validation checks on the data, such as indicating any blank data items, comparing related values within tables and reviewing consistency between tables. **FROM 2016: HSCIC has been renamed NHS Digital**

(2014-15) were published in October 2015¹² but further changes, following the implementation of the Care Act 2014, in 2016, are planned. For present purposes, Tables 1 and 2 below report on referrals (to be renamed 'enquiries' in 2017). The others (Tables 3 - 11) refer to concluded cases and will be included as such in future data collections.

The key data are the number of *individuals with referrals of all types of risk* across England and by Region, and then *concluded referrals by type of risk* relating to the category 'financial & material' risks as compared to 6 other categories of abuse: physical, sexual, neglect & omission, psychological, discriminatory, and institutional. For *concluded referrals* we can then examine them by: whether the subject (victim or person at risk) was known to the council; place of residence (e.g. own home/care home); known need for council support services; lack of capacity or not¹³; action taken; and outcome.

Referrals

Table 1¹⁴ Referrals for individuals (all types of risk) by gender, England - years 2013-14 and 2014-15

	Males with referrals	%	Female with referrals	%	Total numbers
2013-14	42,055	40	61,990	60	104,045
2014-15	40,785	39	62,660	60	103,445

Table 2¹⁵ Referrals by region, England - years 2013-14 and 2014-15

Region	2013-14		2014-15		Total per 100,000 population
	Individuals with referrals	%	Individuals with referrals	%	
East Midlands	7,320	7	8,160	8	222
East of England	11,360	11	11,035	11	233
London	15,805	15	17,240	17	260
North East	5,050	5	4,375	4	209
North West	17,125	16	16,980	16	302
South East	15,050	14	14,350	14	206
South West	9,800	9	10,135	10	233
West Midlands	13,890	13	14,380	14	323
Yorkshire & the Humber	8,650	8	7,245	7	172
England	104,050	100	103,900	100	243

The number of '*individuals with referrals*' sets the general scene. They are broken down by gender and region (Tables 1 and 2) but not by type of abuse. Overall numbers in 2014-15 (103,900) were down very slightly (by 150) on the previous year although increases are expected in next year's returns¹⁶. More subjects of referrals were women (60%) than men (40%). Our case study (set out in the next chapter) is centred on a London borough and so the data in this chapter are set out to provide comparators by region with a focus on London – which had the third highest number of referrals, after West Midlands and the North West, in the year 2014-15. London is also third in terms of the number (260) per 100,000 population after West Midlands and the North West (the average for England as a whole being 243).

¹² A number of changes will be made in the 2015-16 returns, with less emphasis in collecting figures for overall numbers of referrals (to be called enquiries in next year's data and collected only on a voluntary basis) and more (mandatory) collecting of data on cases where investigations have taken place and proceeded to a conclusion.

¹³ In this context, "mental capacity is assessed as the person's ability to contribute to making decisions about their protection, including their participation in the safeguarding investigation, as well as their mental capacity at the time of the incident causing a safeguarding referral." (HSCIC Safeguarding Adults Annual Report, 2014-15).

¹⁴ Taken from HSCIC Table 1.1: Distribution of individuals with referrals by gender, 2013-14 and 2014-15 England.

¹⁵ Taken from HSCIC Table 2.2.

¹⁶ In the first 6 months after the implementation of the Care Act 2014 in April 2015, it was reported that there have been 100,000 safeguarding enquiries by local authorities - indicating a substantial increase possibly due to the introduction of new safeguarding procedures and criteria. See:

<http://www.local.gov.uk/documents/10180/5756320/Stocktake+5+Final+detailed+report/f070979a-4940-4ff3-ab07-95647579ca89>

Concluded referrals

Table 3 shows there were 122,140 *concluded referrals* by type of risk (not individuals) in England during 2013-14 with a rise of 5% to 128,060 in the following year, 2014-15 – in both years broken down by specific type of risk. The numbers of cases of financial and material abuse fell slightly. However such data are partly a product of administrative resources and effort, so this should be borne in mind.

Table 3¹⁷ *Concluded referrals by type of risk (%), 2013-14 and 2014-15, England*

Type of risk	2013-14 %	Numbers	2014-15 %	Numbers
Physical	27	32,775	27	34,385
Sexual	5	6,440	5	6,255
Psychological & emotional	15	18,700	15	19,760
Financial & material	18	22,270	17	21,935
Neglect & omission	30	36,090	32	40,885
Discriminatory	1	1,230	1	870
Institutional	4	4,750	3	3,965
Total number of referrals		122,140		128,060

Across England for both years, most types of risk related to neglect & omission, followed by physical abuse, with **financial & material risk** being the third most common. London follows this pattern (Table 4), with 20% of concluded referrals relating to financial & material risk (higher than the England-wide percentage of 17%).

Table 4¹⁸ *Types of abuse by Region (%)*

Region	Physical	Psychological & emotional	Financial & material	Neglect & omission	Other types
East Midlands	24	15	17	32	11
East of England	30	15	16	31	8
London	24	17	20	32	7
North East	23	15	21	34	7
North West	28	13	16	33	9
South East	27	15	16	34	8
South West	27	17	16	28	12
West Midlands	27	16	18	31	8
Yorkshire & the Humber	26	15	16	32	11
England	27	15	17	32	9

More risks were found to be located 'in a person's own home' than any other place (Tables 5, 6) – unsurprisingly in the light of the circumstances of those who are vulnerable – and the most common source of the risk was attributed to 'a person known to the individual' (Table 7). London had the greatest proportion of 'at risk' people living in their own home (56%) and the smallest living in a care home (22%), the widest disparity across the country. The average for England is 43% (own home) and 36% (care home) respectively.

Table 5¹⁹ *Referrals by the location of risk (percentage distribution), England - 2013-14 and 2014-15*

Location of risk	2013-14	2014-15
Care home	36	36
Hospital	6	6
Own home	42	43
Service within the community	5	4
Other	11	11

¹⁷ Taken from HSCIC Fig 2.1

¹⁸ Taken from HSCIC Fig. 2.2

¹⁹ Taken from HSCIC Fig. 2.5

Table 6²⁰ Location of risk by region 2014-15

Region	Care home	Hospital	Own home	Within community	Other
East Midlands	40	4	39	2	14
East of England	37	7	43	5	8
London	22	6	56	4	12
North East	35	5	48	2	10
North West	38	5	38	5	15
South East	36	7	40	4	13
South West	39	5	44	2	9
West Midlands	37	6	44	3	10
Yorkshire & the Humber	44	8	37	2	8
England	36	6	43	4	11

The commonest sources of risk are from people 'known to the individual' in England, both through their 'social care support services' (36%) or from a range of 'other known individuals' (43%). While risk from 'people unknown/strangers', is considerably lower (14%) across England, 19% of referrals in London relate to this category.

Table 7²¹ Source of risk by Region

Region	Social care support	Other: known to individual	Other: Unknown/stranger
East Midlands	30	58	13
East of England	37	53	10
London	33	48	19
North East	40	51	9
North West	38	46	17
South East	41	43	16
South West	33	58	9
West Midlands	31	45	23
Yorkshire & the Humber	42	49	9
England	36	50	14

Concluded case by conclusion

The outcome (conclusion) of 'concluded cases' (Table 8) shows that around a third (32% and 31%) are substantiated, with almost a further third *not* substantiated (31 and 30%). Around a tenth are partially substantiated and in a small number of cases, the individual asks for the investigation to be stopped: the reasons for this are unknown but we speculate that some may be due either to pressure or to fear of losing 'a friend'. There is little difference between years 2013-14 and 2014-15.

Table 8²² Referrals by case conclusion, England, 2013-14, 2014-15

Year	Substantiated	Substantiated - partially	Inconclusive	Not substantiated	Investigation ceased at individual's request
2013-14	32	11	22	31	3
2014-15	31	10	22	30	7

However, when examined by region (Table 9), the figures show some variation. In London, in almost a fifth of cases (18%) in the year, 2014-15, the individual asked for the investigation to cease: at the other extreme, 3% in the West Midlands and in the South East requested this. London had the lowest rate of substantiated or partially substantiated cases (34%), compared to the highest (48%) in the North East and the South East.

²⁰ Taken from HSCIC Fig. 2.6

²¹ Taken from HSCIC Fig. 2.4

²² Taken from HSCIC Fig. 2.10

Table 9²³ Referrals by case conclusion and region 2014-15

Region	Substantiated	Substantiated - partially	Inconclusive	Not substantiated	Investigation ceased at individual's request
East Midlands	27	13	29	28	4
East of England	38	7	20	27	8
London	26	8	19	30	18
North East	32	16	23	25	4
North West	32	10	23	30	5
South East	36	12	21	28	3
South West	30	15	20	29	5
West Midlands	29	11	26	30	3
Yorkshire & the Humber	27	8	16	40	9
England	31	10	22	30	7

Breakdowns of type of abuse by 'case conclusion' and by region are not given in the HSCIC published report so we cannot make any comparisons in this respect without going into the raw data spreadsheets.

Of particular interest to this research is what number or proportion of people who were the subject of referrals were known to lack capacity. We find that in relation to a total of 88,280 (2013-14) and 104,760 (2014-15) referrals, at least a quarter of individuals are reported as lacking capacity (Table 10), mostly in the older age groups above 65 years (Table 11).

Table 10²⁴ Mental capacity - concluded referrals where individual lacked capacity, England, 2013-14, 2014-15

Concluded referrals where individual assessed as lacking capacity	2013-14		2014-15	
	%	n	%	n
Lacks capacity	28	24,718	25	25,601
Does not lack capacity	44	38,843	46	48,189
Don't know	29	25,501	16	16,761
Not recorded			12	12,571
Number of referrals		88,280		104,760

Table 11²⁵ Concluded referrals where individual assessed as lacking capacity x age, England 2014-15

Concluded referrals where individual assessed as lacking capacity	18-64	65-74	75-84	85+	Not known	No. of referrals
Lacks capacity	20	24	29	30	15	26,370
Does not lack capacity	51	50	44	41	27	48,470
Don't know	16	15	16	18	9	16,890
Not recorded	13	11	11	12	48	13,030
Number of referrals	38,120	12,700	23,580	29,770	600	104,760

Unfortunately the HSCIC report acknowledges that there are "quality issues" concerning the data in the year 2014-15. Several councils did not submit data on the topic and a new category "not recorded" was introduced in the second year. Further, the report does not present region- or outcome-related data in respect of mental capacity.

Comment

These data show that safeguarding individuals either with, or lacking, capacity is a significant responsibility for local authorities and that data on their safeguarding activities are an important source of information for the

²³ Taken from HSCIC Fig. 2.11

²⁴ HSCIC Table 3.1

²⁵ HSCIC Fig. 3.1

purposes of this study. Moreover, this role is increasing with the implementation of the Care Act 2014, according to recent news reports from the local authority umbrella organisation, the LGA (see f/n 16 above). It is also clear that concerns about financial and material abuse constitute a substantial part of councils' safeguarding responsibilities. As such, it features third in the list of categories for concern across the country, including London, and not greatly different in proportion from the first two categories (neglect & omission and physical abuse) – all three of which, it should be remembered, may often be interlinked. Given that financial abuse is generally regarded as an often hidden form of abuse, the fact that it comes to the attention of councils at all is worthy of note. Unfortunately, what we cannot learn from the available statistics is the nature of the outcome of cases apart from the fact that around 40% were either substantiated or partially substantiated and that a quarter of those who were subjects of referrals lacked capacity. But we know nothing from the statistics about whether any redress was obtained or prosecutions pursued.

Office of the Public Guardian data

The Office of the Public Guardian (OPG) is an executive agency of the Ministry of Justice. Its remit is to support and enable people to plan ahead for both their health and their finances to be looked after appropriately should they lose capacity in future, and to safeguard the interests of people who may lack the mental capacity to make certain decisions for themselves. The OPG's core functions are to:

- register LPAs and older enduring powers of attorney (EPA);
- supervise deputies appointed by the Court of Protection;
- maintain the registers of deputies, LPAs and EPAs and respond to requests to search the registers; and
- investigate complaints, or allegations of abuse, made against deputies or attorneys acting under registered powers.

(From: Office of the Public Guardian Annual Report & Accounts 2014-15)

Thus examination of its work in respect of complaints and investigations might be able to throw a light on cases of possible misbehaviour (which could amount to abuse) by those appointed as attorneys by people who had gone on to lose capacity to look after their property and financial affairs, or health and welfare (or both).

While there are many thousands of attorneys and deputies, the role of the OPG in relation to monitoring their activities, once an LPA/EPA is registered or deputy appointed, is largely reactive. Attorneys, once appointed, are not monitored although they are expected to inform the OPG of any major changes in circumstances. Deputies are more heavily formally obligated – having to keep accounts and report annually to the OPG which may also mount investigations into the behaviour of both attorneys and deputies in reaction to complaints and alerts. Cases which arise (investigations instigated, attorneys' and deputies' powers ultimately revoked) cannot be regarded as representing a total picture of all possible and actual misbehaviour (and possible abuse) by attorneys and/or deputies. Some of it may go unseen, and there exists no basis on which we can reasonably estimate the size of 'the dark figure' of OPG-related financial misbehaviour.

The OPG publishes a certain amount of data on an annual basis²⁶. They generally relate to internal management processes, customer satisfaction levels, the number of LPAs the OPG registers and the number of deputies who are appointed and whom they supervise. It also reports on investigations and safeguarding activities during the year.

In general terms, the year 2014-15 saw an increase by a third in the number of LPAs registered and a decrease in the number of EPAs (which were replaced by LPAs under the Mental Capacity Act 2005 and are on steady downward trajectory year by year) (Table 12). This may reflect greater public awareness of the protective benefits of taking out LPAs by people in an ageing society as they grow older.

Table 12 Registering powers of attorney 2014-15

Received	2013-14	2014-15	% growth
LPA	295,000	395,000	+33.9%
EPA	16,000	15,000	-6.2%
Total	311,000	410,000	+31.8%

²⁶ Office of the Public Guardian Annual Report & Accounts 2014-15 <https://www.gov.uk/government/publications/office-of-the-public-guardian-annual-report-and-accounts-2014-to-2015>

Most relevant to our concerns, details of safeguarding activity are also published in the OPG’s annual report although not in tabulated form (Table 13) is for convenience for summarising details in the report and referring also to the OPG Annual report for 2013-14). While the most recent report makes no mention of what happens to the referrals that did not proceed to full investigation, the annual report for the previous year (2013-14) notes that:

Safeguarding referrals were received from a number of sources, including relatives, local authorities, care homes and financial institutions. Where cases were not suitable for investigation, advice was offered or signposting to another agency carried out, such as the local authority or police. A total of 1,406 cases were safeguarded in this way.

(From: Office of the Public Guardian Annual Report & Accounts 2013-14)

Table 13 OPG activity in years 2012-13, 2013-14, 2014-15

OPG activity	2011-12	2012-13	2013-14	2014-15	Change between 2013/14 & 2014/15
Safeguarding referrals	3,653	2,982	2,200	1,970	-10% on previous year
Progressed to full investigation	n/a	480	628	743	+18% on previous year
Concluded cases in year	451	596	597	695	+16% on previous year
Applications to CoP (usually to remove a deputy or attorney)	94	163	229	254	+ 11% on previous year

According to the report, applications to the Court of Protection included removal of an attorney or deputy, freezing accounts and directions to an attorney or deputy to produce accounts (Chapter 4 in this report examines some of these cases.) We note from Table 11 (in the previous section on safeguarding referrals), that there were over 26,000 concluded safeguarding referrals to councils involving individual lacking capacity (and who might therefore be of interest to the OPG). Table 13 shows that the OPG received 1,970 referrals in the same year. We presume these related to cases where LPAs/EPAs had been registered.

As noted, many of the investigations mounted by the OPG result from contacts made by whistle-blowers of different sorts. For the years 2010/11 - 2012/13, Senior Judge Lush lists them as follows²⁷:

Table 14 Source of whistleblower contacts

Whistleblower	2010/11 %	2011/2012 %	2012/13 %
Relatives or friends	44	38	38
Local authorities	18	24	22
Solicitors	10	9	10
Co-attorneys or co-deputies	9	9	6
Others: including banks, doctors, advocates, carers, police, OPG Supervision Team	19	20	24
	100	100	100

(Lush 2016)

Statistics for more recent years are not readily available.

Comment

Responding to concerns about the possible mismanagement of the financial affairs of individuals lacking capacity is one of the OPG’s main responsibilities. LPAs relating to financial & material affairs outnumber health and welfare LPAs substantially, and form the bulk of OPG investigations, along with cases subsequently referred to the Court of Protection (CoP) for LPA revocation. Considerable sums of money and other assets may be involved. In some cases, money amounting to tens or even hundreds of thousands of pounds (especially where housing property is involved) may be misappropriated. At the same time, however, it is important to acknowledge that

²⁷ Lush, D (2016) The role of the Public Guardian and the Court of Protection in combatting financial abuse, paper delivered to the OPG Investigations Unit, OPG, Birmingham.

the financial exploitation of vulnerable adults lacking capacity who have limited assets and low incomes (such as people living on welfare benefits) rarely comes to the attention of the Public Guardian most probably because they have not drawn up and registered an LPA.

The OPG annual report provides a tantalising glimpse of the nature of the issues that arise in relation to safeguarding and the misbehaviour of deputies and, to a lesser degree, attorneys. The details chosen to be included in the annual report vary so it is impossible to examine trends over the most recent three years. There is very little detail provided of the content of the referrals made to the OPG, (e.g. the actors in the case; who has made the referral; the reasons for deciding to progress to investigation; and outcomes of investigations). It is thus hard to judge how far financial misbehaviour amounting to abuse is a major trigger for the initial referrals received or the reasons for proceeding to full investigation. However, those which then proceed to the CoP do become visible because they are published in other places²⁸.

In trying to expand our knowledge of the scale of financial abuse of people lacking capacity, it is important to note that the current number of LPAs and EPAs, though large (with 395,000 being registered annually and accumulating year on year until the deaths of donors) – and which constitute the potential pool, or source, for all possible safeguarding referrals to the OPG – is clearly a lot smaller than the pool of all possible subjects of financial abuse referrals to a local authority safeguarding system (the focus of the previous section), which has a responsibility for *all* adults at risk. However, they do relate to a specific population - those who lack mental capacity.

Court of Protection

The Court of Protection (CoP) makes specific decisions, and also appoints other people (called deputies) to make decisions for people who lack the capacity to do this for themselves. These decisions are related to their property, financial affairs, health and personal welfare. The CoP has powers to:

- make declarations about a person’s capacity to make a particular decision, if the matter cannot be decided informally;
- make decisions about serious medical treatment, which relate to providing, withdrawing or withholding treatment to a person who lacks capacity;
- make decisions or orders about the personal welfare and property and affairs of people who lack capacity to make such decisions themselves;
- authorise deprivation of liberty in relation to a person’s care and residence arrangements;
- appoint a deputy to make ongoing decisions for people lacking capacity to make those decisions in relation to their personal welfare or property and financial affairs;
- make decisions about a Lasting Power of Attorney or Enduring Power of Attorney, including whether the power is valid, objections to registration, the scope of attorney powers and the removal of attorney powers.

(From: Ministry of Justice, Family Justice, Guide to Family Law Courts, December, 2015)

The majority of applications to the CoP are decided on the basis of paper evidence without a hearing being held. Much of the business of the court is routine, in the sense that decisions are mostly non-contentious (over 90%)²⁹, made on the basis of paper evidence and the applicant does not need to attend court. In the July-September 2015 quarter³⁰, 3,716 (57%) of the 6,545 applications to the CoP related to the appointment of property & affairs deputies, comparable to figures for other quarters in that, and previous, years and 7,409 orders were made – of which 3,924 (53%) were to do with property & affairs, representing an increase of 27% on the same quarter in the previous year, in line with a trend already established.

As with the OPG, the CoP is wholly concerned with issues involving capacity and lack of capacity – and a substantial amount of its work is concerned with overseeing the safeguarding of the individual’s property and financial affairs. Both of these are clearly reasons for our interest in its activities and in the outcomes of the cases

²⁸ the BAILII website: www.bailii.org/ew/cases/EWCOP/.

²⁹ See later in Chapter 4 case 43.

³⁰ Family Court Statistics Quarterly, England and Wales, July to September 2015 Ministry of Justice Statistics bulletin Summary casework statistics: Orders made in England and Wales annually 2008 - 2014 and quarterly Q1 2008 - Q3 2015 Tables 17 & 18.

about which it makes decisions. However, detailed statistics are not readily available. We know the numbers of cases coming from the OPG to the CoP and we know some figures relating to cases coming to the court. Quarterly statistics are published in the Family Court Quarterly Statistics relating to number and type of applications and orders made, but they do not classify and categorise cases by content and outcome in any detail.

What is possible, however, is to look at individual cases where decisions have been made about whether or not, or how far, individual attorneys or deputies have breached their fiduciary duty towards the individual. Chapter 4 examines a sample of these and provides an in-depth picture of the nature of the financial abuse of individuals lacking capacity, in situations where attorney or deputies have been appointed with a duty to protect their interests in decisions which they make on their behalf.

Criminal offences – fraud

We thought that another way of finding out the scale of financial abuse in relation to individuals lacking capacity might be through an analysis of crime statistics. Fraud appears to be the obvious crime category to focus on because it involves individuals being deprived of money or other assets through dishonest intent. However, financial abuse in informal settings by family or other informal carers (our concern) is not discussed or even mentioned. While historically, the Crime Survey of England & Wales and Ministry of Justice crime maps barely consider fraud at all, routinely published statistics on fraud³¹ until 2015 grouped many different types of fraud into a general ‘other’ category. Now that statistics are broken down further (as in the National Fraud Intelligence Bureau and Action Fraud reports since 2015) the category most likely to be relevant is fraud by ‘abuse of position of trust’ – coded NFIB 19 under the Home Office counting rules for recorded crime, April 2015.

General fraud statistics³² show that the rate of recorded offences has risen steadily over the past 5 years – although the rate per 1000 population has risen less steeply (from 9 to 11 over 5 years). Fraud specifically ‘by abuse of position of trust’ constitutes 3% of fraud generally compared to banking and credit industry fraud, for example, at 56% or cheque, plastic card and online bank accounts at 45%, although all three rising at a similar rate, by between 7 and 8% over two years. A recent report on cyber-crime, noted that the median cost to the victim as a result of abuse by position in 2014 was £8,100 (Levi et al 2015).

Even though greater attention is beginning to be given to the problem of fraud in general, the crime statistics do not throw much light on our particular concerns. They do not – cannot – tell us much about financial abuse in informal settings relating to people lacking capacity because it does not fit their classificatory model for dealing with fraud. Some of it may be recorded under the non-specific category of ‘other fraud’ but there is no way of knowing.

Thus we neither know how many times it is recorded as having occurred nor whether or not it has been prosecuted successfully. In trying to assess the utility of crime statistics as a means of throwing light on the problem of the financial abuse of a person lacking capacity, we have to ask how often does it ever come to public notice and how often does the criminal justice system play a part in its discovery and prosecution?

The voluntary sector: the example of the Alzheimer’s Society

The voluntary sector plays a key role in providing care and support to people who lack capacity. There is a wide variety of charities established to support the range of conditions and circumstances which people experience by virtue of their incapacity. Some are tiny, and very local; others have a nation-wide remit and have considerable incomes, often derived from large contracts with national and local government to undertake the work they do. Their clients may be people lacking capacity themselves, for whom they may provide housing support, activities and social care, or the families and other informal carers who look after them in the community. Thus the sector is characterised by its closeness to many of the sorts of people with whom our research is concerned. It has a wealth of experience in handling their problems and in understanding the risks they face.

³¹ Home Office publication, Crimes detected in England and Wales 2012/13 (Second edition) Kevin Smith Editor) Paul Taylor and Meghan Elkin, July 2013 HOSB: 02/13

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/224037/hosb0213.pdf

³² ONS Statistical Bulletin Crime in England & Wales, 2015

The Alzheimer’s Society, the main national-level voluntary organisation (covering England, Wales and Northern Ireland) offering support to people with dementia and their families, was an obvious candidate for us to approach as an example of a voluntary organisation which holds information that can throw light on the nature and prevalence of the financial abuse of people lacking capacity. It has a large central headquarters, and a network of local branches. Its potential constituency – people with dementia and their families – is substantial. About 856,700 people are estimated to have dementia in the UK (including 70,162 in Scotland)³³ although its true prevalence is hard to determine because of problems to do with the time and stage of diagnosis and methods of recording cases³⁴.

As well as providing a range of services and support, the Alzheimer’s Society runs a national helpline which receives over 35,000 calls every year. In the year 01/4/2014 - 31/3/15, its helpline responded to 36,328 enquiries. Most (22,596) were from carers, relatives or friends with 19,161 being family members or friends. In 2015 – from 1 May – the society started to classify enquiries that specifically relate to safeguarding issues, using the same categories as those employed by local authorities in their submissions to the HSCIC. In the 6 months between May and October 2015, the helpline received 21,222 calls of which 412 were classified as safeguarding-related (Table 15).

Of these 412 calls, 109 were classified as potential financial & material abuse and constituted 26% of the total received (which themselves were 2% of the 21,222 helpline calls of all types), and ranking second in the 7 categories of abuse listed (in comparison with the HSCIC statistics, on local authority safeguarding data, where it ranks third after physical and neglect & omission categories).

Table 15 Analysis of Safeguarding Calls to the Alzheimer’s Society helpline for 6 months, May - October 2015

	May	Jun	Jul	Aug	Sep	Oct	Total for 6 months	%
SG Discrimination	1	1	1	1	3	0	7	2
SG Finance/material	14	26	20	16	15	18	109	26
SG Neglect/Act/Omit	16	26	16	22	19	20	119	29
SG Physical Abuse	5	11	15	15	14	16	76	18
SG Psych abuse	4	7	12	18	8	5	54	13
SG Sexual abuse	0	6	0	1	1	1	9	2
Safeguarding Follow-up	6	11	5	0	10	6	38	9
Total safeguarding contacts	46	88	69	73	70	66	412*	100%
Total number of ALL helpline contacts received (May – October)	3214	3930	3610	3641	3585	3269	21222*	

*The 412 safeguarding-related calls constituted 2% of the total 21,222 calls received during the 6 months May-October 2015.

The organisation has undertaken its own research on the subject of financial abuse, including surveys of carers of people with dementia about the ethical issues involved in handling the money of a person with dementia and a survey of its own staff in relation to the frequency with which they encounter the problem. In one study, 86 staff from a total of 277 staff from branches across the country responded to a questionnaire circulated on-line. These included service support managers, support workers, dementia advisers and home support workers (see Samsi, Manthorpe and Chandaria 2014; Chandaria 2011). They were asked about how often they encountered problems to do with money management. Almost half said it was a frequent occurrence while only 5% said they had never encountered it.

³³ In 2015, 720,251 of the 856,700 people in the UK with dementia live in England, 45,321 in Wales, 70,162 in Scotland and 20,966 in Northern Ireland. Source: https://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=412

³⁴ Parkin, E and Baker, C (2015) *Dementia - improving diagnosis, care and research and statistics on prevalence*, House of Commons Library, No 07007, 26 November 2015.

Table 16 Alzheimer’s Society survey of staff: Frequency of money management issues reported by Alzheimer’s Society staff working with people with dementia

Frequency	%
Never	5
Rarely (less than three cases a year)	18
Occasionally (three to six cases a year)	29
Frequently (more than six cases a year)	48

Sixty-five respondents identified 3 ‘warning’ triggers that might indicate a problem or a possible ‘at risk’ situation:

- changes in a client’s relationship with money
- a client’s personal vulnerability; and
- suspicious external interest or influence

Because of its concerns about the safeguarding issues often implicit in many of the cases they deal with, the Alzheimer’s Society has adopted the safeguarding policies set out in the London Multi-Agency Adult Safeguarding Policy and Procedures (recently updated) to ensure they offer people with dementia the best protective measures possible.

The Alzheimer’s Society is an example of how the voluntary sector can make a significant contribution to a wider understanding of financial abuse in several ways – through its handling of cases of possible abuse, its range of contact with individuals, their carers and wider families and as a source of insights into and hard data about the scale of the problem. The issue of finance & material abuse is the second most frequently reported issue among safeguarding calls received by the helpline. It is encountered by members of staff and well-understood and recognised by many people with dementia and their families. It has aligned its classification system to that used by local authorities which assists both in sharing information and adopting a consistent approach to its analysis. There may be potential for other voluntary organisations to adopt this approach.

Concluding comment

Although there are limited statistics available which deal directly with the scale of financial abuse of people lacking capacity, those that do exist throw a partial light on the subject from several angles. Safeguarding statistics produced by the HSCIC are already able to demonstrate the range of local authorities’ activity in adult protection and over time will be able to show trends in the scale and type of risks involved. Financial abuse is one of the categories included. Crime statistics and crime surveys provide very little insight into levels of financial abuse of vulnerable people. The OPG produces a limited range of data, likewise the Quarterly Family Court Statistics Bulletin. In contrast, data from the Court of Protection is a rich source of information (although more often qualitative than quantitative – as we shall see in chapter 4) about the links between intra-family dispute and financial abuse. More generally, efforts in recent years to improve the consistency of safeguarding statistics (in the light of changes to the law and attempts to reduce the burden on local government of unnecessary data collection) have been agreed – although criticisms have been made in some quarters, as we note in the next section, suggesting that important data may be lost as a consequence.

It is apparent that data collection in relation to financial abuse is undertaken neither systematically nor comprehensively. This perhaps mirrors the fragmented way in which the prevention or containment of financial abuse is tackled generally – dealt with by different agencies, with different sanctions at their disposal. When it is a matter of considering financial abuse specifically in relation to people lacking capacity, the conclusion is also disappointing.

Part 2

Impressions from talking to experts

Another route into developing an understanding of the financial abuse of people lacking capacity was to talk to professionals with practical experience of the issue. In a series of conversations with more than 30 professionals in the judiciary and the law, banking, building societies, advice-giving and local authorities, and in both national and local voluntary organisations³⁵, we were able to build a composite picture of their perceptions of how financial abuse can affect those lacking mental capacity in a wide range of situations. Seven clusters of viewpoints and perspectives were identified:



Each of these perspectives is based on the reservoir of knowledge, action, attitudes and experience particular to the different professional groups involved. The following sections summarise their views.

Capacity issues

One overarching concern among those involved primarily with the law³⁶ related to the tension between older approaches to defining capacity and more recent ones – especially in relation to the impact of the Mental Capacity Act 2005. The major difference since the Act, broadly speaking, had been the emphasis it places on supported, rather than substituted, decision-making and the acknowledgement of the fluctuating nature of capacity in relation to decision-making for many individuals. The impact for those involved in cases of

³⁵ These included judges, lawyers, safeguarding officers, managers, investigating officers, police officers, nurses, advice workers, OTs, policy officers – from the front line to chief executives.

³⁶ Especially the judges and safeguarding professionals

safeguarding and protection (at both local and national levels), including the OPG and Court of Protection (CoP) had been substantial.

But the situation was not static. Some of the experts we spoke to (particularly the two judges and some lawyers) were concerned about the impact of the United Nations Convention on the Rights of Individuals with Disabilities in relation to its statements about mental capacity. The judges were particularly concerned with whether the Mental Capacity Act 2005 (MCA) was compliant with the Convention. If not, the basic aims of the Act were failing to be met. Essentially the question revolves round the definition of mental capacity and the best interests decision-making framework – which legislators had thought the MCA addressed appropriately. The judges both referred to the Essex Autonomy Project’s report³⁷ on the issue which concludes among other things that:

- the MCA was not compliant
- its definition of mental capacity violates the anti-discrimination provisions of CRPD
- the best-interests decision-making framework of Section 4 of the MCA fails to satisfy the requirements of CRPD

It goes on to make a number of recommendations to amend the MCA accordingly.

One of the judges we spoke to said he had lost a debate organised by the department of philosophy at Essex University on the issue of MCA compliance with the convention but reflected that that perhaps was simply an indication of the difference between “the philosopher and the pragmatic judge”.³⁸ Thus the debate about compliance continues. It remains a contested area and, as such, differences of view will continue to have an impact on current interpretations of the MCA within the safeguarding community.

A particular matter of concern has been the low level of public awareness of the risks associated with the experience of diminishing or fluctuating capacity since the passage of the MCA. On the one hand awareness of the provisions of the Act has grown, as demonstrated by the growth in the number of LPAs being registered every year (395,000 in the past year, a growth of 33% on the previous year). On the other hand, during the same period, the number of investigations undertaken by the OPG (prompted often by whistle-blowers of various sorts) into possible breaches of duty by attorneys has also risen. Applications by the Public Guardian to the Court of Protection for the revocation of attorneyships or deputyships, as a consequence, have also increased. As will be seen in a later chapter, not all revocations relate to behaviour which is necessarily abusive (or finance/material assets-related) but it is one way in which the problem of financial abuse is publicly revealed. Hence our interest in the work of the OPG and the CoP.

In relation to the working of the MCA itself, one of the judges stressed his concern that many of the professionals working in fields involved with capacity issues knew too little about the MCA 2005 Code of Practice³⁹ – a view confirmed by the House of Lords inquiry into the working of the Act (House of Lords 2014). He also expressed concern that few lay people – including attorneys and non-professional deputies – had any knowledge either, as often became apparent in the cases he heard in court. In this context, sources of advice – be they from lawyers, independent financial advisors and the like – were not always as reliable as they could be.

As well as remarking on the changing understanding of the nature of capacity and the implications of this for courts, professionals and lay people alike, several of our experts expressed concern about the impact of the notion of ‘undue influence’ on individuals who may be vulnerable to malign intent whether they lack capacity or not⁴⁰ [see also Appendix 3, Case study 1]. They felt that its definition was currently too narrow especially when so much emphasis now is placed on autonomy and supporting individuals to make decisions themselves. It may expose them to actions by friends or family members (and others) which are contrary to their best interests.

³⁷ Martin, W, Michalowski, S, Jütten, T and Burch, M (2014) *Achieving CRPD compliance: Is the Mental Capacity Act of England and Wales compatible with the United Nations Convention on the Rights of Persons with Disabilities? If not, what next? An Essex Autonomy Project Position Paper*, Report submitted to the UK Ministry of Justice 22 September 2014.

³⁸ <http://www.mentalcapacitylawandpolicy.org.uk/2014/03/14/>

³⁹ Mental Capacity Act 2005 Code of Practice Issued by the Lord Chancellor on 23 April 2007 in accordance with sections 42 and 43 of the Act.

⁴⁰ As Senior Judge Lush remarked in a lecture in November 2015: “I hope that, when we review the Mental Capacity Act, as we surely must do soon, we take into account undue influence, which is currently outside the scope of the Act, and include it with capacity in a more holistic piece of legislation on decision-making.” <https://www.5sah.co.uk/news-and-events/articles/2015-11-27/a-gilded-cage-is-a-cage-no-less-the-mental-capacity-act-interfaced-with-the-un-convention-on-human-rights-of-disabled-people-and-the-eu-convention-on-human-rights>

Further, it may go hand in hand with ‘abuse of trust’ – often associated with the financial abuse of individuals, vulnerable through declining capacity, where ‘trusted’ people violate that trust through their financial exploitation. People with learning disabilities were particularly vulnerable in the eyes of some of the experts – they cited ‘mate crime’ as an example, where a friend with a dominant personality would ‘borrow’ money and not pay it back often on a regular basis (with the individual too nervous to ask for it); or overbearing parents using their adult son or daughter’s money for their own purposes rather than for their offspring. Some of those in legal and financial organisations responsible for the management of large financial settlements for individuals who had suffered traumatic brain injury were particularly alert to the risk of undue influence being exerted on their clients where more substantial sums could be involved.

Safeguarding

The tension between empowerment and protection which underpins much of the debate around the MCA, is paralleled in safeguarding circles by an awareness of another tension – that between personalisation and adult safeguarding. The concept of ‘personalisation’, as noted in chapter 1, has dominated social work theory and practice for more than a decade, as noted in chapter one. In practical terms, it means that individuals’ needs should be met by a (local authority) response which is tailored to the individual’s situation and preferences (rather than offering access to a fixed set of services). In many cases it also means being offered a personal budget, and sometimes a direct (cash) payment, which the individual controls. ‘Person-centredness’ must be the core of all provision. The latest guidance on implementing the concept, and relevant here, is the documentation produced by local authorities in 2014 and 2015^{41, 42} along with the very recent update of the official guidance to the Act which sets out the principles upon which safeguarding under the Act is now founded⁴³:

Six key principles underpin all adult safeguarding work

Empowerment

People being supported and encouraged to make their own decisions and informed consent.

I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens.

Prevention

It is better to take action before harm occurs.

I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help.

Proportionality

The least intrusive response appropriate to the risk presented.

I am sure that the professionals will work in my interest, as I see them and they will only get involved as much as needed.

Protection

Support and representation for those in greatest need.

I get help and support to report abuse and neglect. I get help so that I am able to take part in the safeguarding process to the extent to which I want.

Partnership

Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.

I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together and with me to get the best result for me.

Accountability

Accountability and transparency in delivering safeguarding.

I understand the role of everyone involved in my life and so do they.

⁴¹ LGA (2015) Making safeguarding personal: a toolkit for responses, Fourth Edition.

⁴² ADSS/LGA (2014) Making Safeguarding Personal: Guide 2014

⁴³ Department of Health, The Care Act 2014, Care and Support Statutory Guidance, update, 21 February 2016

<https://www.gov.uk/guidance/care-and-support-statutory-guidance/safeguarding>

Making safeguarding personal

In addition to these principles, it is also important that all safeguarding partners take a broad community approach to establishing safeguarding arrangements. It is vital that all organisations recognise that adult safeguarding arrangements are there to protect individuals. We all have different preferences, histories, circumstances and life-styles, so it is unhelpful to prescribe a process that must be followed whenever a concern is raised

(From Chapter 14)

The safeguarding experts we consulted (chairs, managers, policy officers) were broadly optimistic that this emphasis on personalisation was improving local authority safeguarding procedures. It meant ensuring that full account was taken of the need to support people at risk in decision-making and by recognising the attendant rights of those individuals to make decisions that might be unwise (provided they were not made as a result of undue influence or total lack of capacity). In relation to safeguarding, they welcomed the recognition of the complexity of relationships within families and between friends which can sometimes be involved in abusive situations (where sustaining a relationship may be as important to the victim as removing the abuse)⁴⁴. However, they saw that this could sometimes make safeguarding interventions difficult – in situations, for example, where the person exposed to risk from a close family member did not necessarily want the relationship to be ended. Instead, new approaches – one informant gave mediation as an example – might sometimes be used to restore relationships, closing down abusive behaviour in the process. There was some recognition however that financial abuse might not be amenable to this sort of safeguarding intervention, especially where capacity might be at issue.

While they acknowledged the importance of the Mental Capacity Act 2005 (especially in relation to the best interests and ‘right to make unwise decisions’ requirements), rather than focus on it, they tended to speak more about the continuing impact of the *No Secrets* guidance issued in 2000 and the preparations that were being made for the implementation of the Care Act 2014 which was to replace it (and which came into effect during this stage of our investigation, in April 2015). They saw the new Act as an achievement of the aim of introducing personalisation which had been in process for many years.

As safeguarding took on a more public profile, they kept abreast of developments in the field (through a network of colleagues) in order to share intelligence about implementing the Care Act 2014. They hoped that the newly conferred statutory status of the Safeguarding Adults Boards (SABs) under the Act would give them more authority and would ensure that they were better resourced, more streamlined and more effective.

Their views about safeguarding progress so far were mixed. Although the new arrangements were helping in some respects, old problems persisted. Inter-agency working, though seen as a central requirement for a system to work effectively, was not always straightforward. They had encountered problems to do with joint assessments of capacity and felt that sharing of information between agencies could sometimes be problematic. Common commitment to full participation was sometimes in question – agencies varied in their records of regular attendance, with Department of Work and Pensions and OPG representatives not always attending. Standards of proof in cases of suspected abuse differed between police and other agencies and this could affect decisions made about taking cases forward. There was also a suggestion that police were less familiar than their social work colleagues with the MCA⁴⁵. More generally, some felt that over the years local authorities had given greater priority to safeguarding children as opposed to adults – and that this was not surprising given the hostility sometimes expressed towards the profession in the media when children had been found to be at risk.

⁴⁴ The delicate issue of tackling abuse within the family comes into focus here. Much of the financial abuse affecting people who lack capacity involve family members. At the same time many people lacking capacity are cared for by their families and sometimes those who abuse may also care. One comment at a roundtable ‘expert discussion’ on financial abuse which we attended cautioned against “demonising the family” by portraying it as the source of abuse. The evidence considered in this report suggests that as much care should be taken to ensure that, where abuse occurs, it should not be permitted to remain hidden.

⁴⁵ See parallels in relation to mental health: Cummings, I and Jones, S (2010), Blue remembered skills: mental health awareness training for police officers, *Journal of Adult Protection*, 12, 3, 14 - 19.

Criminal justice

Our police experts felt the police were playing an increasingly prominent part in the safeguarding system with representation on SABs around the country, with a number of them chairing SABs, or SAB sub-groups. They knew of former police-officers who on retirement had moved over from policing to work in local authority safeguarding teams. While commending this, some of our experts (police and others) also acknowledged that the relationship between the criminal justice system and safeguarding processes is not always a smooth one. Several felt that one of the challenges facing safeguarding – especially in terms of financial abuse – is understanding and identifying abuse that would meet a criminal standard of proof, so that cases can be taken to court and successfully prosecuted. Non-police colleagues did not always acknowledge this. They also pointed out that beyond this, the crown prosecution service might also apply a public interest test in making a decision about prosecuting someone or not – which could also result in no action being taken, regardless of the police view. This, they argued, frustrated victims of abuse, or those supporting them if they lack capacity, when they find that in their situation there is no means of seeking redress or seeing the perpetrators brought to justice. Moreover, financial abuse that takes place within the family or between friends barely figures in official crime statistics – neither as a separate category nor in terms of numbers of incidents reported (see earlier).

Police experts also felt pressures in other directions. These included having to respond to other priorities, laid down by other decision-makers within the police service along with demands from the centre which took time away from other duties (including safeguarding) – especially in London, as a capital city with many other sorts of demands being made on the police. This meant that attention might sometimes be diverted away from safeguarding. However, there had been many collaborative initiatives developed in recent years to make safeguarding of different types more effective: SABs (Safeguarding Adults Boards); MARAC (Multi Agency Risk Assessment Conference), principally concerned with victims of domestic violence; MOPAC (Mayor’s Office for Policing and Crime); and FALCON (Fraud and Linked Crime Online), the chief co-ordinating mechanism for the MPS (Metropolitan Police Service) response to fraud, including scams and, especially, cyber-fraud. The financial abuse aspects of these collaborative arrangements have hitherto received no evaluation.

Voluntary sector

Experts from the 4 different voluntary organisations we consulted tended to have a different perspective on certain issues from those in the statutory sector in respect of certain issues. They had direct experience of speaking to those supporting, and sometimes living with, people lacking capacity, usually via their organisations’ help/advice lines and this directly informed their views. Figures are hard to come by – voluntary organisations tend to lack the resources to analyse their activity in very great detail. They may log overall numbers of telephone calls or emails they receive, but beyond categorising them in broad terms, they are often not able to pursue further analysis, each having its own method of classifying calls which may not tally with others. Some receive high numbers of calls about a wide range of topics, as much about the need for advice and information and advice about welfare benefits, pensions or wills as about abuse. Where abuse is recorded it may not differentiate between different sorts of abuse. However, common issues emerged – an expert whose organisation has branches across the country remarked how sceptical staff in local branches were about the notion of a ‘trusted family member’ when it came to relying on the honesty of some families looking after the finances of relatives who lacked capacity. For these local offices, he remarked, financial abuse was a repeatedly reported concern for advisors, though not necessarily an easy one to tackle.

One strength that advice-giving organisations possess is their ability to provide detailed case studies of cases of suspected abuse as provided by, and based on, the experience of (mostly) a supportive family member or concerned friend. Our experts were able to provide us with a number of such cases (see *Appendix 2: Case studies 2 & 3*).

Helpline providers saw the importance of their role as one which is valued, through offering people opportunities to air fears without having to make decisions there and then as to what steps to take next. In general, callers to voluntary organisation helplines are family members or friends concerned about a loved one. This was not always the case though. One of the experts whose helpline had received 16,000 dementia-related calls during the past 7 years, told us that 18 calls in the previous month had come from people who themselves were living with dementia. One organisation dealing with calls predominantly to do with abuse received over 20,000 calls per year, many of which concerned financial matters. In the case of another advice-giving organisation, between 40-

50 cases to do with general financial issues are received each week and are classified as complex enough to require further attention (moving to 'level 2' of concern). Of a recent sample of 28 of these given to us, 3 concerned suspected financial abuse, one of which is shown here:

X has recently discovered that Y [a relative] has been gifting large sums of [GF's] money £2500 and writing weekly cheques for food for £200 and not providing receipts. X spoke to Y who said that GF would want this but has never given away gifts and it is not within his usual course of spending

Case of potential abuse reported to advice line A

Voluntary organisation representatives had mixed views of the statutory sector. They saw themselves as sitting between individuals (family members, those lacking capacity) and the "authorities". They were confided in [via the anonymity of a telephone helpline] by members of the public as well as their known clients precisely for that reason - they were not so tightly bound by a duty to report suspected abuse (though increasingly the safeguarding procedures adopted by statutory authorities are being adopted by voluntary bodies which sets out guidelines for reporting⁴⁶).

Some also had jaundiced views about the effectiveness of the official safeguarding process and about the seriousness with which many cases of financial abuse were or were not taken. One expert from the voluntary sector said that he thought that safeguarding staff in some local authorities simply went through the routines of establishing capacity or not and left it at that. It was partly the result of working under too much pressure, but also that attitudes to work had changed – with it being seen more as administrative than professional these days. He said:

There are many issues that I could note here if I had time to write at length but the chief issue that concerns many of the folk I've spoken to over the years is the failure of the Police and Adult Safeguarding to intervene in issues of financial abuse or exploitation of elderly people even when substantial amounts of money and property are involved. It's very common almost to the extent of being routine that both Police and Adult Safeguarding advice people that there's nothing that can be done to investigate, seek recompense or charge the abusers. Many folk find it very difficult to get good advice from CAB, solicitors and other advice organisations about financial abuse. *Advice line worker B*

We found that those who have face-to-face, personal dealings in their caring role with people who lack capacity or their close family and friends generally held similar views about financial abuse. They reported that financial abuse was a phenomenon commonly encountered in the course of their work, as a possibility, a suspicion or a fact. A number of the health and social care experts, working in voluntary organisations concerned variously with dementia, brain injury and learning disabilities, had previously worked as health or social care workers (e.g. nurses, OTs, social workers) in the statutory services and spoke of their past experience of having to handle delicate intra-family relationships possibly involving financial misbehaviour. Sometimes it would be reports of abuse by a paid worker, another family member, a friend or neighbour, but on other occasions it was individuals lacking capacity themselves being suspicious (sometimes, perhaps, unwarrantedly or "mis-imagined") of being abused by one of their nearest and dearest. These latter cases often created worries for putative victims which were hard to overcome through reassurance.

In one organisation, much effort had been invested in ensuring staff were trained in safeguarding practice (and updated annually) and were aligned with local authority safeguarding procedures, with case-recording mirroring local authority practice as set out in Care Act guidance. They had close contact with a wide range of people with acquired brain injury and were well aware of the sorts of issues that arose in relation to their capacity, or not, to manage financial decisions.

⁴⁶ See, for example, London Multi-Agency Adult Safeguarding Policy and Procedures, November 2015

A number of cases were described:

Potential financial abuse by daughter. Client alleged her daughter was trying to “force” her to give benefit back pay to her to pay for her wedding. Client has capacity to manage finances (*located in London Borough CC*).

Potential financial abuse by landlord (no formal agreement, payment in cash without receipts, **assessed by social services as not having capacity to manage finances**, resulting in taking out and carrying large amounts of money in cash). Social Worker had already made application to Court of Protection for deputyship. Support worker continued to monitor incidents and making regular reports to allocated Social Worker (*located in London Borough AA*).

Potential financial abuse by main carer (ex-husband) who took complete control of client’s finances following injury. Allocation of IMCA. Multiple Strategy meetings held. **Suspected not to have mental capacity to manage finances**, referrals made to Psychiatrist / Psychologist for Mental Capacity Assessment and Social Services safeguarding team leading investigation and support (*located in London Borough CC*).

Another of the organisations we consulted supports people living with dementia and provides professional development training for its dementia care nurses. Seven of the nurses responded (anonymously) to a questionnaire handed out by the course leader at our request to around 50 of their 140 nursing staff. They were asked what experience of financial abuse committed by relatives, friends, acquaintances or informal carers they had had in the course of their work. Of the 7 nurses who responded, all confirmed they had encountered it and 6 of those 7 said they had had cause to report their worries about specific cases to management. All of them had come across cases of stealing money, personal property and valuables, while 6 had encountered examples of individuals at risk coming under moral pressure to make financial decisions in favour of the abuser, as well individuals being deceived (by lying) into making financial decisions in favour of the perpetrator. Five of the nurses said they had encountered cases of perpetrators making gifts to themselves from the victim’s own money and 3 had found perpetrators making unauthorised gifts to others from the victim’s assets. Unfortunately, the 7 respondents are insufficient to treat as a representative sample, but this is a useful indication for future research, and shows a rate of 14% of those professionals sampled.

Extracts:

My experience of it - it often happens in families. Either Power of Attorney (POA) is manipulated (which is easy) or [a] family member moves the person with dementia into care quickly to claim their finances. Sometimes benefits (e.g. Attendance Allowance) is misused by [a] family member. I think that the POA structure is weak and does not hold up when someone is being financially abused. *Dementia nurse (d2) (d2(d2))*

There is complexity about what is in the best interest of the p.w.d. [person with dementia] + what they would want for their family member i.e. carers may feel morally entitled to assets that would otherwise impact on care eligibility (i.e. Thresholds for paying for care). In other words better for ‘me’ to have it than it goes to the govt/social services! *Dementia nurse (d6)*

I have also come across a case where property may have been gifted + sold but with the aim of avoiding paying for care..... money and gifts have been given to people in exchange for small services but the value of the gift far outweighed the cost of the service.... *Dementia nurse (d3)*

Vulnerable adults being tricked by con men (knocking on doors demanding money for work not completed) and in some cases been taken to the bank to withdraw the cash. *Dementia nurse (d4)*

The experiences of the voluntary sector experts we spoke to seemed to confirm the view, held by many professionals working in what is a closely personal and carer relationship with people lacking capacity, that financial abuse is frequent but under-reported – and that it is hard for professionals to tackle it because of the difficulties of obtaining convincing evidence.

Policy frameworks

Officers with policy responsibilities in some of the non-statutory organisations to whom we spoke held mixed views about the safeguarding policy framework within which the sector was operating, sometimes differing from their statutory service counterparts. These included views about the success and consequent benefits of inter-agency collaboration as well as about general *policy* directions in the safeguarding field too. This difference appears to be due in part to their structural position. Professionals working in the statutory services (local authorities, courts, police) are necessarily committed to their roles and duties as laid out formally in their organisation's statements of aims and objectives – which are themselves laid down to varying degrees by government and the law. Those located in the non-statutory sector, however, being less 'officially' constrained, may feel freer to adopt a questioning and sometimes critical view of official policy. They were far more ready to voice their scepticism about official policy goals conditioned, as they were, by the reality of daily practice working under pressure with their particular client groups. Professional background, organisational allegiance and sectoral differences have, in other research, all been shown to play a part in the construction of attitudes to everyday practice (Dalley 1989).

A specific view was expressed by one expert about what were seen as differences in safeguarding practice before the Care Act 2014 and now (2015) in the current lead-up period to its implementation. Up until the Act, safeguarding (adult protection) had been governed broadly by community care legislation from the 1990s, the guidance issued under *No Secrets* in 2000 and, later, the Mental Capacity Act 2005⁴⁷. Forthcoming changes, according to this view, could mean some detriment for people at risk. So much would now depend on the Care Act – and the guidance had not yet been fully worked through⁴⁸ – with greater demands on the system being made yet with insufficient resourcing. Moreover, there appeared to be less commitment on the part of the legislators to developing a complete picture of the scale of abuse experienced by vulnerable people. Changes to the way in which HSCIC statistics were compiled, he suggested substantiated this worry. The number of counts that were subject to mandatory reporting had been reduced and some had been abandoned or "replaced" (even though the aim was to build a national picture of safeguarding). For example:

SG1 Demographic Tables in 2015-16⁴⁹

- Collect counts of 'individuals involved in section 42 safeguarding enquiries'. This will be *mandatory* and *will replace* collecting counts of 'individuals involved in safeguarding referrals'.
- Collect counts of 'individuals involved in safeguarding concerns' and 'individuals involved in other safeguarding enquiries' on a *voluntary basis*.
- *Cease* collecting information about whether individuals were already known to the Council.
- There will be a *voluntary* table to collect the total counts of safeguarding concerns, section 42 safeguarding enquiries and other safeguarding enquiries. *This will allow us to gain a national picture of total safeguarding activity during the year.* [our italics]

⁴⁷ See chapter 1 of this report.

⁴⁸ Updated guidance was published on 21 February 2016 (see earlier), some months after the relevant interview took place

⁴⁹ HSCIC (2015) Guidance for completing the Safeguarding Adults Collection (SAC) 2015-16

The same expert felt that safeguarding lacked any comprehensive legislative structure, no central vision or ideological commitment and that a gap was beginning to develop between attitudes and outlook in the safeguarding community and in the judicial system.

Another expert had concerns about the impact that developments in other policy areas would have on safeguarding activity. New pension freedoms (to dip into pension pots rather than being required to buy once-and-for-all annuities⁵⁰) were predicted as putting people at risk of exploitation by unscrupulous people. He foresaw an increase in cases reported to his organisation. He questioned whether existing protective structures (such as the Court of Protection) would be able to counter these dangers. The rapid growth of on-line banking and other technological innovations was outstripping the ability of the safeguarding authorities to keep abuse in check. He was concerned that the safeguarding system would not be able to keep up with constant developments of this kind.

In general, voluntary sector experts saw their organisations as having a distinctive role in drawing the attention of the statutory services to issues which may be hidden from official view. They were in a position to plot trends and identify new issues. Growing social problems came to their attention as a result of personal testimonies made to them by members of the public – as in the case of the financial abuse of vulnerable people. Thus their knowledge and views were sought by official bodies (one example cited was the Financial Conduct Authority).

Custodianship of assets

As with the voluntary sector, lawyers, banks and building societies are also in a position to identify the severity of the risks of the financial abuse of vulnerable people and provide counsel and advice to those at risk. But they are also in a strong position to provide various means of protecting the *assets* as well as the individuals who are under threat directly – lawyers, in drawing up appropriate safeguards (e.g. in advising on and drawing up wills, LPAs and trust and estates arrangements, acting in disputes relating to fraud)⁵¹; and banks and building societies in providing havens for the actual assets – and in cases where large settlements have been made on individuals as a result of accidents which have left them severely brain-damaged or otherwise disabled, providing direct management of those assets⁵².

Because of this custodianship role, the financial institutions are sometimes criticised for being both too protective and too lax – too protective by refusing to cooperate with attorneys where they have perfectly legitimate power to make financial decisions on behalf of the donor, or too lax by permitting illegitimate financial activity to take place, undertaken by non-authorized individuals, supposedly on behalf of the person lacking capacity. Experts from this sector were well aware of this tension and several described steps their sector had been taking to get the balance right. They recognised that it was necessary to ensure principles and tactics were in place throughout their organisations to ensure good practice – but acknowledged it was difficult to ensure these were embedded at all levels of the organisation, given that the staff who were most often confronted with dilemmas about whether or not to accept requests to make financial transactions were often those who were the most junior and least experienced. They described various strategic attempts to improve public confidence in their commitment to improve matters⁵³. They were increasing their capacity in analytics in order to design technical strategies for spotting patterns of, and raising alerts to, possible abuse. They were keen to share ideas on a broader basis to improve practice in this area.

Another expert from the same sector, agreeing that it was important to strengthen front-line staff's ability to handle difficult situations, suggested that it was important to provide appropriate training (for example, involving role play exercises and discussions with senior management) which would build their confidence in handling suspicious situations. One of the difficulties was, he argued, that it was difficult to get a measure of the problem. There are few statistics or other sorts of evidence that relate incidents at the counter to police or court statistics. Where they knew LPAs were involved they reported cases to the OPG and then to the CoP rather than to the

⁵⁰ Between April and June 2016, 159,000 people withdrew £1.8bn from their pensions, bringing the total to £6.1bn since the reforms in 2015 (<https://www.theguardian.com/money/2016/jul/28/pension-freedom-withdrawals-accelerate-to-top-6bn>)

⁵¹ Law Society (2013) *Financial abuse: practice note*.

[http://www.lawsociety.org.uk/support-services/advice/practice-notes/financial-abuse/Law Society](http://www.lawsociety.org.uk/support-services/advice/practice-notes/financial-abuse/Law%20Society)

⁵² One of our experts represented a major bank's wealth investment & management division.

⁵³ One of us attended one of their conferences held to gather intelligence on improving practice in this area.

police who have to take time in searching for evidence that would make a case. In his view, the authorities generally focused on the disruption of the behaviour rather than seeking to make a case to take to court and conviction (for which sound evidence may be hard to compile). He firmly believed that, as opportunities for abuse developed with increasing reliance on digital remote access in conducting financial transactions, protection had to be 'designed in' to systems of protection and prevention. This had to come from the centre (the policymakers and legislators) and not just the financial institutions themselves.

He was well aware of the difficulties involved in tackling intra-family abuse because of its hidden nature. One way forward, he suggested, would be to try to stigmatise the financial abuse of vulnerable people – he argued that by highlighting the particular nastiness of such behaviour it would become the subject of public disapprobation, placing a social taboo on it, similar to that which now characterises child abuse.

In dealing with the legal aspects of the financial affairs of clients, lawyers see and have to deal with disputes and misbehaviour, and the outcomes. Inevitably (because of the costs involved), this mostly involves the affairs of wealthy individuals, often where the individuals lack capacity. One of our experts suggested that the steep increase in the number of deputies being appointed annually might be a reflection of an increasing amount of financial abuse going on. Additionally, the increasing number of lawyers, and their professional organisations, specialising in the area of mental capacity, old age and property law is associated with the growth in the number of people surviving into old age, sometimes with a significant decline in mental capacity. Their role has become increasingly specialised in this area – although one expert, a lawyer, drew attention to the fact that disputes still arose despite lawyers having been involved in advising and drawing up LPAs in the first place. He regretted that professionals did not always keep themselves up to date.

Concluding comment

In the second part of this chapter, we have reported on the views of a range of professionals ('experts') on financial abuse as they came across it through their work. We have thus been able to assemble a picture from several different perspectives. They were able to give examples, often in some detail. Many of them believed that abuse was often committed without the perpetrators ever being identified and brought to book.

The professional views that we have tapped into ranged from the first line of protection – that of councils bearing generalised responsibility for safeguarding adults – to the specialised institutions charged with oversight and implementation of protection legislation (OPG and the CoP), the criminal justice system involving the police and the courts, and the voluntary organisations which respond to the care/support and advice/information needs of people lacking capacity. We are aware that two areas of institutional responsibility have not been explored – the statutory health services, that is, the NHS (although we have spoken to health care professionals working in the non-statutory sector) and the statutory social security services (the Department of Work and Pensions) – especially in relation to appointeeships which would provide insights into the financial exploitation of people with few assets and resources. Time and resources did not allow for further investigation to cover these two areas.

None of the data sources considered in this chapter presents – on its own – a full picture of the nature or extent of financial abuse in society, particularly as it affects people lacking capacity. Taken together, however, they begin to show that it might be widespread, found in many different settings under a wide range of circumstances. Statistics form a very modest part of the picture.

Chapter 3

SAFEGUARDING ADULTS IN ONE LONDON BOROUGH (LBX): TACKLING FINANCIAL ABUSE



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SAFEGUARDING ADULTS IN ONE LONDON BOROUGH (LBX): TACKLING FINANCIAL ABUSE

Background

Our plan to conduct an extended case study was based on our view that it would be an effective way of expanding general understanding of the nature of financial abuse as it affects those lacking mental capacity. Through a case study, we expected to provide a detailed picture of financial abuse in one specific area, explored from a range of perspectives, with detailed statistical information to give the study substance, and with the possibility of being able to generalise from some of the findings to other settings.

We planned to focus on a particular geographical, administrative (local government) area because of its administrative coherence and broadly aligned systems for policing, NHS and social services, courts, safeguarding arrangements and an active voluntary sector. We chose London to search for an area with these characteristics for a practical reason – ease of access for researchers who were London-based.

We aimed to establish a picture of what is known overall about the extent and dynamics of the financial abuse of people lacking mental capacity within the case study area, including:

- the formal record of its extent in the area through statistics gathered locally and nationally;
- the mechanisms that exist for identifying and preventing financial abuse;
- professionals and voluntary sector groups involved;
- the extent of professional and lay awareness and understanding of financial abuse; and
- the strength and weaknesses of existing surveillance/monitoring/preventive procedures as perceived by local actors (professional and lay).

Demography

We chose a London Borough (LBX) which, according to the 2011 Census, was typical of the heterogeneity of London as a whole in several ways:

- *age profile*: overall, it is described by the council as a young borough, with a mean age of 35 (compared to London as a whole of 35.6 within a range of 41.4-30.9) and median age of 33 (compared to London as a whole of 32 within a range of 40-29).

Age band	2011	%
0-4	22,446	7.21
5-19	55,179	17.73
20-64	200,914	64.56
65-89	31,489	10.12
90+	1,187	0.38

- *ethnicity*: it had a total population of 311,215, high on ethnic mix, made up of 36% white; 5% mixed heritage; 33% Asian/Asian British; 19% Black/Black British; 7% other groups.
- *religious affiliation*: this mix of affiliations was comprised of 48% Christian; 18% Hindu; 12% Muslim and 10% saying they were of no religious persuasion.
- *housing tenure*: there had been a 12% decrease in owner occupation since 2001, down to 44%, with an increase in private renting at 32%, up from 18% over, the same period. Social housing stood at 24%.
- *economic activity*: while having an above average rate of unemployment for a London borough, there was economic diversity within the borough – with the percentage of working age people in receipt of unemployment benefit (JSA) ranging from 11.5% in one ward in the southern part of the borough to 2.6% in one in the northern part (out of 21 wards in all).

From: 2011 Census KS102EW Age structure, Local Authorities in England & Wales [in relation to LBX]

This wide socio-economic and cultural mix, reflecting the heterogeneity of Greater London as a whole, made it likely that attitudes towards family obligation, wealth ownership and inheritance, mental capacity, dependency and caring responsibilities, together with attitudes and motivations towards financial abuse, would also reflect that mix. As we shall see, safeguarding referral rates for the borough were not dissimilar from other London boroughs. It was therefore not an atypical place for reports of financial abuse – there was neither a lot more of it nor a lot less.

It would, we concluded, provide a good basis for our proposed investigation.

Case study methods

We adopted a mixed-methods approach – using statistical analysis alongside interviewing key individuals within the area and examining any documentary records that were available.

Statistics

We planned to analyse whatever statistics existed relating to financial abuse and residents in the borough were available – and expected that national statistics would be available that could be broken down to local level.

Rapid appraisal

As well as looking at quantitative data we also planned to conduct a rapid appraisal (Ong 1991) – focusing on the role of key individuals and institutions, mapping their responsibilities with regard to financial abuse, within the defined geographical area of the borough, to discover what was known and what could be shown through further investigation to enhance understanding of the nature and extent of financial abuse. It could involve:

- safeguarding adults board members
- health and wellbeing board members
- lawyers
- police officers
- social workers
- local voluntary sector members
- community health professionals
- medical practitioners (primary and secondary care)
- complaints managers in different agencies
- pastoral leaders from faith groups

Some would be senior figures in their organisations, others would be frontline staff with direct experience of cases. We also hoped to establish contact with voluntary carers/support groups established to offer families and vulnerable people themselves informal support and help.

In interviews with this range of individuals, we planned to explore their experience of encountering or dealing with financial abuse from their own particular standpoint – as professionals with specialist expertise of financial abuse in relation to their particular clientele, gaining insights that could be distinctive of their own position. We hypothesised that the blend of professional knowledge, individual perception and familiarity with different aspects of vulnerability would be likely to vary accordingly. Similarly the experience of non-professionals, and volunteers, would also produce distinctive insights.

Part 1

Safeguarding referrals in LBX

The main source of relevant statistical material was the HSCIC returns on safeguarding in England for the year 2014-15 (the most recent at the time of the research) are the Safeguarding Adults Returns (SARs) submitted annually by local authorities and are published annually in October (and reviewed earlier in chapter 2 of this report). Data are presented on a national (England) and regional basis. Performance data analysts at LBX made data for the borough (a constituent part of the larger data set) available to the research project for more detailed analysis. This section considers some of those data.

Referrals opened and concluded - All types of risk⁵⁴

In LBX, for the year 2014-15, 1720 safeguarding concerns were raised, 367 referrals for individuals at risk were opened and 254 cases were concluded. This information can be broken down, for all types of risk (7 categories in total), into the 2 stages of investigation as follows:

- referrals opened; and
- referrals concluded

The seven categories are: physical; sexual; psychological & emotional; financial & material; neglect & omission; discriminatory; institutional. They are the categories used in the national data set and reported by local authorities to the HSCIC on an annual basis. We were specifically interested in the returns relating to financial & material risk.

The following Tables 1 – 4, relating to all types of abuse provide a profile of the referrals – the topic (type of abuse), the age of the possible victims, plus their gender and ethnicity, and the status of their mental capacity, and whether or not they were already known to the council.

Table 1⁵⁵ 'Referrals opened' and 'referrals concluded' in the year: all types of risk

	Stage 1 Number & % of all types of referrals opened	Stage 2 Number & % of all types referrals concluded
Physical		84 (33%)
Sexual		7 (3%)
Psychological & emotional		36 (14%)
Financial & material	97 (26.4 %)	52 (20%)
Neglect & omission		70 (27%)
Discriminatory		2 (0.8%)
Institutional		3 (1%)
Totals	367	254

In terms of total numbers of concluded referrals, financial & material (F&M) risk was ranked third (after physical and neglect & omission) in frequency among those types of abuse for which referrals opened and cases concluded. Of 351 alerts for F&M risk, 97 referrals were *opened* as cases with 52 *concluded* in the reporting period (a ratio of roughly 1:7 concluded cases to alerts).

'Referrals opened': Characteristics of the individuals who were subject of referrals opened in the year (all types of risk by age, gender, ethnicity, primary support needs and whether known to the council)

Further investigation provides further details of the individuals who were subjects of the referrals opened during the year. The data can be broken down by age, gender, ethnicity and whether or not they were already known to the council⁵⁶.

Table 2 'Referrals opened': By age, known to the council or previously not known: all types of risk

	18–64	65–74	75–84	85–94	95+	Age unknown	Total
Already known to council	82	17	47	65	10	0	221 (60%)
Previously unknown	76	16	32	16	4	2	146 (40%)
Total	158	33	79	81	14	2	367

⁵⁴ In this report we may refer to types of risk and types of 'abuse' interchangeably, while acknowledging official recording refers to 'types of risk'.

⁵⁵ Tables here refer to data from SG1 – SG6 in the SARS submitted to HSCIC

⁵⁶ Known/Unknown: "Already known (where the individual has had previous contact with social services prior to the safeguarding concern being raised), or "Previously unknown to the council." From - HSCIC, Safeguarding Adults, Annual Report 2014-15.

Overall, 60% of the individuals involved were already known to the council, with 40% unknown. In terms of chronological age, 'younger adults' (18 – 64 years) constituted 43% of the individuals who were the subject of referrals (158 in number) while older adults (65+) (207 in number) at 57%, with proportionately more of the older among them (85+) being known to the local authority.

Table 3 By gender, known to the council or previously unknown, referrals opened: all types of risk

	Male	Female	Not known	Total
Already known to council	92	129		221
Previously unknown	57	86	3	146
Total	149 (41%)	215 (58%)	3 (0.9%)	367

Women as subjects of all types of referrals (58%) outnumbered men (41%). There was little difference between them in the proportion of each known already by the council.

Table 4 By ethnicity, known to the council or previously unknown, referrals opened: all types of risk

	White	Mixed/multiple	Asian/Asian British	Black/African Caribbean/Black British	Other ethnic group	Not known	Total
Already known to council	102	2	43	55	3	16	221
Previously unknown	47	0	30	31	5	33	146
Total	149 (41%)	2 (0.5%)	73 (20%)	86 (23%)	8 (2%)	49 (13%)	367

The ethnicity of the individuals who were the subject of referrals broadly reflects the ethnic makeup of the LBX population as a whole, although white individuals are over-represented and Asian individuals under-represented compared to the general population undifferentiated by age.

Table 5 By primary support need: all types of risk

	Physical	Sensory	Memory and cognition	Learning disability	Mental health	Social	None	Total
Already known to council	143	2	8	49	9	9	1	221
Previously unknown	40	1	1	8	11	17	68	146
Total	183	3	9	57	20	26	69	367

Of the individual subjects of the opened referrals, most had physical support needs (183) of whom 143 were known to the council. A relatively large number (68) had no support needs and were not known to the council, but following this came people with learning disabilities (57), most of whom (49) were known to the council.

'Concluded referrals', all risks: [mental capacity](#)

In terms of currently accessible data on referrals opened in the year in relation to mental capacity, the following data on *concluded* cases have been included here. These involve concluded cases as a whole broken down by mental capacity of the person at risk where just under half were reported as lacking capacity and a breakdown of all individuals by age and capacity.

Table 6 Concluded cases, **mental capacity**: all types of risk

	Numbers	%
Lacking capacity	104	45
Not lacking capacity	128	55
	232	100

Table 7 Concluded cases, **mental capacity**: by age

	18–64	65–74	75–84	85–94	95+	Age not known	Total
Yes (lacks capacity)	52 (53%)	13 (65%)	15 (29%)	20 (38%)	3 (23%)	1	104
No	45 (46%)	7 (35%)	35 (67%)	31 (58%)	10 (77%)	0	128
Don't know	1 (1%)	0	2 (4%)	2 (4%)	0	0	5
Not recorded	0	0	0	0	0	0	0
Total	98 (100%)	20 (100%)	52 (100%)	53 (100%)	13 (100%)	1	237

The focus of our research is on those lacking capacity so these figures are important for the study. In Table 6, a substantial number of those who were the subject of concluded cases (104), that is 45% of all cases where capacity status was recorded, lacked capacity. Broken down, in Table 7, over half of those in the younger adults age group (18–64) and two thirds in the age group 65 – 74 (but a small number overall) lacked capacity, as did a third of the remaining older age groups (38 out of a total of 114 individuals).

Financial & Material Risk (F&M) - gender, age, ethnicity, opened and concluded cases

Financial & Material risk is the central topic of this research and we have included as many tables relating to it as possible in this section. As with the general tables already presented (Tables 1-7), we have where possible covered opened *and* concluded cases.

Financial & Material Risk (F&M): Opened referrals

Gender

Males and females are almost equally represented in those who were the subjects of opened F&M referrals (97 in total). This equal representation is carried on into the smaller number (52) of referrals where the case was concluded in the year in which it was reported.

Table 8 Referrals opened in the year, **F&M**: by gender

	Number of individuals	%
Female	47	48
Male	48	49
Unknown	2	2
Total	97	99

Ethnicity

In respect of financial & material abuse, the percentage of individuals categorised as white (55%) is higher than those classified as white across *referrals opened* for all forms of risk (41%), Table 4 above, while the percentage for Asian/Asian British is lower at 15% (as compared to 20% at the earlier stage, Table 4) (see table below). [n.b. The figures for *referrals concluded* in Table 12 below are hard to comment on because of a large proportion (46%) which are not categorised for ethnicity].

Table 9 Referrals opened, F&M: by ethnicity

	Number of individuals F&M	%	% ethnicity for all types of risk referrals (number –367)
Asian or Asian British	15	15	20
Black or Black British	22	23	23
Not Stated / Undeclared	1	1	–
Other Ethnic Groups	1	1	2
Unknown	5	5	13
White	53	55	41
Total	97	100	

Financial & Material Risk (F&M): concluded referrals

Age

Cases were broadly spread across the age range – but with more proportionately in the 65+ categories.

Table 10 Concluded cases, F&M: by age

	18–64	65–74	75–84	85–94	95+	Total
Number	17	6	13	13	3	52

Gender

Table 11 Concluded referrals F&M: by gender

	Number of individuals	%	
Female	26	50	
Male	25	48	
Unknown	1	2	
Total	52	100	

Males and females were evenly represented.

Ethnicity

Table 12 Concluded referrals, F&M: by ethnicity

Ethnicity	No of individuals	%
Asian or Asian British	3	6
Black or Black British	6	11
Not Stated / Undeclared	1	2
Unknown	1	2
White	17	33
#N/A	24	46
Total	52	100

The data in Table 12 on ethnicity are deficient in the sense that that 46% of cases are not categorised.

Age and mental capacity

Table 13 Concluded referrals, F&M: by age and mental capacity

	18–64	65–74		75–84	85–94	95+	Total
No	1	1		3	5		10 (19%)
Not known				1	1		2 (4%)
Yes (lacks capacity)	16	4		8	6	2	36 (69%)
Not recorded		1		1	1	1	3 (6%)
Total	17	6		13	13	3	52 (98%)

Of the 52 cases that were concluded during the year, over two thirds (69%) involved individuals who lacked capacity, spread across every age category.

Table 14 Concluded referrals, F&M: proportion of those lacking mental capacity who were offered an advocate

	18-64	65-74	85-94	Total	%
Lacks capacity	3	1	1	5	14

Five out of the 36 individuals lacking capacity were offered an advocate. The council has an obligation to do this when someone who is subject to a safeguarding investigation has 'substantial difficulty' in being involved in the process, but this duty falls away if they have a suitable person to support them.

Table 15 Concluded referrals, F&M: by source of risk

	No of individuals	%
Other – Known to Individual	26	50
Other – Unknown to Individual	15	29
Social Care Support	11	21
Total	52	100

In the case of half of the referrals concluded within the year, it shows that the source of risk, (i.e. the suspected/assumed, substantiated perpetrator), was known to the individual while in a further fifth of cases, the victim was receiving social care support.

Table 16 Concluded referrals, F&M: by location/setting

Location	Number of individuals	%
Care home	9	17
Other	3	6
Own home	30	58
Public place	1	2
Residential care – permanent	1	2
Service within the community	2	4
known	6	11
Total	52	100

Perhaps useful to relate to Table 15, Table 16 shows that well over half of victims (58%) were living in their own/family homes, with a further 17% living in a care home. [Our interest in intra-family issues connected to financial abuse is relevant here].

Of the 52 cases involving financial and material risk that were concluded during the year, just under a third (15 cases – 29%) were substantiated and a further 4% were partly substantiated (Table 17). Another fifth (21%) were closed as inconclusive. And 22 cases (42%) were determined as 'not substantiated'. Of these same 52 concluded cases, police involvement is reported in 9 cases (Table 19) (whether these related to a proportion of the 15 'substantiated' cases reported in Table 16 is not clear). In 6% of cases, it was stated that the risk remained while in 40% of cases it had been removed. No action was taken in 11% of cases (Table 18).

Table 17 Concluded referrals, F&M: by conclusion

	No of individuals	%
Investigation ceased at individual's request	2	4
Not determined / inconclusive	11	21
Not Substantiated	22	42
Partly substantiated	2	4
Substantiated	15	29
Total	52	100

Table 18 Concluded referrals, F&M: by action and result

Action/result	Number of individuals	%
No action taken	6	11
Risk reduced	22	42
Risk remains	3	6
Risk removed	21	40
Total	52	99

Table 19 Concluded referrals, F&M: by police involvement

Police involvement	Number of cases
No	17
Not sure	2
Yes	9
N/A	24
Total cases	52

Comment

Financial & material (F&M) risk was ranked third in type of abuse (after neglect & omission and physical abuse) referred to the safeguarding authorities in LBX (consistent with ranking across England as a whole). F&M cases constituted a fifth of all concluded safeguarding cases – similar to other boroughs in London which in turn was slightly above most other regions across England.

As such, it is clear that financial abuse is an active risk facing certain sections of the population in LBX, spread across age groups and ethnicities (although poor data makes it difficult to comment on ethnic composition in relation to concluded cases). A significant number (over half) encountered the risk while living in their own homes, and a person whom they knew was involved. Over two thirds of those referred in relation to F&M risk lacked capacity, half being younger adults and the remainder being over the age of 65, including 2 individuals over 95 years. In terms of outcomes, in a third of concluded cases the risk was substantiated or partly substantiated – but only a handful involved any police action.

The statistics provide an overview of safeguarding activity in relation to financial & material abuse – but inevitably cannot provide any real detail on the nature of that abuse or, importantly, the nature of the outcome of safeguarding interventions (e.g. what actually happened in relation to risk ‘reduction’ or ‘removal’ – or risk ‘remains’. That would require scrutiny of case records.

Part 2

Fieldwork – interviews

Within the constraints of time allowed for the project, we were able to interview 17 individuals who, as part of their professional roles, held safeguarding responsibilities (over varying degrees and at various levels), within the borough area⁵⁷:

⁵⁷ Although we had anticipated interviewing individuals working in the health sector, we realised this was over-ambitious given the time-scale and resources. We also realised, given the focus was on *financial* abuse rather than physical or emotional abuse, or neglect, that it was better to concentrate our effort on the professionals most directly involved (council staff and the police, together with voluntary organisations concerned with the client groups we were particularly interested in. (We also spoke to a dementia nurse now working for a national charity who had previously worked in LBX). But we acknowledge that financial abuse will sometimes be associated with other types of abuse and that health workers may have insights that we have been unable to tap. We also attempted to interview two local solicitors but received no response and so far an interview with an older age charity, though promised, has not been arranged.

Council:

Seven employees of the council – 4 members of the safeguarding adults team, 1 member of the debt recovery department and 2 members of the trading standards department – plus the independent chair of the safeguarding adults board (who was not a council employee) and the manager responsible for training. (9)

Police:

Three serving officers involved with safeguarding (including a chief inspector who also sat on the safeguarding adults board and chaired the sub-group responsible for advising on s44 duties re Safeguarding Adults Reviews). (3)

Voluntary sector:

Five voluntary sector employees, representing learning disabilities, mental health and brain injury clients. (5)

Aims and methods

Our aim was to investigate their understanding of the nature of the financial abuse of people lacking capacity from the perspective of their job roles in respect of:

- its scale;
- its characteristics;
- its complexity;
- their ability or self-perceived ability to tackle it;
- current outcomes in relation to their duties and the priorities laid down by their organisations.

As noted earlier, our approach to studying how the council and other local agencies tackled the problem of financial abuse within the borough was based on a hypothesis drawn from previous research that policy implementation and professional practice are affected by tensions and conflicting pressures such as:

- fragmentation in organisational responses to alleged abuse;
- structural gaps between the agencies involved;
- over-reliance on prescribed routines and processes;
- differences in professional and agency understanding of mental capacity;
- differing perceptions of financial abuse of individuals lacking capacity;
- contrasts in professional knowledge bases.

We developed topic guides for our interviews and discussions with informants within the borough, a method more suited to exploratory investigation such as this than strictly defined interview schedules designed for use in larger scale surveys.

Council perceptions of financial abuse

Background

At the time of our study, the council safeguarding adults team had a staff of 12 led by a Safeguarding Team Manager. Safeguarding Adults Managers (SAMs) managed individual cases and were supported by investigators and liaison officers. The social care assessment, planning and review functions were divided into different teams, headed by managers. If a case had an allocated social worker or care assessor they would usually be involved in any strategy discussion or protection plan (including any that led to an enquiry), but the SAM would retain overall responsibility for the safeguarding enquiry, in line with their statutory responsibilities under the new Care Act 2014 taking effect in 2015. The safeguarding adults team had links to, among others, the client affairs team (who undertook financial assessments and case work with individual clients), the support planning teams, the debt recovery team, as well as the Council's legal and the trading standards departments.

As with other councils in London, the LBX council worked to the pan-London safeguarding adults procedures which had been under review for much of the period during which the fieldwork took place – the new version was published at the end of the fieldwork period⁵⁸ and had been modified to take the implementation of the

⁵⁸ London Multi-Agency Adult Safeguarding Policy and Procedures, November 2015

Care Act 2014 into account. This introduced wider responsibilities for the council in terms of the wellbeing of its residents and, it could be argued by some, represented a shift in emphasis in the balance between personalisation and protection.

The pan-London procedures (in both old and new versions) laid down a clear pathway for handling safeguarding alerts both within the public services (NHS and local authority) and in partner organisations including the voluntary sector. Those with safeguarding responsibilities in external agencies had to assess whether situations and incidents warrant further enquiry and investigation, with a clear requirement to report concerns to the local authority safeguarding team where appropriate. Once received by the council, further procedures then come into play. The good practice guide (below) lists the sort of enquiries that might come to a council and sets out a list of those who might take the lead in handling them.

GOOD PRACTICE GUIDE⁵⁹

Types of safeguarding enquiries	Who might lead
Criminal (including assault, theft, fraud, hate crime, domestic violence and abuse or wilful neglect.	Police
Domestic violence (serious risk of harm)	Police coordinate the MARAC process
Anti-social behaviour (e.g. harassment, nuisance by neighbours)	Community safety services/local Policing (e.g. Safer Neighbourhood Teams).
Breach of tenancy agreement (e.g. harassment, nuisance by neighbours)	Landlord/registered social landlord/housing trust/community safety services
Bogus callers or rogue traders	Trading Standards/Police
Complaint regarding failure of service provision (including neglect of provision of care and failure to protect one service user from the actions of another)	Manager/proprietor of service/complaints department Ombudsman (if unresolved through complaints procedure)
Breach of contract to provide care and support	Service commissioner (e.g. Local Authority or NHS CCG)
Fitness of registered service provider	CQC
Serious Incident (SI) in NHS settings	Root cause analysis investigation by relevant NHS Provider
Unresolved serious complaint in health care setting	CQC, Health Service Ombudsman
Breach of rights of person detained under the MCA 2007 Deprivation of Liberty Safeguards (DoLs)	CQC, Local Authority, OPG/Court of Protection
Breach of terms of employment/disciplinary procedures	Employer
Breach of professional code of conduct	Professional regulatory body
Breach of health and safety legislation and regulations	HSE/CQC/Local Authority Link to – 2015 MoUxxxxvii
Misuse of enduring or lasting power of attorney or misconduct of a court-appointed deputy	OPG/Court of Protection/Police
Inappropriate person making decisions about the care and wellbeing of an adult who does not have mental capacity to make decisions about their safety and which are not in their best interests	OPG/Court of Protection
Misuse of Appointeeship or agency	DWP
Safeguarding Adults Review (Care Act Section 44)	Local Safeguarding Adults Boards

The same document⁶⁰ also makes it clear how the issue of capacity is to be handled:

⁵⁹ London Multi-Agency Adult Safeguarding Policy and Procedures, November 2015, p 78 (possible financial & material abuse-related concerns highlighted in green)

⁶⁰ London Multi-Agency Adult Safeguarding Policy and Procedures, November 2015, p 43

3.1 Mental Capacity and Consent

The Mental Capacity Act 2005 provides a statutory framework to empower and protect people who may lack capacity to make decisions for themselves; and establishes a framework for making decisions on their behalf. This applies whether the decisions are life-changing events or everyday matters. All decisions taken in the adult safeguarding process must comply with the Act.

The Mental Capacity Act outlines five statutory principles that underpin the work with adults who may lack mental capacity:

- A person must be assumed to have capacity unless it is established that he lacks capacity. [2]
- A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.[2]
- A person is not to be treated as unable to make a decision merely because he makes an unwise decision. [2]
- An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
- Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

Learning from Safeguarding Adults Reviews continues to show that staff working with adults who lack mental capacity are not fully complying with principle 5 above.

The independent chair of the Safeguarding Adults Board

The independent chair of the safeguarding adults board (SAB) explained that the chair is the key person in the safeguarding adults infrastructure of any local area, responsible for oversight of the way in which protection in its widest sense was delivered. In LBX, the chair had previously worked in a senior role supporting the adult social care department prior to her appointment as independent chair of the board in 2014. As part of this role, she had been involved in reviewing arrangements for recovery of social care debt. This review had resulted in a significant rise in referrals to the safeguarding procedures within the borough, due to concerns regarding financial abuse or mismanagement by those who required social care, but lacked capacity to manage their finances. She said that she was pleased with the work that had been done and the outcomes achieved, including ensuring safeguarding training had been delivered to all staff responsible for financial assessments, and that training for social work staff included a focus on duties owed by those acting under LPA/EPA or deputyship – although staff turnover meant that there was always a need to keep training levels monitored and refreshed.

The SAB met six times a year. Its membership was drawn from organisations within the borough⁶¹ which had a key role in supporting, protecting, overseeing and/or providing services to adults of all ages who could be in some way at risk of abuse or exploitation⁶². It had a number of sub-groups which oversaw the discharge of its various duties, among them case review, monitoring and evaluation, learning and development, and community engagement and awareness.

In the chair's view, financial abuse was a significant and complex problem, and one which the partnership had often had to deal with in its safeguarding role. The complexity was, in part, due to a difference in perception about what constituted abuse in a financial context, even between agencies represented on the Board. Where financial misbehaviour within families was concerned, problems often arose between the threshold for criminal investigations (e.g. for theft) and civil obligations to protect an adult at risk from abuse. In addition, principles of good practice in safeguarding rightly required the adult at risk to be central to the decision-making. This could raise difficulties since allegations of intra-familial financial abuse could often create direct conflict for the individual concerned – on the one hand not wanting a family carer to be investigated for fear of jeopardising their mutual relationship but aware too (to varying degrees) of the injustice of the abuse. Similarly the council in

⁶¹ Police, social services, primary care (CCG), secondary health care (NHS Hospital Trust) mental health care NHS mental health trust), council member, voluntary sector representative (Mencap), Department of Work & Pensions, OPG, ambulance service, fire service, (see Appendix for full details)

⁶² "The way in which a SAB must seek to achieve its objective is by co-ordinating and ensuring the effectiveness of what each of its members does," The Care Act, 2014, section 43 (3).

such enquiries might also be torn – acting as both the safeguarding authority and also as the financier of social care. Where there was no dispute regarding mental capacity, tensions such as these were usually resolved through the involvement of advocates or, if necessary, through an application to the Court of Protection.

But this was harder to resolve when the issue might be one of undue influence or “estate planning” for an adult whose capacity was deteriorating and where the use of LPA powers could be to the attorney’s advantage. At the time of the interview, the introduction of a “care cap” under the Dilnot proposals⁶³, whereby self-funded care costs were to have been capped at a lifetime total of £72,000 from mid-2016, was still expected. The expectation had been that this would reduce the demands on an individual’s assets (about which public resentment had burned for a long time) and would perhaps have reduced the number of “estate planning” cases that came to their attention. Ironically, while the chair understood the rationale for this policy change (and the benefits it would mean for families in this position), she foresaw additional burdens being placed on the council as a result, because of the growth in its duty to assess the eligibility of many more self-funding individuals, and to bear the costs of their care in due course.

According to the chair, there was another factor which could also lead to allegations of financial abuse or neglect within families. This sometimes occurred in situations where a third party (often a family member) had agreed to ‘top-up’ the cost of a care home fee in order to secure a preferred provider of accommodation. Failure to pay them subsequently, though legally agreed – although a relative is under no legal duty to accept the commitment at the outset – might sometimes be part of a pattern of abusive behaviour by relatives, taking advantage of both the vulnerable person and the local authority.

But councils, as she saw it, were not only faced with pressures from the misdemeanours of their residents. Another matter of concern was the fact that duties placed on councils under the newly implemented Care Act 2014 to foster the wellbeing of their residents, including safeguarding them from abuse, were not as clearly defined as they might have been. Her concern was that this omission could lead to confusion in the future as to which were the primary duties for councils to comply with.

From the council’s perspective, the council’s dual roles of safeguarding and social care financing raised significant dilemmas for officers responsible for determining how best to employ very limited resources to address possible financial abuse. She saw this as raising some specific and difficult questions which would benefit from clear guidance from the Courts or Department of Health. For example:

- In cases where families, or anyone acting on behalf of someone who has lost capacity, allowed debts to run up (specifically in relation to the provision of social care assessed as necessary to meet the needs of an adult) or refused to make available the personal income/allowance to those in receipt of care, should this not be recognised as constituting financial abuse by them against their relative? Guidance on investigating and prosecuting for s44 MCA offences of ill-treatment or wilful neglect would be welcomed.
- Would it not be reasonable to reverse the light touch approach to monitoring LPA/EPA/Deputies so the burden was no longer on local authorities to instigate proceedings either in the Court of Protection or civil courts?
- Would it not be reasonable for the local authority to impose decisions, against the will of an adult at risk or their ‘appropriate person’ including a deputy/donee of EPA/LPA or an advocate, if they had suspicions of financial abuse and believed the adult may be subject to undue influence/pressure?

In discussing the day-to-day discharge of safeguarding duties, the chair felt that support and cooperation from and between various agencies was essential although she recognised a number of difficulties arise for safeguarding staff. In particular, relationships with the DWP, police and the OPG could sometimes be problematic. Sometimes these were understandable from *their* perspectives but they still created difficulties for the team which found dependence on the actions of other authorities both inhibiting and frustrating. One major issue that she saw was the fact that social services staff had no power of entry to assist in respect of safeguarding investigations and it often meant they had to rely on the police to take action to investigate – only to find that the police regarded the evidence or degree of abuse was too “low level” to meet the criminal burden of proof so that they would be unable to take further action until there had been further, substantial loss. (However, she cited one example where they had been able to bring a case to court resulting in a successful criminal prosecution

⁶³ *Fairer Funding for All: the report of the Dilnot Commission on the Funding of Care and Support*, July 2011

of “mate crime” a few years previously where an individual at risk had signed an EPA to a family friend and had been financially abused by the attorney. It had ended in prison sentences for the perpetrators).

In relation to the OPG, a safeguarding case had to involve an LPA or EPA to sanction its intervention. Even where this condition applied, the chair said it could be difficult to secure the OPG’s involvement in safeguarding investigations, even where there were significant concerns about donee or deputy behaviour. She noted that staff had reported a need to “pester” and re-refer until action was taken. Further, there was no longer a named contact at the OPG to attend the SAB which, she felt, indicated a distance between them and other front-line representatives which needed to be improved.

In cases where the OPG did not get involved, the council might refer cases to the police – but often found that the crown prosecution service (CPS) would rarely find it to be in the public interest to prosecute. Sometimes the council would make direct applications to the Court of Protection – for example, for revocations of LPAs where misappropriation of the donor’s funds was suspected. These usually involved cases where the local authority had become suspicious because of debts that had been run up to the council. But the council, because of a possible conflict of interest, would then have to ask the Court of Protection to appoint the official solicitor to act on behalf of the individual. This could cause significant delays, possibly due to work pressures at the CoP. It was a matter of concern to her that social care debts and their recovery were becoming an increasingly large part of the council’s legal department workload, placing additional pressures on staff who could be better deployed in providing advice and support on other safeguarding work.

The safeguarding team

The team was organised around a structure of the Safeguarding Team Manager, 4 Safeguarding Adults Managers (SAMs), 3 investigation officers and 4 safeguarding liaison officers. We interviewed a SAM and three investigating officers (IOs) and were able to build up a picture of the cases they dealt with, their relationships with other departments and agencies and the everyday concerns which confronted them. Safeguarding adults within the council had undergone some refocusing and restructuring during the previous year. This had been well-received and interviewees felt confident that it had been beneficial and that the team was now more focused and better-led.

They reported that they attend Safeguarding Adults Board (SAB) meetings and MARAC⁶⁴ meetings from time to time in an administrative role, taking minutes and preparing reports. They also attend the SAB sub-groups which carries out specific work of the board in the same capacity.

One interviewee had been a police officer earlier in his career and, on joining the council safeguarding team, had undergone the safeguarding training for police officers and social workers which included ABE interviewing techniques⁶⁵. In discussing perspectives within the safeguarding environment, he felt that attitudes between the two agencies differed fundamentally and described the differences between his past and present employment thus: “social work is like a breath of fresh air [in contrast to the police] – is the person safe, has the risk been alleviated?” For the police, it was more about detection as opposed to “is life better?” although he did concede that the police has become more “quality of outcome”-based (i.e. along the lines of ‘is life better’) than before. He described the pressures that all those working in safeguarding felt: “it’s about having to manage risk in the real world” and this was difficult while having at the same time to streamline the service and be more efficient on top of facing pressures created by inter-agency differences. He wished there could be a “pool of co-operation” between themselves, the police and other agencies such as the banks. This view was confirmed by other members of the team. One remarked that the police were more likely to ask “is it prosecutable?” while the safeguarding team was more concerned for the client and his/her wellbeing.

One IO described how styles of investigation differed between themselves and the police. The safeguarding team tended to get on with the task, compile the evidence and let it speak for itself. The police on the other hand would keep going back for more, often asking them to assist in this. This persistence, it seemed, could lead to there being a risk of “contaminating the evidence” when that happened. Further, there was always a sense that the police were under heavy pressure, and that there could be delays in getting investigations underway.

⁶⁴ MARAC – Multi Agency Risk Assessment Conference

⁶⁵ ABE – Achieving Best Evidence interviewing techniques

Contrasts in outlook and failures in collaboration with outside agencies were well-recognised. Differences in styles of investigation when instances of possible abuse had been reported sometimes created problems. Banks would act when requested to do so by the police but were reluctant, to the point of refusal, when similar requests were made by members of the safeguarding team – even when there was a need for immediate action. They gave examples of clients clearly at risk and being exploited by relatives (for example, being pressed to make withdrawals from their accounts, sometimes joint accounts, under circumstances which were clearly suspicious). This could include the individual being accompanied to the bank in person, the use of false signatures or the exercise of an LPA for purposes which were clearly in the interests of the attorney alone (such as the purchase of clothes for self or the transfer of funds from the client to own account). Even when team members made direct representations to the bank, staff said they had no power to intervene. Joint accounts presented particular difficulties because both account-holders had to agree to the account's closure and often, in cases where they were trying to amass evidence of misappropriation, investigators wanted to keep the process of closure secret from the wrongdoer. It was galling for team members to see how banks would respond speedily to police requests for help while at the same time rejecting their requests.

Gathering information and evidence about possible financial abuse was often time-consuming and complicated. There may be little feedback when the abuse happens over a long period of time, creating tensions for staff between duty to the council and duty to clients, and it could often lead to bills not being paid with arrears building up – which then had repercussions for the housing department if tenants were involved and fears arose that the rent would never be paid. In the team members' view, relatives got used to dipping into their loved one's bank accounts and didn't necessarily see it as abuse. Trying to get to the bottom of cases like this was often difficult. It could involve having to deal with banks (as already described) but also with some of the individuals involved, including alleged perpetrators (often closely connected to the victim), and care agencies in cases where workers might be suspected.

Team members were not only frustrated by working relationships with the police and banks. They were dismissive of the OPG ("it's a joke"). It was, they said, too often loath to be involved in local cases. They acknowledged, however, that its response, rightly, was that it could only get involved if the person lacked capacity – otherwise, it would not be a case of abuse but an "unwise decision." Nevertheless this was frustrating. As a result, they tended to by-pass the OPG and go straight to the police and the CoP.

Practical and procedural issues could often arise around capacity. Whether individuals were found to lack capacity or not could be crucial. Where capacity was accepted as lacking the council might take over management of their affairs. When this was the case, they referred clients to the client affairs team – a process which might take a frustratingly long time to be sorted out, leading to other longer term problems. When the council was responsible as deputy or appointee (in relation to the Department of Work and Pensions), it "has the money" and was responsible for the conduct of expenditure often on a day-to-day basis, using a cash-card. An amount (perhaps £100) would be loaded onto the card for everyday expenditure such as food shopping. The question would arise – who to give the card to? Who, in the circle of relatives, neighbours, friends, could be relied on to be trustworthy? Sometimes the client affairs team had been known to block the card if they didn't think the money was being spent appropriately – which then meant more pressure on safeguarding team members who had to search for alternative arrangements.

Family disputes often bedevilled their attempts to sort out problems. As a result, the team found themselves 'micro-managing' the affairs of the person at risk. One officer said that he had long-term, continuing involvement with about 5 families at the moment but found it difficult to obtain any real change – mediation had been attempted which on one occasion made things worse. It was hard to make the correct decision as to when to withdraw professional support.

One interviewee commented that this sort of long-term involvement compromised the principles of personalisation, saying how hard it was to leave clients to get on with their lives (as personalisation would require) at the same time as having to remain in touch sufficiently to reduce any risk involved. "Personalisation can be problematic – who oversees it? The carer too can be in vulnerable situations – such as being wrongly under suspicion – so it goes in both directions." Risks were all around. One cited the case of an advocate from a well-known charity being found to be an abuser.

Of a different order, a further worry was about the safety of people who pay for care themselves, or who are fully funded by the NHS, and who as a result are not routinely known to the council – how could *they* be safeguarded?

A picture emerges of complexity, full workload, sometimes blurred boundaries and difficulties in collaborating with external agencies.

Debt recovery team leader

The leader of the debt recovery team was a lawyer and had had past experience of working in the area of debt recovery and fraud in a number of other London boroughs. The team that he led was a specific project at present, meaning that it was funded on a year by year basis and determined according to priorities for the council. He was ambitious about his mission to increase debt recovery rates with an aim of retrieving £100k per month. The focus of much of his attention related to the issues also raised by the independent SAB chair – the increasing problem of social care debts to the council run up by those in receipt of social care or their families on their behalf. In relation to financial abuse *per se*, he felt that much of the work of the debt recovery team lay around the boundary between ‘capacity’ and ‘lacking capacity.’ The degree of complicity that the individual might have had with any attempt to deprive the council of its assets, to defraud it, or to run up arrears purposefully often turned on the degree to which that person had, or lacked, capacity. In coming to an understanding of the full case, there always had to be, in the first instance, a presumption of capacity and any reasons for questioning this had to be identified carefully. Case files always had to be reviewed in detail to see if there was any evidence of *lack of capacity*.

He had a robust view of the challenges he faced in the role, balancing empathy with scepticism. He had been amazed by the range of reasons that people offered when they were first contacted to account for the debt they were in and the pleas they made for mitigation (from cancer to a mother dying abroad). Some would give in and agree they were at fault, others would hold out and refuse to repay regardless of their degree of responsibility. He had come across many sorts of resistance, such as an elderly client in receipt of home care together with her son colluding in their joint refusal, and another complicated case where one of a group of brothers, acting alone, denied he had taken out a mortgage on the parents’ property with power of attorney.

He described the difficult options, often ethical, facing the council. How far could the council take action by withdrawing care services in cases where debt had grown? The council had to ensure both that it could not be accused of failing in its duty of care to vulnerable residents and also in its duty to be financially responsible. It could take action under deprivation of assets legislation and it could pursue individuals to bankruptcy but this was a costly course of action. He noted that other councils, unlike LBX, had adopted different methods of paying care home fees which could decrease the likelihood of debt building up. He also noted that in his experience some care homes were complicit in the way debts ultimately falling to the local authority would be built up. He favoured improving the processes involved in setting up relationships between local authority, care home, clients and families to prevent fraudulent activity from developing – involving, for example, a new assessment form stating clear warnings about fraud, which the parties would have to sign.

He expressed disappointment that some of his social work colleagues were not always willing to cooperate in trying to get messages across to clients about risks associated with money matters. He estimated that to his knowledge there might be between 60 – 100 cases of mostly elderly people, probably lacking capacity, who were at risk. Social workers would sometimes say it wasn’t their job to talk about finance to clients. He also felt that working relationships could be improved between council departments and outside agencies. He regretted that councils had no power to demand the freezing of bank accounts to stop money disappearing. Banks are usually very reluctant to take such action (although they have the power to do so). He considered that the DWP was rarely interested in hearing that an appointee is mispending the victim’s benefits money or pension. Too often they were unwilling to revoke appointeeships, which results in the council having to go to the CoP for a deputyship. He also felt there were times when the police “fob you off” – and do not pass cases on to the CPS for prosecution. Police were willing to act in clear-cut cases – such as forged signatures (which constituted fraud); otherwise it was sometimes difficult to get them to take action. Whether or not the police share this view, it has consequences for future willingness to act by repeat players.

Trading standards

The role of trading standards officers in preventing scams and other techniques of defrauding vulnerable citizens is well recognised across the country⁶⁶. In our geographical location of interest, Trading Standards was a joint department based in the LBX offices and covering two adjacent London boroughs, LBX & LBY (a third borough had broken away some time previously). We interviewed two officers from the joint department. We were interested in how much of their work was devoted to the prevention of financial abuse, especially in relation to people lacking capacity, and what relationships they had with safeguarding colleagues within their councils and with other agencies such as the police and banks.

They described the work of their team which operated with a complement of 9.5 officers spread across the two boroughs and was responsible for a wide range of activities – from consumer protection and fair trading through to under-age trading, anti-counterfeit detection and rogue traders. They were aware of the issue of the financial abuse of people at risk and reported one initiative which had just started – a ‘no cold-calling’ zone in one ward in LBY (the partner borough), set up at the suggestion of the local police, in the hope that it would reduce nuisance visits by unscrupulous traders and which could be rolled out to other parts of the two boroughs if money were forthcoming. In their view, funding cuts had had a negative impact on the scale of activity that they were now able to undertake – the civil advice team no longer functioned and they had lost the funding that used to be available for pursuing civil scams, concentrating only on those which constituted crime. Links with other boroughs had shrunk – a general occurrence elsewhere. They were aware of the level of door-step crime from national statistics held on the issue (in fact, they said, it was more serious in the shires than in London) and from the national CAB service which took and filtered calls down to local level.

While they were aware of the implications in the Care Act 2014 for the council’s safeguarding duties, they considered that realistically it would be difficult for trading standards to move beyond its current advisory and preventive role. They had had little contact with the safeguarding team at the moment but felt it would be very valuable to open up communication to share experience, monitor emerging issues and make best use of reduced funding through joint training.

Police

We interviewed three officers serving with the Metropolitan Police Service in LBX, a detective chief inspector (DCI), a detective sergeant (DS) and a detective constable (DC). The DCI is a member of the SAB and chairs the Board’s case review sub-group.

The DS and DC had been involved in handling cases of financial and other abuse and with the varying structures of safeguarding over several years. Most cases of abuse they had dealt with over the years had involved domestic violence and abuse by formal carers (rather than financial abuse by relatives). The DS and DC both described their roles within the new community service unit (CSU) which had been restructured during the previous 6 months. The emphasis was on “risk” and was now linked to “vulnerability” rather than on specific types of abuse – such as domestic violence (which had predominated in the past) or financial abuse. The new emphasis on risk had introduced greater flexibility of approach – but the old hierarchy of violence and burglary still had a tendency to dominate. In their view, policing was subject to a number of influences – including public perceptions of policing, the media and priorities set by the Home Office and the Mayor’s Office on Policing and Crime (MOPAC)⁶⁷.

Each borough had a financial fraud team which could liaise with banks and other relevant organisations. They had found the banks willing to cooperate with the police and would refer cases to them, contacting a liaison officer who was versed in the requirements of the Data Protection Act to ensure compliance. Cases of possible financial and other abuse could come to the police in three ways – directly reported to the police station and flagged as VA (vulnerable adult); via Action Fraud (the national fraud reporting agency hosted by the City of

⁶⁶ The financial abuse research team at Brunel University has run two annual conferences on *Safeguarding Adults at Risk from Scams* (2014, 2015) which have demonstrated both the impact that trading standards departments play in combating scams and the potential opportunities for links to be developed between trading standards and safeguarding teams within local authorities.

⁶⁷ See MOPAC (2015) Annual Report 2014/15 and Update on the Police and Crime Plan, July 2015. Fraud is included under the ‘business crime’ category.

London Police which dispersed cases to borough-level police teams to be picked up by officers locally); and via the council's safeguarding adults team. Cases sometimes could not be proceeded with, especially in cases where the victim might lack capacity, because other supporting evidence was not available or, in some cases of domestic violence, the victim didn't wish to proceed. Because a borough didn't have a major investigation team which would have a dedicated DCI in charge, 'within-borough' investigations were led by an "officer in the case" (OIC) who might sometimes change as the case proceeded: this could lead to unevenness in procedure and sometimes outcome. Lack of compatible computers across London often made smooth liaison difficult. For example, the Case Overview Preparation Application (COPA) system could not link with the crown prosecution service (CPS) system).

The DCI described his involvement with the SAB. He had been a member since before it became a statutory requirement but at that time, it had almost fallen apart. It had now been re-established – the chair played a big part in this. The police had seen some big organisational changes too with the establishment of CSUs. He was, and had been, the lead on most of the public protection issues such as JIGSAW, MASH and MAPA⁶⁸. Since the SAB's revamp, he had attended most of the meetings that had been held. He also chaired the case review subgroup.

In his role as chair of the sub-group, he had been developing procedures and processes for dealing with cases – his approach was based on going into only sufficient detail to enable decisions to be made. It was essential for the police to develop a system for recording at the time all 'adults that come to notice' in relation to possible 'at risk' status. They might not be investigated then but if anything happened later, it could be shown that the police had done the right thing previously. If not, the police would be seen to have been failing. In addition, a system also needed to be established for 'serious incidents requiring investigation' reporting. The Mental Capacity Act training in adult and child protection for police officers and social workers had helped clarify some of these issues.

In discussing the process by which cases came to be prosecuted, he said that it was generally the police who made the decision – they only sent cases up to the CPS where they thought there was enough evidence and a strong enough case to go to prosecution. He considered the police should not simply swamp the CPS with cases that they (the police) ought to be making decisions about.

The sub-group had started on a need-to-meet basis but had already met five or six times in six months – more times than the main Board meeting. He had noticed a change in emphasis recently on vulnerability – as part of personalisation – and the need to hear the voice of the vulnerable person. Traditionally, the police had worked to precise guidelines and the voice of the individual vulnerable person had not come into it. The changes had meant that the way individuals were flagged in records had changed with more attention paid to the details of why they should be classified as such – rather than using 'vulnerable' as a catch-all category. He expressed some scepticism about the motivation of those at the centre – who were too keen on sending down requirements and priorities without reference to actual situations on the ground. He commented that mental health problems took up a lot of police time, saying "most roads lead to mental health problems as the start or the cause".

Voluntary sector

We visited three voluntary organisations, dealing with mental health problems, learning disabilities and brain injury. We approached a number of others (notably old age, but were not able to arrange interviews within the timescale).

Mental health

We interviewed the chief executive of the charity and also spoke to a team member about her work. Among other projects and services, the organisation provided support to 70 tenants in over a dozen houses owned by a housing association. It was contracted to the council for this service. Tenants could stay for up to two years and were then expected to move on to their own independent accommodation (usually private rented). Of existing tenants, two or three had been there for 20 – 30 years under the old-style system of secure tenancies. This arrangement was no longer possible even though the prospect of moving on was not always appealing to tenants

⁶⁸ See <http://policeauthority.org/metropolitan/committees/sop/2011/1013/09/index.html> for details - mostly involving multi-agency collaborative initiatives on sex offending and public protection, now largely superseded.

as they came to the end of their stay. It meant that there was roughly a turnover of 10 –12 tenants moving on in any one year.

The tenants were now classified as having low support needs as opposed to high needs (the result of down-grading because of cost pressures in the previous three years). Because of the change in classification, the charity could no longer accept people with high support needs even though in reality, in the view of some of the staff, many of the tenants actually did have that higher level of need. This presented a problem as there was a shortage of hospital places at the other end of the scale.

According to our informants, financial abuse was not uncommon and they knew of several tenants who had experienced it. One particular case stood out – an older man who had been with them for 20 years but had refused to move on. A former tenant stole £13k (saved over the years from his pension) from him and was later sentenced to 4 years imprisonment. In this case, the council and later the Court of Protection (to decide on his capacity or not) were both involved, but it took a long time for the case to be dealt with, as is not uncommon with frauds. But the same person was still open to abuse from others – drug dealers, for example – who targeted him because they were aware of his vulnerability. Another example was a middle-aged female tenant who had an ex-‘boyfriend’, now in his 50s, since her teens and who would do odd jobs for her, charging her exorbitantly. Much to their concern, her support workers found the council would not respond to their alerts.

The risks and vulnerabilities characterising tenants were numerous and included:

- failure to understand the value of money (for example, giving £50 to unscrupulous acquaintances to buy a loaf of bread);
- overcharging individual tenants to undertake caring tasks or odd jobs;
- intercepting bank cards belonging to individual tenants which are then used without the bank intervening (by refusing them or failing to flag the account);
- safeguarding alerts raised, but no action from the police or the council, so the dangers persisted.

He raised the issue of what was an ‘unwise decision’ (and not a ‘lacking capacity’ issue) and how it was always present. The individual, if not lacking capacity, should always retain the right to exercise unwise choice, but where capacity was lacking, protection had to be given. This was not always straightforward.

Often they might see tenants with dominant personalities who would ‘borrow’ money from more vulnerable neighbours all the time but never repay it. Staff would try to advise and discourage tenants from borrowing or lending but it was often difficult for individuals to hold out against the pressures of the mini-communities that develop in some of the houses. The organisation’s staff had to provide a great deal of support in protecting them from harm. It was impossible to evict tenants simply for being overbearing – this could only be done in cases of stealing which had a chance of prosecution. They also had seen cases of people saving up their personal independence payments (PIP) – formerly disability living allowance (DLA) – only to be manipulated into letting unscrupulous ‘friends’ take advantage of them.

They estimated that they probably had two to three cases at any one time where there were tenants at risk of financial abuse: this is equivalent to 4% of their tenants (although it should be noted that being at risk does not equal the ‘fraud rate’).

They also came across other sorts of cases which could not be classified as abuse but reflected the problems faced by clients who had little understanding of money management. They cited cases of tenants taken into hospital on a long term basis, falling into arrears with their rent because housing benefit is suspended after a year. The housing association couldn’t force them to surrender their tenancy and so they came out of hospital faced with the burden of rent arrears to manage. They felt that such tenants needed far more support from the authorities – they cited the community mental health team as an example.

Relationships with other organisations with interests in the same field varied. They described frustrations with getting the safeguarding team to respond to their concerns seriously or taking a long time to get decisions made when they did. They judged that mental health services in the borough were less than good – their local NHS trust had been criticised in this regard by the regulator, the Care Quality Commission. They had reasonably good relations with the local police and mentioned one particularly sympathetic officer who himself was often outraged to see their tenants exploited – only to find they would refuse to give evidence against the people who had been exploiting them.

They said that they had little contact with other professionals in the borough who had safeguarding responsibilities. They did not have a representative on the safeguarding adults board [n.b. the voluntary sector as a whole is represented on the board by the representative of a single organisation]. They would welcome more involvement in borough-wide safeguarding activities.

Learning disabilities

We interviewed a member of staff of a charity in the borough which supported people with learning disabilities and also spoke to a team member. Their chief executive was a member of the safeguarding adults board. In the past the organisation had been heavily involved in the Supporting People programme, a national scheme which helped individuals in social housing by meeting the care and support needs. Our informant had been in charge at that time of providing floating support to residents until national policy changed and the programme was modified across the country. The charity had lost out to another organisation in contracting for the new scheme that was introduced after the changes. He felt that as a consequence, significant numbers of individuals lost much of the support they had needed and previously received. Some had “gone off the rails”.

He reflected on wider changes that had taken place over the years: the push to close care home accommodation had had a big effect on making people more vulnerable than before, as they didn’t understand the split between housing benefit and care costs or how to manage their money accordingly. There used to be direct contact with DWP but that had gone now. It was important to remember the significance of transition points in the lives of people with learning disabilities when their circumstances changed substantially. Sometimes expectations (by support staff or case assessors of their abilities) might either be reduced or, conversely, overestimated, with difficult consequences in either direction.

He worried that some individuals who needed support weren’t getting it anymore. Response times from workers seemed now to be longer, leading to pressure building up. There was a tendency for them to deal only with the obvious cases, not the hidden more intangible cases. Under the old system they had been able to monitor people’s safety – setting up systems that were protective and which enabled people to exercise choice in a “managed” way (like having secure safes for saving money in). The support worker would have the combination code and only open the safe in the presence of the individual.

Family relationships could be difficult and complicated. He had known of cases of brothers and sisters of learning disabled clients taking advantage of benefits money or of money unexpectedly received from parents or other relatives and friends. He had encountered cases where a relative (grandmother) who had managed her grandson’s money (as his appointee) resented it when he went to live in a care home because she was faced with a loss of what she regarded as *her* income; or in another case, of a young man with learning disabilities living at home, who never went on holiday to the Caribbean but his parents did (on his money). The impact of parental deaths, in the case where parents have looked after adult children with learning disabilities for many years was sometimes overlooked. What happened to their money if wills had not been made putting it into trust? Who knew what happened to the money and to the changed circumstances of their adult children?

Very occasionally financial abuse might be perpetrated by an outsider on an opportunistic basis. Bank staff could be helpful by alerting them when a regular client who usually came in on his own to withdraw money would be accompanied by a stranger. They would refer the matter to the police in these instances. But they also had to accept that sometimes a person with learning disabilities might make unwise decisions (for example, indiscriminate hoarding, or buying rubbish at car boot sales) about which nothing could be done. It was often hard to make a distinction between abuse and unwise decisions. Occasionally, too, a support worker might become abusive. Vigilance was always necessary.

In the past he had been on the learning disabilities board and had run a housing sub–group. He was now involved with their advice service promoting choice and independent living and with campaigning and policy work. He thought the charity did a good job – even closing some cases because the individuals could manage for themselves and were “doing really well now”. But it was important to acknowledge that people don’t “recover” from learning disabilities which they have been born with. It was necessary to get the balance right for them.

Brain injury

We interviewed the administrator of a small brain injury charity – affiliated to a national organisation. She worked mostly on her own administratively, supported by volunteers and board members. She came from a

psychotherapeutic background in the arts. The main practical activity of the charity was a day centre session at a local community centre providing “informal social rehabilitation”. The group did a range of things – from arts & crafts to cognitive exercises, cooking and films. She gave occasional talks – as did relatives sometimes.

Clients could self-refer, otherwise they were referred by relatives, GPs, hospitals, case managers. In all cases there was a formal assessment and each client had to be supported by his or her local authority (which pays the charity). Referrals could be turned down on several grounds – such as too early in recovery, or needing assistance with medical or personal care. Each person had to be relatively independent and “self-care capable”. The organisation did not have the resources to take on clients who were more dependent.

Sometimes behavioural issues might be identified. The charity could signpost but not make referrals to other services itself. They obtained benefits advice through volunteers. And their national organisation maintained a directory of helping organisations.

Our interviewee described a number of cases of possible or potential financial abuse which she had encountered:

- A young man, early 30s, working every day and attending the support group. He had received a big payment from the NHS as a result of his brain injury, and had his own house, car, together with a monthly amount and was financially very stable. He had been “given capacity” to manage financially himself. He had recently started a relationship with a young woman with a child. The charity had concerns that in this position he could be vulnerable to exploitation.
- A recent case of a young man in his 20s living with his mother, who had had a big pay-out for his brain injury was a concern for them but nothing so far had happened. They were worried and alert.
- A woman living on her own, 25 years after an accident, whose parents had died recently. Her brothers were worried and wanted some help from the charity. She had started going out late at night and was very vulnerable to exploitation by men. It was “a borderline case – until something happens”.
- One particular case which she thought should go to the Court of Protection was of a young man – whose mother had died but whose father was still alive – and who was expected to inherit the family house when his father eventually died. His older sister was fighting to have his (the father’s) will changed so she would have a share of it. The young man was worried and didn’t know what to do.
- She knew of another case where a man whose marriage had broken down post-accident and his ex-wife was fighting for the house. There was a son but he was grown up. The charity planned to give support and sign post him to advice. The national charity had an emergency fund and could help with legal fees sometimes.

She thought that men could be particularly vulnerable because it was a matter of pride for many of them that they didn’t want to speak about their worries and problems. Family networks provided a lot of support (but sometimes they could be the people who exploited their brain-injured relatives).

Concluding comment

Our informants from both the statutory and voluntary sectors presented a picture of challenge and complexity facing them in tackling the issue of financial abuse. Some of the pressures were organisational – inter-agency, inter-departmental differences which affected the ability of staff to achieve collective objectives across boundaries. Some came from the impact of new legislation and changes of emphasis in policy direction. Others, affecting those working more closely to the individuals involved because of their particular roles, resulted from the difficulties that people lacking capacity might experience in their daily lives, at risk from people they thought of as friends or trusted family members. Protecting their wellbeing – the core duty of the professionals involved – was sometimes at risk of being vitiated by the circumstances of daily life.

Chapter 4

THE COURT OF PROTECTION: USING COURT OF PROTECTION DATA TO EXPLORE FINANCIAL ABUSE AS A FEATURE OF FAMILY LIFE



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THE COURT OF PROTECTION – USING COURT OF PROTECTION DATA TO EXPLORE FINANCIAL ABUSE AS A FEATURE OF FAMILY LIFE

Introduction

As we have set out in an earlier section of the report, the aim of this research project has been to explore the nature and extent of the financial abuse of people lacking mental capacity, and what is being done to protect them. We have explained elsewhere why establishing a prevalence rate for it is methodologically hazardous and we have therefore looked for other ways of assessing the phenomenon. This has involved looking at national and local statistics from various sources, interviews with experts in the field from different professions and agencies and a focused study of one local area. Now, in this section, we examine the way in which our understanding of financial abuse can be extended by analysing cases heard in the Court of Protection.

The Court of Protection – function and scope

The Court of Protection (CoP) is a specialist court established in 2007 to safeguard the affairs of vulnerable people under the Mental Capacity Act 2005. It makes decisions on financial and welfare matters for people lacking mental capacity. Statistics on Court of Protection activity, however, are hard to come by. The Family Court Statistics Quarterly April to June 2015⁶⁹ states:

“In April to June 2015, there were 6,744 applications made [to the Court of Protection] under the Mental Capacity Act 2005, up slightly on the equivalent quarter in 2014. The majority of these (56%) relate to applications for appointment of a property and affairs deputy. There were also 7,679 orders made, an increase of 36% on April to June 2014 – the trend in orders made mirrors that of applications and has been steadily increasing since 2010. The majority (58%) of orders related to appointing a deputy for property and affairs.”

Beyond this, there appear to be no detailed data for the CoP published on a yearly basis on numbers and trends. The Office of the Public Guardian (OPG) publishes the number of safeguarding alerts it receives and provides information on how many of these result in applications to the CoP for revocation of attorneyships, deputyships or other action. Senior Judge Denzil Lush, in a paper delivered at a seminar in December 2014⁷⁰, reported that he had dealt with 313 safeguarding applications from the Public Guardian (PG) in 2014 as compared to 185 in 2013. This reflects what he sees as a steady increase over several years. His paper provides a range of details including the relationship of abusive attorney to donor, showing that most often it is adult sons and daughters, sometimes singly, sometimes together. He also reports some of the outcomes, noting “where I am aware of them,” which most often involved the revocation of attorneyships and the appointment of deputies.

Although formal statistics are few, discussion with Senior Judge Lush and other experts in the field suggest that a majority of cases involve close family relationships and often reveal fractures and bitterness which in many cases led to actions that can be construed as abuse. These insights prompted our examination of a sample of cases heard by the Court of Protection in order to explore the characteristics of abuse that has occurred or is alleged to have occurred.

Case analysis

From the 63 cases heard in the Court of Protection during the period 1 January – 9 November 2015 and posted on the BAILII website⁷¹, we selected 34 which appeared to deal with matters that related to the exercise of power of attorney, both proper and improper, in matters to do with property and financial affairs⁷² (the subject of our

⁶⁹ *Family Court Statistics Quarterly April to June 2015*, a Ministry of Justice Statistics Bulletin, published September 2015

⁷⁰ Lush, D (2014) *Financial crimes committed against the Elderly and infirm: a review of its increasing prevalence and how effective practitioners, public bodies and the courts are at tackling it*, delivered to a STEP seminar, London.

⁷¹ www.bailii.org/ew/cases/EWCOP/. Cases cited in this chapter are referenced ‘EWCOP’ + case and paragraph numbers.

⁷² i.e. excluding health and welfare LPAs.

enquiry). We rejected 27 cases as not relevant (14 because they dealt with deprivation of liberty orders and 13 dealing with issues to do with medical treatment). On checking once the analysis had been completed, we found that we had overlooked two which on further scrutiny would have been relevant.

Case characteristics

The subjects of the cases⁷³ were predominantly female (74%) and elderly (over 70). A very small number were younger – three who were under 30 and another two between 31 and 60. In terms of the condition leading to their lack of capacity, most had dementia (25) with a small number having mental health conditions, acquired brain injury or learning disabilities. In another two cases, the donors in each case were found not to lack capacity – one who was inquiring about technical aspects of his LPA in terms of appointing successor attorneys in the future, and another who suffered from schizophrenia and during consideration of the case, was found to have fluctuating capacity to make decisions relevant to the issues being considered (where the case was dismissed because of this). Twenty-one of the donors were living in care homes, while 12 were living either in their own home or with their family.

Table 1 Gender of case subject

Gender	-n	%
Male	9	26
Female	25	74
Total	34	

Table 2 Current age of case subject

Age Bands	
0-29	3
50-59	2
60-69	2
70-79	12
80-89	11
90+	4
Total	34

Table 3 Case subject's condition in relation to mental capacity

Condition	
Dementia	25
Learning disability	1
Mental health, plus 1 with capacity but with an mh condition	3
Acquired brain injury	3
ABI + dementia	1
Has capacity	1
Total	34

Table 4 Place of residence

Residence	
Care home	21
Own home	7
With family	5
Not known	1
	34

Most cases were applications for attorneyships or deputyships to be appointed, revoked or decisions about them to be reconsidered (decisions often made initially on the basis of the papers and not at an attended hearing). Some were applications to appoint attorneys which were contested by other members of the families. A majority of cases (Table 5) were brought by the Public Guardian, usually after investigation by the OPG into the way in

⁷³ i.e. those who had made the LPAs or EPAs or were the subject of deputyships

which a power of attorney had been exercised. In the other major category, family members were the applicants, often in challenges to other family members as a result of their dissatisfaction with current or proposed arrangements in which the other relative(s) were thought to be (or would be in the future) taking material advantage of their position as attorneys (in ways that either clearly damaged the interests of the donor – or, more veiled, furthered their own personal interests).

Table 5 Number of cases x applicant category

Applicant	-n	%
Public Guardian (PG)	18	53
Donor	1	3
Family (incl two cases + donor)	13	38
Council	2	6
Total cases	34	100

In terms of those responding to applications (Table 6) most were members of donors’ families (26 solely family members and 3 family members with others):

Table 6 Number of cases x respondent category

Respondent	-n	%
PG	1	3
Donor	1	3
Donor + CICA	1	3
Family	26	76
Family + donor	1	3
Family + lawyer	1	3
Council + family	2	6
Deputy	1	3
Total	34	100

Not all cases showed signs of financial misbehaviour (clear or potential). Table 7 shows the distribution – with most cases being those where the PG was the applicant:

Table 7 Cases where potential financial abuse (FA) was identified or claimed x applicant category

Applicant	Cases
PG	13
Family	4
Council	1
Total	18

Many of the 18 cases where the PG was the applicant were characterised by evidence of family disputes (Table 8):

Table 8 Cases characterised by intra-family disputes or disagreements x applicant category

Applicant	Cases
PG	13
Family	9
Council	1
Total	23

In 14 cases, there were indications of financial misbehaviour and intra-family disputes co-occurring.

Case details

Of the 34 cases, 18 involved behaviour by attorneys or deputies which was alleged to constitute a breach of their fiduciary duty, the contravention of their authority and/or a failure to act in the donor (or P)’s best interests. In some cases, this alleged misbehaviour could indicate financial abuse involving, among other misdeeds, fraud or misappropriation of funds.

Common examples which either raised suspicions or indicated such misbehaviour included cases where there was:

- failure to provide accounts to the Court or OPG;
- arrears in the payment of care home fees;
- failure to provide the donor, resident in a care home, with a weekly personal allowance;
- no separation of the attorney and donor's funds (co-mingling);
- spending on purchase of or repairs to property not the donor's;
- holding donor's money in an account in own name;
- gifting to self and own family above permissible levels;
- unjustified and false claims as to why donor's money had been spent;
- chaotic incompetence in managing the property and financial affairs of the person lacking capacity.

Complicity between attorneys was sometimes involved, with a co-attorney remaining wilfully or lazily ignorant of the actions of the other(s) and shuffling off responsibility for becoming involved in managing the donor's affairs. In other cases, an attorney might have acted alone, without reference to co-attorneys whether being jointly and severally responsible. Misuse of a donor's funds did not, it appears, always result from fraudulent impulse; sometimes it was grounded in naïve incompetence, bitter intra-family disputes or the pressure of personal problems.

Reports of cases often included statements from the attorneys involved in tones that ranged through contrition, faux surprise, apparent amazement, brazen self-justification to argumentative contestation of the judge's view.

One man, for example, used a number of self-serving excuses: the shock and distress of a drink driving charge and the associated legal costs along with the need for money to pay the deposit for his son's university fees in USA, plus the costs of flight and car insurance. Senior Judge Lush (who heard 32 out of the 34 cases we examined), however, found something rather different: the man's purchase of property for himself out of his mother's funds and the pocketing of the rental income. The judge remarked with surprise on the man's readiness to pursue action against the council on a DOLS⁷⁴ issue during the same period and also noted his use of a range of solicitors with the apparent intention of obfuscation:

"I wonder whether this is a smokescreen to ensure that no one firm or company is fully aware of his ineptitude and deceit," para 43, and concluded "I am satisfied the revocation of the LPA is in accordance with the law and necessary for the prevention of crime," para 48, EWCOP55.

In one case – where it turned out that the senior judge did not need to consider an earlier order made on the papers because it was now apparent that BN had capacity – the applicant and respondents fell into dispute between themselves. Senior Judge Lush concluded:

"I regret to say that the hearing degenerated into a slanging match between CN [the daughter] and her mother [the donor] and CN's daughter [one of the two attorneys]. Voices were raised and tears shed as either side trawled through decades of family history describing any incident that could possibly discredit the other. Fortunately there was no need for me to embark upon a fact-finding exercise because none of these incidents had the slightest bearing on the issue I was required to determine," para 26, EWCOP11.

In some cases, though, the key players were contrite and apologetic for their behaviour. In case 21 (see later), the respondent made several apologies:

"I apologise for this communication after the hearing. I was a bit out of my depthI would also like to apologise for the invoice sent to the OPG. It was a hot-headed attempt born out of frustration Thank you again for your time and understanding during the hearing. I will not trouble you again," para 28, EWCOP21.

⁷⁴ Deprivation of Liberty Safeguard (DOLS)

Indicators of possible abuse

As far as abuse is concerned, analysis of the cases selected suggests that they are characterised by behaviour which falls into two broad categories –

- behaviour that *could be associated* with abusive behaviour and therefore should be classified as alerts (*triggers*) of suspicion; and
- behaviour which *in itself* appears to be abusive.

Thus the existence of care home arrears, as Senior Judge Lush remarks several times, relates to the former, while evidence of gifting by the attorney of large amounts of a donor's money to self or relatives is a case of the latter.

Suspicion triggers

Failure to keep and provide accounts

The Mental Capacity Act Code of Practice⁷⁵, para 7.67, states, in relation to attorneys, that:

“Property and affairs attorneys must keep accounts of transactions carried out on the donor's behalf. Sometimes the Court of Protection will ask to see accounts..... The more complicated the donor's affairs, the more detailed the accounts may need to be”

while with respect to deputies, para 8.56 of the Code states that:

“Deputies must carry out their duties carefully and responsibly. They have a duty to:

- act with due care and skill (duty of care)
- not take advantage of their situation (fiduciary duty)
- indemnify the person against liability to third parties caused by the deputy's negligence
- comply with the directions of the Court of Protection.

Property and affairs deputies also have a duty to:

- keep accounts, and
- keep the person's money and property separate from own finances.”

In situations where an LPA does exist, the OPG may be alerted (sometimes by another attorney, a council or an unconnected whistle-blower or concern-raiser) to alleged misbehaviour by an attorney, and an investigation may be mounted involving requests for accounts to be provided which remain unfulfilled. Where the OPG investigation officer remains unsatisfied that all is in order, the PG may apply to the CoP for revocation of the LPA.

The CoP itself may undertake investigations and request accounts to be provided – for example, in advance of hearings or when a hearing is postponed for further information to be gathered. Attorneys sometimes fail to respond, raising suspicions that there may be other issues to be concerned about. In the cases explored here, comments by the senior judge suggest that in some instances such failure may be part of a general failure to meet fiduciary duty which in some instances may result from incompetence or ignorance on the part of the attorney involved.

In the case of deputies, appointed by the CoP and supervised by the OPG when an individual has lost capacity and no LPA exists, part of their duties involves regular reporting back to the OPG, usually on an annual basis. Failure to do so may be one of the factors (others may be reports from whistle-blowers and family members or suspicions raised by local councils) that prompts the OPG to investigate the wider situation – leading usually, where concerns remain, to applications by the Public Guardian (PG) to the CoP for the deputy to be relieved of his/her duties.

⁷⁵ Mental Capacity Act 2005, Code of Practice, Issued by the Lord Chancellor on 23 April 2007 in accordance with sections 42 and 43 of the Act

In at least 12 of the cases, the senior judge noted that failure to keep or provide accounts had at some point featured in the case. The decision in one case describes the primrose path towards complete financial misappropriation, with the failure to account properly at the outset:

“Their failure to keep accounts of the transactions carried out on the donor’s behalf or to produce any record of her income and expenditure would alone be sufficient to warrant the revocation of their appointment. However in this case both attorneys, and in particular DA, have compounded their culpability by taking colossal advantage of their position and obtaining personal benefits far in excess of the limited power that attorneys have to make gifts of the donor’s property.... DA has also failed to keep the donor’s money and property interest separate from her own interests,” para 34, EWCOP41.

Sometimes, ineptitude, affection and mismanagement all go hand in hand. In a case where the PG was applying for a reconsideration of the revocation of an EPA made on the papers after the complaint by the attorney’s sister (his co-attorney) that she was concerned about her step-brother’s management of their father’s affairs, it was clear that he had failed to comply with a duty to keep and supply accounts and to produce them despite requests from the PG that he do so. He had also failed in his fiduciary duty by co-mingling his step-father’s funds with his own in his own account, created a credit card for using his step-father’s funds and let his care home fees fall into arrears. But he claimed:

“I am a kind and caring person and of good character who has devoted as much time as possible to a man who deserved to be looked after by his family in the best possible way....I still have his best interests at heart and visit him as often as I can usually once a week and make sure he has everything he needs,” para 23, EWCOP2.

The senior judge however, in confirming the revocation, concluded:

“He may be an affectionate and attentive stepson but that’s not the point. He has been a hopeless attorney and has broken almost every rule in the book and I sense that he has done so wilfully,” para 36, EWCOP2.

Sometimes an attorney’s failure to comply with requests from the OPG for an account, appear to be the result of a total inability to fulfil the responsibilities of the role. But the senior judge is unlikely to accept this as an acceptable reason to excuse him from his duty to comply with the OPG’s request:

“I appreciate that BW is married with five children, two of whom have special needs; that he works full time as a civil servant; that the time he has to deal with his father’s affairs is very much limited and that he is currently stressed, but these are reasons for disclaiming the attorneyship rather than persisting in performing it inadequately,” para 28, EWCOP9.

Other cases were complicated, touching and warranted humane handling. In case 33, concerning HS, a 52 year old woman who had developed Huntington’s disease in her late thirties, Senior Judge Lush was asked by the PG to reconsider two orders he had made the previous year – to revoke an EPA and to appoint the local council deputy for HS’s property and affairs. HS’s former partner RA, although subsequently married to KA, had been her attorney under the EPA but had been in fierce dispute with the council over the personal care he was providing to HS. He had also acknowledged he had not kept professional records and had allowed crossover of funds.

Some of the documents presenting RA’s side of the case and pertinent to the previous hearing, had been mislaid and had not then been considered by the judge, but these were now available. Further, at this later hearing, as an addition, the 18-year old son, CA, was joined as party to the case. The senior judge was impressed with witness statements commending the commitment of CA to his mother’s welfare and his overall maturity for one so young. Taking into account RA’s long-term support and continuing concern for his former partner and considering CA’s willingness to be appointed deputy rather than the (costly) alternative of a panel deputy being appointed – and with warm testimony in support of CA by a mental health nurse consultant and the likelihood that the PG would have no objection (despite his earlier position) – the senior judge appointed CA to be his mother’s deputy for property and affairs.

Care home arrears and failure to provide a personal allowance

We found 10 cases of care home fees in arrears (out of the 21 cases where the donor was resident in a care home, Table 4). They were often linked with the withholding of a personal allowance from the resident by the attorney or deputy. Senior Judge Lush frequently drew attention to the association between these failures and other misbehaviour, as extracts from several cases makes clear:

“As I have said elsewhere “with almost unerring monotony in cases of this kind, a failure to pay care fees and a failure to provide a personal allowance are symptomatic of more serious irregularities in the management of an older person’s finances,” ” para 28, EWCOP19.

“As is frequently observed in cases of this kind, failure to pay care home fees, a failure to provide an adequate personal allowance, a failure to visit, and a failure to produce financial information to the statutory authorities, go hand in hand with the actual misappropriation of funds,” para 38, EWCOP55.

Senior Judge Lush also remarked that using the excuse (as seems to be common) that the attorney is waiting for the outcome of a decision on NHS Continuing Care (i.e. full payment of care home fees by the NHS) is no excuse for withholding payment of fees:

“While attempts to resolve the dispute are taking place, the attorney should continue to pay the donor’s care fees. If it transpires that the donor qualifies for NHS Continuing Care and has been eligible for some time, the NHS will refund any overpayment of care fees,” para 36, EWCOP55.

Of the 10 cases where care home fees were in arrears, 8 seemed to show evidence of some financial misbehaviour amounting to abuse. For example, in case 68, where there were care home arrears of £29,000, the donor’s son, her attorney, had charged his mother a daily rate of £400 for visiting her and, according to the OPG investigation officer, had also paid himself over £49,000 from her funds, claiming it was for time he had spent pursuing a claim against the local health board in Wales on her behalf. Further, in his witness statement and contesting the need to replace him as attorney by a panel deputy, he said:

“I am the sole heir and because of my mother’s dementia and current poor health, there is no need to protect the estate’s financial interests which are effectively mine,” para 28, EWCOP68.

Senior Judge Lush made his view very clear:

“The Public Guardian believes the amount of £117,289 is an excessive amount to claim for out of pocket expenses. I would put it more strongly than that. I believe that charging one’s elderly mother a daily rate of £400 for visiting her and acting as her attorney is repugnant,” para 41, EWCOP68.

He went on:

“Martin suggested that the appointment of a panel deputy would be a waste of time and money because his mother’s estate is effectively already his. I disagree. The panel deputy will, for the first time in eleven years, place Sheila at the centre of the decision-making process rather than view the preservation and enhancement of Martin’s inheritance as the paramount consideration,” para 42, EWCOP68.

In contrast, in case 10, while he revoked the LPA and appointed a panel deputy to act as SM’s deputy for property and affairs, he was less condemnatory of the attorney’s behaviour:

“The statement that MO handed to me is the testimony of someone who is at breaking point. It is not in SM’s best interests that her financial affairs should be continued to be managed by a person who is unable to cope and clearly finds the responsibility of acting as attorney overwhelming,” para 32, EWCOP 27.

He also pointed out that SM’s grandson, a fellow attorney, should have taken his responsibility seriously too:

“he should have acted as a check and balance on MO rather than allow her to wreak havoc with SM’s finances; his failure in this regard makes him partly responsible for the loss to her estate,” para 33, EW COP27.

Co-mingling of funds

Failure on the part of attorneys to keep the donor’s funds separate from their own is often found to be one of a wider set of misdeeds. Case 41 (already cited) is a case in point where the main issue was the over-gifting from the donor’s funds to themselves – from funds that were held together with the attorney’s own funds. The reasons for doing so vary. Attorneys may mix up donor funds with their own deliberately to draw a veil over what is going on. On the other hand they may argue, perhaps disingenuously, that it is a result of incompetence or mismanagement:

“I knew that my duties as attorney required me to keep my mother’s funds separate from my own. This was the sole reason I opened the account..... I had opened the account so that the account name read Mr BW [the attorney’s initials] re (name of property) and I believed that this was sufficient to fulfil my duties. The intention has always been that this was my mother’s account and that I was simply managing it on her behalf. I confess to not realising that I also ought to ensure the name was my mother’s and not my own. As soon as I was informed that the account needed to be in my mother’s name I went into my local Barclays branch to have it changed. The branch informed me that this was not possible,” para 35, EW COP19.

Senior Judge Lush gave this short shrift:

“I simply don’t believe it,” para 36, EW COP19.

In other cases, it appears that taking on the role of attorney is too much for some individuals and, they claim, mistakes happen. In a case (c 27) where the senior judge decided to revoke an LPA, he did so on the basis that one of two attorneys had mixed her own funds with those of the donor (her mother), had gone on to use her mother’s funds for her own benefit, had also allowed care home fees arrears to accumulate, had failed to account to the PG, and had spent the donor’s money on herself, her husband and sons. The attorney, a woman suffering severe physical health problems herself, described her feelings about the mess she was in:

“As I have said all along, I love my mum and my family with all my heart and I’m heartbroken to think other people think otherwise..... It’s such a shame that bad situations, a lack of good communication, and confusion has thrown everything up in the air and comes down in a mess..... The last few years have been a nightmare for me, mentally and physically; what with losing my mum to this dreadful illness, trying my best to get the help she neededthen all this Court of Protection mental stress, and my physical pain getting worse My head is about to blow and I don’t know how much more I am expected to take....Please trust me. I could not be more sincere and honest about this if I tried. This has all been a case of grief, sadness confusion and mix ups” paras 21 & 22, EW COP27.

The senior judge pointed out that her son, a joint attorney with her, should have taken some responsibility in ensuring his grandmother’s affairs were managed properly. Both attorneys, he concluded, had failed to act in the donor’s best interests.

Sometimes, though, there seems to have been wilful ignoring of their duties as attorneys to keep funds separate. In case 72, Senior Judge Lush stated that the respondent had failed in her fiduciary duty as attorney by continuing to pay herself an allowance for caring for her mother after her mother’s admission to a care home, she had failed to account satisfactorily for the transactions she had carried out on her mother’s behalf and had:

“contravened her duty to keep her money separate from the donor’s. She had defiantly opened an account in her and [her mother] D’s joint names soon after her brother Martyn assumed overall control of the management of D’s property and financial affairs” para 43, EW COP72.

Abusive behaviour

Gifts to self and others

The law permits an attorney to pay self and other family members (and others) small amounts from the donor's estate but for something more than this he must apply to the court for permission. A failure to do this may find the attorney in breach of his fiduciary duty or contravene his authority. Further, it may be associated with other mishandling of property and financial affairs.

In one case (c 6), inappropriate gifting was discovered almost accidentally. The local authority had taken an interest in the donor after being alerted by the police on two occasions – once, when the donor had been found walking in the middle of the road late at night and then when she had been reported as a 'missing person'. The social services department contacted the family offering an assessment of the donor's care needs and at that point was informed by one of the attorneys, the daughter, that their mother (the donor) had gifted £75,000 to the family. The daughter claimed that at the time her mother had capacity to make the decision to gift the money. The PG having been informed by the local authority investigated and applied to the court for the revocation of an LPA on the grounds that the two attorneys, a son and a daughter, appointed jointly and severally two years previously, had contravened their authority.

In his decision, Senior Judge Lush found as fact that the cheques totalling £75,000 had been signed by the daughter in her capacity as attorney. He stated that:

"These gifts far exceeded the limited authority to make gifts which conferred by section 12 (2) of the Mental Capacity Act 2005 and in this respect GB (the attorney) contravened her authority as attorney. SG (the brother, also attorney) was a party to the transaction and he also contravened his authority as attorney," para 32, EWCOP6.

He also stated that the two siblings had breached their fiduciary duty in taking advantage of their position as attorneys.

In case 30, another instance of attorneys making gifts to themselves "far in excess of the limited authority conferred upon attorneys generally by section 12 of the Mental Capacity Act" was described. Not unusually, disputes between the attorneys, a son and a daughter of the donor, figured in the details of the case which involved the affairs of a 91-year-old woman (EL) with assets in both the UK and Greece. A witness statement by an OPG investigation officer described how both siblings regarded their mother's assets as theirs – i.e. as their inheritance:

"CS (the daughter) had received £22,553.31 and PL (the son) had received £19,925.63 from the account.... Both attorneys regard the money in their mother's account as their inheritance and consider that they are entitled to dip into it during her lifetime," para 16, EWCOP30.

There had been a history of disagreements about managing their mother's affairs and most recently a failure to adhere to a Schedule of Agreed Responsibilities arrived at in a previous court hearing at Bournemouth County Court. Senior Judge Lush dismissed the suggestion that the son should be appointed sole deputy if the LPA were to be revoked, allotting most responsibility to him for the original breakdown in the attorneys' relationship. He revoked the LPA and invited a panel deputy to apply to be appointed as EL's deputy for property and affairs.

In case 41, the donor, a 77-year old woman diagnosed with vascular dementia, had executed LPAs for property and affairs and for health and welfare and appointed two of her three children as attorneys, jointly and severally. The PG applied for revocation of the property and affairs LPA on the grounds that the attorneys had "used their power carelessly and irresponsibly" after an investigation prompted by the elder son (who was not one of the attorneys) having contacted the OPG expressing concern at the sale of his mother's property.

The OPG investigation listed a range of concerns – the donor's maisonette being sold (for £730,000); one attorney's own mortgage being paid off with the donor's money and a monthly rental income of £850 being

drawn on the vacated property; of another £80,000 of the donor's money being spent on building works at that attorney's own property; and the residual money in the donor's bank account having dwindled to £7,000.

The attorneys (the daughter in particular) argued that they had done everything in the interests of their mother who had gone to live with the daughter (in the house bought with the donor's own money and in which she and the two attorneys held shares (20% - the donor; 40% each - the 2 attorneys).

Senior Judge Lush was not persuaded. He stated:

"I am satisfied that the attorneys have behaved in a way that contravenes their authority or is not in the donor's best interests. Their failure to keep accounts of the transactions carried out on the donor's behalf or to produce any record of her income or expenditure would alone be sufficient to warrant the revocation of their appointment. However, in this case both attorneys, and in particular DA (the daughter) have compounded their culpability by taking colossal advantage of their position and obtaining personal benefits far in excess of the limited power that attorneys have to make gifts of the donor's property under section 12 of the Mental Capacity Act. DA has also failed to keep the donor's money and property interests separate from her own interest in respect of the property she owns in South Norwood," paras 33 & 34, EWCOP41.

But the third sibling (the elder brother who was not appointed as attorney) did not escape the judge's criticism:

"As regards the appointment of ES as OL's deputy for property and affairs, I do not believe he has sufficient detachment or impartiality to manage his mother's affairs and to ensure that her interests and position are properly considered. I sense that he is motivated partly by a desire to salvage his own inheritance and partly by a craving for revenge against his sister and brother," para 38, EWCOP41.

But every case is not what it seems at first. In case 29, an application was made by the PG for revocation of CC's appointment as deputy for his mother's property and financial affairs on the grounds he had contravened his authority and failed to act in the best interests of his mother. It was stated that following an OPG review of the annual deputyship report forms submitted over three years, questions were raised about payments to himself for caring for his mother, the estimate he made of the value of her house in Bristol, and substantial amounts spent on renovating the property and on her care fees, all in the absence of evidence to support the expenditure.

On the face of it, it was not dissimilar from other cases considered by the court. However, the senior judge took into account CC's witness statement along with those of his brother and sister. CC said:

"I believe I have always been open and honest with my intentions with and in agreement of all the client's (his mother) other children as perceived as what the client would have wished. I honestly believe that I have acted in the client's best interests having paid due consideration to the client's various alternative care options and wishes," para 23, EWCOP29.

The senior judge gave retrospective approval of CC's decisions and authorised future payments from their mother's funds. He noted that there was no monetary gain in retaining the property on which the money had been spent and noted "the deputy and his siblings are retaining it simply out of respect for her wishes. The property is her pride and joy," para 32, EWCOP29.

Incompetence

The question of whether misbehaviour has taken place through incompetence is often at issue. This may result from ignorance (wilful or inadvertent) of the duties and authority conferred on attorneys on appointment or from their general unsuitability. In case 70, Senior Judge Lush pointed to the ignorance one of the attorneys had exhibited:

"Audrey had some strange ideas about the functions and duties of an attorney acting under an LPA.I asked Audrey a few basic questions about the principles of the Mental Capacity Act 2005, best interests decision-making and the fiduciary duties of an attorney..... the answers to these questions required no more knowledge than the information that is already contained in in Part C of the LPA which Audrey

signed she didn't have a clue and I am inclined to agree with the Public Guardian that her actions are more a consequence of her ignorance rather than her own self-dealing..." paras 38 & 39, EW COP 70.

But he went on to comment:

"what concerns me however is that Audrey has no intention or desire to learn about the principles or best interests decision-making or her fiduciary duties as an attorney. One of her personality traits is inflexibility or rigidity in thought and behaviour" para 40, EW COP70.

Resolution of the case was achieved by revoking the LPA and appointing Audrey as deputy thus enabling the OPG to provide some oversight to her management of her mother's property and financial affairs.

Ignorance of the nature of fiduciary duties was seen again in case 14, where the daughters of PL were objecting to the appointment of their brother as deputy for property and financial affairs:

"the striking feature of this case was that neither the applicant nor the respondents had any idea about the fiduciary duties and practical responsibilities that a deputy is expected to undertake and the roles of the Court of Protection and the Office of the Public Guardian in ensuring his compliance," para 24, EW COP14.

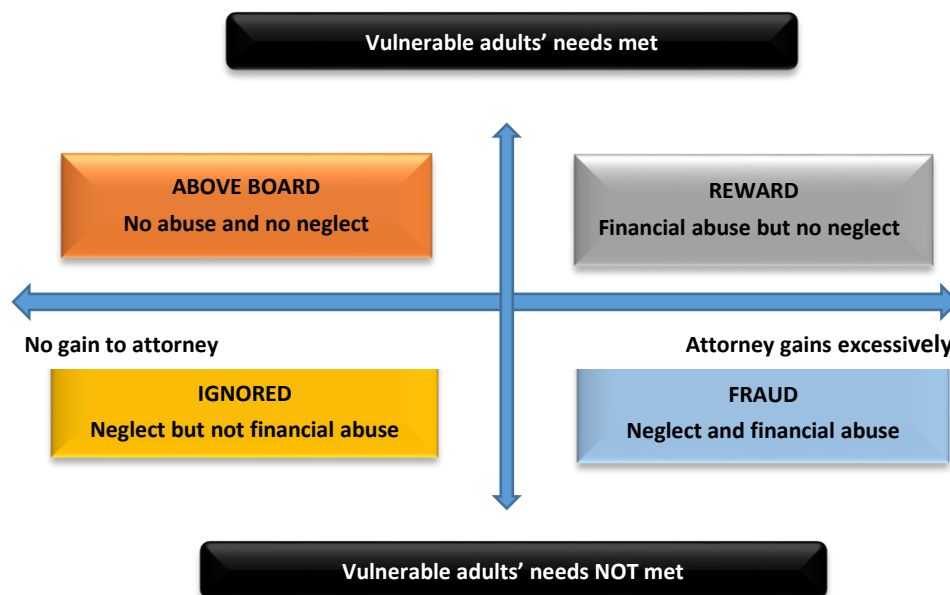
In case 2, referred to earlier, the senior judge considered the meaning of 'unsuitability' in response to the PG's application to reconsider the partial revocation of an EPA. He had found PB had contravened his authority and had failed to act in RG's best interests even though he "may have been an affectionate and attentive stepson.....[but] he had been a hopeless attorney" paras 35 & 36, EW COP2.

Neglect and hoarding

Some studies have identified 'hoarding' as a category of financial abuse which could be relevant in the sort of cases investigated by the OPG (or PGO prior to 2005) and heard at the CoP. Hoarding as a form of financial abuse was described as "the hoarding of a vulnerable person's resources for future gain which is also a form of exploitation and may be associated with culpable neglect"⁷⁶.

While we did not find any clear examples of neglect and hoarding in our sample of 34 cases, we did come across cases where there may have been an element of interest in preserving the assets of a donor for, perhaps, the attorney's later benefit such as the denial of personal allowances by relatives of donors living in residential care homes – to their obvious disadvantage. Such neglect may be the result of pure carelessness and irresponsibility. On the other hand it might be an indication of a wider concern to conserve the donor's assets for their own benefit in the long-term (i.e. as their inheritance). The Brown *et al* grid, "Fig 3. Gain and need as indicators of abuse," (Brown *et al* 2005, p 17, slightly modified) sums it up with hoarding possibly taking place somewhere within the bottom right-hand cell of the quadrant:

⁷⁶ Brown, H, Burns, S and Wilson, B (2005) *The role of the Public Guardianship Office in safeguarding vulnerable adults against financial abuse*, Canterbury Christ Church University College (p16/17)



Ironically, we did find one case which at first sight might fit this category – of a deputy apparently conserving (possibly ‘hoarding’) the donor’s funds, only to find it was anything but that. The PG was seeking a reconsideration of a decision made on the papers to revoke the appointment of the respondent, MP, as his partner’s deputy and replace him with a panel deputy (case 21). CJ had suffered a heart attack and brain damage at the age of 52. Her partner had later been appointed her deputy to manage her property and financial affairs.

There were complicated issues involved and included evidence that the partner as deputy had failed to provide the OPG with accounts over a period of three years. There had been a substantial damages award made to CJ which had remained untouched in a special account in the Court Funds Office. Her deputy (her partner) said he wished to conserve this in the hope it could be used for future stem cell treatment (rather than use it now for her benefit and wellbeing).

The senior judge upheld the earlier decision to revoke the deputyship though stating he was certain there had been no “dishonest misappropriation” of CJ’s funds and that “there was something faintly endearing about MP”. He also went on to ask for the panel deputy, once appointed, to investigate:

“whether it is in CJ’s best interests that her damages award is retained to pay for future stem cell treatment (which may never become available in her lifetime) or whether it would be better to apply the award for the purpose for which it was intended when the settlement was agreed,” para 44, EWCOP21.

Her best interests, he implied, would be best served by looking at using the funds now rather than conserving them.

Reflections on the cases

The Senior Judge’s handling of cases – the mix of blunt observation and compassionate understanding

The senior judge was not averse to making clear and sometimes acerbic comments in expressing his view of individuals who have misused their powers under the law. His comments, already cited, in cases 68, 66 and 55 are examples.

But conversely, as in cases 21 and 33, analysis of cases shows that he also expressed empathy and understanding in dealing with cases where there was no fault or where there has been no intention or malice in failures to manage the donor’s affairs appropriately. In certain cases he expressed his concern about the impact of any decision he might make on the individuals involved in the case and the financial health of the estate involved –

often making careful calculations of the costs involved in placing someone in residential care, or bringing in home care; or the costs of appointing a panel deputy when dealing with estates of lesser value (cases 33, 67). Wherever possible, he makes appointments which are supportive – such as agreeing to the appointment of ‘successive deputies’ who can pick up fuller responsibility in due course (case 52); or revoking an LPA and appointing the former attorney as deputy – to ensure more oversight (through OPG supervision) of the management of the donor’s property and affairs (case 70). In others, he will try to appoint a non-professional deputy to save on costs (of a professional) to the dwindling estate (cases 10, 57) or attorneys who may be family members, like the one being relieved of the duty, but who are more competent.

The poisonous effect of intra-family disputes

Many cases were characterised by intra-family suspicions and jealousies, often displayed between siblings (Table 8). In case 14, two sisters objected to their brother’s application to be sole deputy for the management of their father’s property and affairs, asking instead for all three of them to be appointed. There had been a history of allegations and counter-allegations of the abuse of their father between the siblings, with the sisters asking the county council to investigate their brother’s actions. The council had investigated but dismissed their suspicions. In his witness statement to the court, the brother’s view of his sisters was made clear:

“they are not the slightest bit interested or concerned with my father’s welfare. They are interested in his money. They have already shown no inclination to agree that essential payments be made for his wellbeing and if they were made joint deputies, I fully expect they would stand in the way of such essential payment [in this case the installation of a shower and a stair-lift]”, para 19, EW COP14.

Senior Judge Lush commented that the siblings, both applicant and respondents, did not “have any idea about the fiduciary duties and practical responsibilities that a deputy is supposed to undertake,” para 24. Nor did he think it would be satisfactory or possible to appoint all three as deputies because of their patent inability to co-operate with each other.

He later remarked “unfortunately some deputies take advantage of their position and family members are often the worst offenders,” para 31, c 14. His decision was to appoint the brother as sole deputy, and requiring him to obtain and maintain security of £550,000 – (their father’s assets calculated as being £580,000).

Many of the cases displayed a confused mixture of incompetence, mutual suspicion between different family members and misuse of the donor’s funds. In one case (c 49), five siblings were in disputation among themselves (three against two). Two of the daughters had been appointed deputies and one of the sons argued that he was being made to leave their father’s property in which he had lived rent-free although their father had pledged he would always have a roof over his head. The two siblings who were deputies were seeking to sell the property in order to pay for care home fees now that the father had been placed in residential care. Their brother responded, claiming there was an Irrevocable Deed of Gift with regard to the property which protected his right to live there and that he was a victim of their “bullying and relentless harassment which was beginning to affect his health”, bringing a case against them under the Family Law Act 1996 (para 26).

In affirming the two daughters as deputies, Senior Judge Lush criticised the applicants (their three other siblings) who sought to contest this and criticised their behaviour:

“I am singularly unimpressed with the applicants’ conduct. Having made the application they failed to follow it through. They didn’t file any responses to the deputies’ witness statements……. They didn’t turn up to the hearing and of course their application was unsuccessful. They lit the fuse and ran away. This is a case in which a departure from the general rule [on costs] is justified,” para 47, EW COP49.

He then went on to say that one of the applicants, along with the others, would be expected to pay her share of the costs despite the fact that normally she would have been likely to have been exempted (her husband was on welfare benefits), saying that this did “not grant her immunity from an order for costs being made against her,” para 48, EW COP49.

In several cases, disputes between siblings often centred on the failure of one or other of them to fulfil what they saw as their family obligations to love and care for their ageing parent. Sometimes a sibling would make these allegations only to be found to be wanting in exactly the same areas of failure. In case 61, Stephanie claimed that:

“her brother Paul was controlling our mum’s finances without legal authority. He has made no money available for her personal needs. I suspect he is renting out her villa in Spain and keeping the proceeds even though he claims it has stood empty for years,” para 15, EWCOP61.

Their sister Tina responded saying:

“The villa is in my mum’s and brother’s name. Social services have proof of this. Stephanie has only visited my mother 4-6 times in four and a half years. I don’t believe Stephanie has my mum’s best interests at heart,” para 19, EWCOP61.

The senior judge preferred to appoint Tina as their mother’s deputy saying that Stephanie was unsuitable because of her poor relationships with her siblings and with the management at the care home where her mother lived.

Intra-family disputes sometimes led to the involvement of the council and the police. In case 23, Donna, one of the applicants and granddaughter-in-law, claimed that the donor’s son-in-law had been removing funds from the donor’s savings. Allegations in relation to this abuse were made to the safeguarding team at the council, the care home and the police– but “none of them took it seriously”. With regard as to whom to appoint as deputy, the senior judge said that the grandson, Alan, would be unsuitable because:

“he is completely in thrall of his wife (i.e. Donna)” and that together “they have shown they have no intention of collaborating with other members of DC’s family, or her care team or her social workers and for that reason alone they are unsuitable to be personal welfare deputies”. Furthermore, “I do not believe that it would be in DC’s best interest to appoint Alan and Donna as her deputies partly on account of the hostility that exists between them and the rest of DC’s family and the care staff who look after DC. I believe that such hostility would have an adverse impact on the administration of DC’s property and affairs and that the appointment of an independent deputy would not only be preferable but would also be in DC’s best interests” paras 32 & 33, EWCOP23.

The council was appointed deputy for property and financial affairs.

At this point it is important to note that not all cases where there is evidence of intra-family disputes show sign of financial abuse of the person lacking capacity. Assessment of the 23 cases where there were clear indications of family disputes and infighting (often involving arguments about who should act as attorneys or deputies), 14 appeared to display evidence of possible financial abuse – just over half.

Failures of attorneys to observe their joint responsibilities

It was striking to see that in a number of cases, attorneys, who had been appointed jointly, or jointly and severally, failed to observe their cooperative responsibilities as attorneys. Each attorney has to fulfil the responsibilities which fall to him or her. Where appointed jointly, this meant, for example in case 19, that:

“BW should have acted jointly [as laid down in the LPA] with his brother rather than allow him to have a free rein in the management of their mother’s property and financial affairs. For this reason he is jointly liable for any loss to ID’s estate [their mother, the donor]. Furthermore, if MD turns out to be a man of straw, BW could find himself wholly liable for the loss to ID’s estate and there is a potential conflict between his interests and his mother’s interests” para 34, EWCOP19.

In another case, a grandson was not absolved of his responsibility as a co-attorney and was relieved of his attorneyship because:

“he should have acted as a check and balance on MO, rather than allow her to wreak havoc with SM’s finances; his failure in this regard makes him partly responsible for the loss to her estate,” para 33, EWCOP27.

The tensions that are shown time and time again to exist within families do not necessarily sit comfortably with their duties to work jointly often imposed by attorney- and deputy-ship arrangements. And those self-same arrangements may exacerbate pre-existing tensions that had not surfaced before.

Comment

Family values

The role of the family, and society's view of it, is at the centre of most cases coming before the CoP. Family members are the key players in a majority of cases. Most people named as attorneys in LPAs registered with the OPG are related by birth or marriage to the donors involved. The notion that family members are the best people to act as attorneys and be appointed as deputies (with close friends the best alternative) is embedded in court practice and indeed most cases deal with cases involving family members (for good or ill). As Senior Judge Lush points out, over 90% of cases he hears are uncontentious⁷⁷, so it is fair to accept that the notion of 'family is best' is a sound one. In line with that assertion, the senior judge remarked in one case:

"The CoP hastraditionally preferred to appoint a relative or friend as deputy rather than a complete stranger out of respect for their relationshipnow reflected in Article 8 of the European Convention on Human Rights but there are other more practical reasons for choosing a family member.

A relative will be familiar with P's affairs and aware of their wishes and feelings. Someone with a close personal knowledge of P is also likely to be in a better position to meet the obligation of a deputy to consult with P and to permit and encourage them to participate as fully as possible in any act or decision affecting them," paras 37 & 38, EW COP58.

and in another case:

"The court has complete discretion as to whom it appoints as a deputy though generally speaking, in the absence of any good countervailing reason, it is in the best interests of the person who lacks capacity to appoint a relative or close friend in preference to a stranger," and "In this case there is no countervailing reason to prevent the court from appointing CA to be his mother's deputy for property and affairs," paras 45 & 47, EW COP33.

As noted, friends too are important. Indeed, the senior judge was sympathetic to the case for a trusted friend to be appointed deputy rather than a relative in several instances but:

"I should briefly summarise the law by saying that nobody (whether a family member or a trusted friend) has an automatic right to be appointed as deputy. The court has complete discretion as to whom it appoints but it must exercise its discretion judicially and in AW's best interests....," para 52, EW COP16.

He went on to point to the devotion of AW's friend (DB) as opposed to his relative (DW) and appointed the friend (DB).

The judge made a similar decision in another case. This time SB, a former neighbour and, it was suggested, her unmarried partner, was preferred as deputy over SB's two sons who had

"abused his position of trust as an attorney benefitting from his office and by failing to act with honesty and integrity (BB)" and

"failed to safeguard his mother's finances from depredation by his co-attorney; to engage with the OPG; and comply with court orders (RB)," para 30, EW COP7.

Decisions in both cases were based on positive views of family relationships and those who were closest.

For the same reason – that family is best, followed by trusted friends and others close to the person lacking capacity – panel deputies (drawn from a panel of officials) are regarded as deputies 'of last resort' (the phrase used in a number of the cases examined⁷⁸), which means that they would only be appointed where no other more suitable person existed. But this view notwithstanding, analysis of the cases reveals the varied and complex circumstances of family life and shows how these conventional assumptions may prove unfounded, or at least unreliable, to the detriment of the individual at the centre of the case (the donor, or P). The assumptions often

⁷⁷ Senior Judge Lush: "over 90% of the applications to the court involve non-contentious property and financial matters" case 43, para 1.

⁷⁸ e.g. case 33, para 46 "a panel deputy is a deputy of last resort and should be appointed only in cases where there is no other suitable person who is able and willing to act."

embedded in public discourse about the ‘family’ – of goodwill, mutual support, blood being thicker than water – are often challenged by behaviour and attitudes as revealed in court.

Having to take responsibility for the property and financial affairs of a relative, often a parent, seems sometimes to have one or other of two negative impacts – that it poisons pre-existing relationships further, or that it precipitates bad feeling where none existed in the past. Several cases⁷⁹ showed families fighting openly amongst each other following a pattern established years ago – bickering and near violence in court characterised two of them. In one case, the senior judge reported what one man said of his relationship with his sister:

“In response to my enquiry about his and Julian’s relationship with their sister Lisa, Gary said “My sister and myself can’t abide each other. If she was dying in the street, I’d leave her there.” He thought that Julian’s relationship with her may be marginally better,” para 25, EW COP66.

In others, concern that their parent’s assets might now be being mishandled by a sibling provoked suspicion and hostility where none had existed in the past. Composite, multi-generational families (made up from several marriages, with several siblings, half-siblings, grandchildren and in-laws all involved) sometimes complicated matters, although the way in which splits occurred did not necessarily follow expected patterns (case 23). Alliances might have been forged between a grandchild and an uncle, for example, rather than a grandchild and parent.

From time to time, the proprietorial attitudes and assumed entitlements of some adult children towards their parents’ assets (seen as ‘their inheritance’) were revealed. In a case of possible large-scale gifting (to self and brothers), the OPG investigating officer alleged the attorney had said “if EG [her mother] doesn’t mind and she is well-cared for, what’s the harm,” c 6, para 10. In the case where the attorney was described by the senior judge as “callous and calculating” and his behaviour as “repugnant”, the attorney had stated:

“I see no need to replace myself [by a panel deputy]. I am the sole heir and because of my mother’s dementia and current poor health, there is no need to protect the estate’s financial interests, which are effectively mine.....I am the sole beneficiary of the estate and restitution I made [of money he had already misappropriated] would come straight back to me on my mother’s death which considering her present state of health is likely to occur sooner rather than later,” para 28, EW COP68.

Assumptions about rights to inherit parental estates engender strong feelings within families. These can sometimes be exacerbated by official policy in an area of law different from family or mental capacity law.

Two such policy areas are reflected in some of the cases analysed here: one, is the liability to pay for social care which because it is means-tested⁸⁰ may tempt families into financial action termed ‘deprivation of assets’, where, contrary to the law, they dispose of their relative’s funds to their own benefit, bringing them down to below the means test level, thus avoiding having to pay the full cost of social care. Case 6 mentions this in para 20. GB had gifted £75,000 of her mother’s money to herself and her brothers which the local council then decided to treat as deprivation of assets, assessing the donor has having notional capital of £92,465.54 at the time she was receiving social care services.

The second aspect relates to NHS Continuing Health Care arrangements, whereby individuals are entitled to have their whole care home fees paid out of NHS funding if their medical condition qualifies them. In general, people are not familiar with the rules that govern this right and it causes much resentment if their ailing relative fails to qualify. Disputes about paying care home fees often arise and payment is withheld. As already noted, the existence of such arrears often triggers suspicions of financial misappropriation.

These policy ‘traps’ often colour and sour relationships within families and are frequently noted in public discourse⁸¹.

⁷⁹ e.g. case 11 para 26 (see earlier)

⁸⁰ See Dalley, G and Mandelstam, M (2008) *Assessment denied? Council responsibilities towards self-funders moving into care*, R&RA, London.

⁸¹ Goldberg, A (2012) Families hide their wealth to avoid care home costs <http://www.bbc.co.uk/news/business-17147047> (doi 11/1/2016)

The involvement of other agencies

We noted that councils are sometimes involved in applications to the CoP and that in some cases they figure in arrangements for the appointment of deputies (we also noted one case (c 27) where the council, Milton Keynes, refused to act as deputy). They raise concerns with the OPG and may provide evidence when OPG make applications to the court. We noted cases where they had alerted the OPG to the possible occurrence of financial misbehaviour, in circumstances where they have come into contact with an individual who lacks capacity and is dependent wholly on the good faith of their family. We have not identified any relevant statistics to be able to quantify council actions.

In five cases (6,19,23,70,66), there were indications of police involvement but these mostly concerned incidents where disputing family members had made allegations and counter allegations about financial abuse taking place – which were not followed up by the police. Not all involved allegations of financial abuse. One call to the police was the result of a cup of tea being thrown by one sibling over another and another one was of a daughter behaving badly when visiting her mother at a care home. In case 6, both police and council had been directly involved – the police finding the donor wandering at night and the council following this up to find evidence of financial abuse by family members.

We have not identified any statistics to quantify police involvement.

Dismissal of cases

It is important to note that applications made by the PG are not automatically confirmed by the court. We noted four that were dismissed and others were only partially upheld. On one occasions (c 10), the senior judge commented:

“At the beginning of this Judgement, I said that this case was unusual, insofar as I rarely dismiss a safeguarding application made by the Public Guardian. It is also unusual because there is no evidence on the part of dishonesty of the part of the attorneys, and, although they failed to produce satisfactory accounts, I would be very surprised if any of them misappropriated their father’s funds. The principal criticism is that they have been applying DT’s funds towards the maintenance of their mother (his wife) who would otherwise be reliant on means-tested benefits,” para 47, EWCOP10.

It would therefore be wrong to conclude that there is a sure and certain pathway through the process of applications and revocation.

The impact of legislation on human rights and the rights of people with disabilities

A theme that runs through the cases is the stress placed on compliance with human rights legislation. Decisions must reflect the Mental Capacity Act 2005 (under which the CoP was established) which is founded on a strong human rights framework. In addition, increasing emphasis is placed on rights under the European Convention on Human Rights (Cases 70, 62, 58, 16) and UN Convention on the Rights of People with Disabilities (Cases 70, 14), along with reminders to witnesses and others of the guidance provided in Mental Capacity Act Code of Practice (Case 72). Decisions must be made on the basis that they are the “least restrictive” on the person lacking mental capacity, that they are in their best interests and that their rights to autonomy and, where capacity is not lacking, to make “unwise decisions” must be respected. As we have noted elsewhere in the report, tensions may be encountered between expectations based on a human rights interpretation of the law relating to capacity and the perceived duties of the authorities to safeguard vulnerable people.

Conclusion

The case analysis reported in this chapter is part of a broader piece of research looking at the financial abuse of people lacking capacity from a set of differing but complementary perspectives. A feature of the research as a whole is that it focuses on abuse that takes place largely within the domestic, family setting – the private domain – and is therefore liable to be hidden from public view. Its occurrence, once revealed, challenges fondly-held assumptions about the nature of family life and also demonstrates the seriousness of some of the abusive behaviour that people lacking capacity are prey to. In contrast, much of the research on financial abuse

undertaken to date has investigated abuse committed by outsiders, in person, on-line or by telephone (especially scams of various sorts) – abuse which is serious indeed, but perhaps less morally-charged than the abuse of trust that is often involved in financial abuse within the family. Further, more is known about the character of abuse by strangers – the media are interested in pursuing it, and charities exist to support its victims.

With respect to researching intra-family financial abuse, the distinctive contribution that analysing CoP cases makes is the way the court process can be shown to shine a light on the details of this often-hidden type of abuse. Witness statements and responses to questions asked by the judges during hearings provide a rich source of information which is readily available to the researcher. Findings of fact are made and decisions taken.

A number of interesting questions arise from the scrutiny that the court process makes possible. Some of the misbehaviour revealed before the court arguably amounts to crime (at least in the view of the lay person). But we have seen in earlier chapters that this is a complicated issue. A comment by Senior Judge Lush in relation to a case he heard in 2014 (the year before the cases examined in this report) explains the position:

“There are significant differences between a police investigation and an investigation conducted by the OPG. When the police investigate an alleged crime, they need to consider whether there is sufficient evidence to present to the Crown Prosecution Service (‘CPS’) to guarantee a realistic prospect of conviction, which in this case would have been on a charge of theft or fraud by abuse of position. The CPS would have had to prove that JM was aware that he was acting dishonestly and they would have had to prove this ‘beyond reasonable doubt’, the standard of proof in criminal proceedings. The decision not to prosecute him simply means that the CPS was not totally confident that it would be able to prove JM’s guilt so as to ensure a conviction. It does not imply that his behaviour has been impeccable.” *Taken from: OPG v JM [2014] EWHC CoP B4*

As noted earlier, the issue of whether a case is referred to the police and whether the crown prosecution service decides to prosecute depends on several factors, particularly the standard of the available evidence, and specifically whether or not, as Senior Judge Lush remarks, it meets the standard of proof needed in criminal proceedings.

Further, in terms of redress, the CoP is not set up to pursue this beyond its own authority – for example, in one case which involved gifting of £640,000, the senior judge mentions that obtaining redress for money taken would have to be pursued in the Chancery division (case 41, para 19). The civil court is the main conduit for redress – or at least for the recovery of what has been taken. The CoP and the OPG have powers of investigation but their legal duty relates to whether the law protecting those lacking mental capacity is being breached and whether those given power under the Mental Capacity Act 2005 to act for such individuals contravene that authority and/or fail to act in the best interests of those for whom they act. The police and the crown prosecution service play very little part.

In this respect, it mirrors the experience of safeguarding teams in local councils where the police, although represented on adult safeguarding boards (and sometimes chairing them), pursue very few cases of financial abuse that the safeguarding process reveals. The police themselves report that they are unable to follow up cases because, too often, required levels of proof are not met or other priorities imposed by higher authority (such as the Home Office) take precedence. As for the attorneys or deputies and other members of the family involved in abusive behaviour, little punitive action apparently seems to follow its revelation before the court, though we had no opportunity to follow up professional disciplinary or media reports. Revocation of an LPA and the appointment of deputies are the main means of protective intervention for the donor. Little beyond that seems to happen to the abuser.

Two big policy questions thus remain unanswered:

- how does a person lacking capacity and who has suffered financial abuse obtain redress, restitution and protection? and
- how can abusers be held to account for the misappropriation of money and other assets beyond being stripped of their appointment as attorney or deputy?

Chapter 5

DISCUSSION OF THE FINDINGS, CONCLUSION AND RECOMMENDATIONS



CHAPTER 5

DISCUSSION OF THE FINDINGS, CONCLUSION AND RECOMMENDATIONS

In this final chapter, we bring together the findings of our investigation and then look at some of the broader questions that have emerged. Our research has attempted to explore the nature of the financial abuse of people lacking mental capacity. We have done this by examining a range of available data, both quantitative and qualitative, and consulted a mix of informants from different professions and agencies, both national and local. In doing so we have built up a better-informed picture, though still incomplete, than existed before. While we have expanded understanding of the issue, we have perhaps raised as many questions as we have answered – partly because of the limitations of time and resources but, importantly, partly because of the size and inherent complexity of the topic. We conclude by making recommendations for policy and research at the end of the chapter.

Quantitative data: safeguarding

Safeguarding activity by councils was the chief source of hard data on officially reported cases of possible financial abuse. Having examined the data, we now know something about the scale of the phenomenon as reported to the safeguarding authorities – but not enough. Financial abuse as a whole ranks third among seven types of abuse identified, after neglect & omission and physical abuse. This is the case, not only in LBX, our case study area, but also in London as a whole, and across England. From the published tables for England, we know the number, gender and ethnicity of individuals who were the subject of safeguarding referrals who lacked capacity but we don't know this for financial abuse on its own – although we do know it for the case study area⁸². In LBX, over two thirds of concluded financial & material abuse cases involved individuals lacking capacity. We also know, at every level (England, London and LBX), the proportion of perpetrators ('source of risk') known to the individual (possibly) abused. We know the 'technical' outcome of cases where they have been investigated – but only in terms of whether they have been concluded and whether the risk has been substantiated or not (or partially) and whether the risk has been "removed" or not. For example, in 2014-15, 41% were substantiated or partially substantiated but half were not. In London the proportion of substantiated or partially substantiated risk was lower than for England as a whole. But we do not learn anything more about the nature of the risk or its "removal." Delving deeper into the raw data, in respect of this issue and others, would not provide answers: the information is simply not gathered. Further, there are plans to limit the scope of existing data collection in the annual return so the trend is in the reverse direction. Furthermore, there is no obvious basis for estimating the general incidence or prevalence of financial abuse as has recently been done with some e-crimes by the Office of National Statistics (Levi et al 2015; Levi, forthcoming). This is because the mechanisms for identifying financial abuse are much weaker than they are in online and offline banking and payment card fraud. It is not possible to deduce whether any rise in financial abuse against 'vulnerable' people is a real one or represents a rise in awareness and/or willingness to intervene.

Other quantitative data sources: Court of Protection, OPG and, voluntary sector

In relation to other data sources – the Court of Protection, the OPG and voluntary sector organisations – hard data were not much in evidence. While qualitative data from these sources were often rich with accounts of abuse – by various means – committed by family members, care staff, trusted friends, and strangers, the statistics gathered by those organisations did not classify cases to the same level of detail as employed by the safeguarding authorities.

We have some rudimentary information on the cases handled by the OPG. Most of these are to do with property & financial affairs (rather than health & welfare) and may result in investigations being mounted into the conduct of attorneys and/or deputies: these may therefore involve financial misbehaviour. We know, for

⁸² We relied on data published in the HSCIC annual reporting for England-wide and regional statistics and on the statistics department of LBX, our case study area, for our local data. Additional data would have been forthcoming for LBX if there had been more time available in which to prepare the report.

example, from their own reports, that there has been a steady increase in the number of LPAs registered in recent years, perhaps indicating a greater public awareness of some of the risks facing older people if they begin to lose capacity, as well as demographic trends. We also know that the number of investigations mounted by the OPG has increased. We are aware that the OPG refers cases to the Court of Protection where they are dissatisfied with the behaviour of attorneys or deputies, but we do not have a clear picture of the scale of this. The Court of Protection publishes case reports which can be counted and which are a vivid source of qualitative data (which we analysed in chapter 4). Some voluntary sector organisations compile their own statistics and some are adopting the classificatory categories used by the safeguarding authorities, which is a promising development in the search for data consistency. But quite apart from the fact that people have different thresholds before applying the categorisations above, there is insufficient information published from these sources as a whole to provide us with a reasonably comprehensive picture of the nature and scale of financial misbehaviour in respect of the group of people (those lacking capacity) with whom we are concerned⁸³.

Qualitative data

Qualitative data however can illuminate and complement the statistics. Our informants, national and local, speaking from direct professional experience of dealing with cases of financial abuse of various types in a wide range of situations were able to provide some context to the statistics we examined. Lawyers, OPG officials, judges, described their experience of the wide range of misbehaviour by those in whom vulnerable people, or the authorities, have placed their trust. Social workers in safeguarding teams recounted their experiences of having to “micro-manage” clients at risk in order to protect them from possible abuse. Support organisations in the voluntary sector described the reality of risk in some of their clients’ lives – where they are open to financial abuse from dominating ‘friends’, or exploitation by family members – and provided a different perspective from the professionals in statutory organisations to whom we spoke.

National-level informants gave us a policy perspective that suggests that financial abuse has been recognised only very recently as a serious issue – and much of the growing interest is focused on abuse via cyber-crime and other scams which affects a much wider range of people than persons lacking capacity. The banks and other financial institutions, trading standards authorities and the police are all beginning to take an active role in trying to devise strategies to combat ‘vulnerability’: but they are less able to play an effective part in protecting people who are at risk as a result of their lack of capacity. The abuse of people in this situation often takes place in isolation from these developments – a problem which needs further serious consideration in policy and practice terms.

The Court of Protection cases provide insights from a very different perspective – from the statements of individuals who themselves have been implicated as possible abusers of relatives who lack capacity and from family members who may have made accusations about their culpability. However, as chapter 4 shows, not every case that comes to the Court of Protection reveals evidence of misbehaviour amounting to financial abuse – carelessness, incompetence and ignorance or good intention, all may be involved. Our analysis found that over half of cases could be classified as financial abuse. In cases where there had been wrongdoing – misappropriation of the donor’s assets in various ways – there was little indication as to whether any action beyond revocation of the attorneyship or deputyship could or would be taken. But in over two thirds of the cases, whatever the outcome, we found instances of intra-family tensions and disputes, often with well-founded causes – such as jealousy, anger at the mistreatment of a vulnerable relative, the greed of some and the altruism of others. Such detail cannot be found by examining the hard data.

The case study analysis also reveals a picture of the operation of the safeguarding system from those who work in it at various levels. The hypotheses relating to organisational or system dysfunctionality that we proposed initially are borne out by their accounts. Multi-agency collaboration is weakened by different priorities and different standards for decisions, action and evidence along with competing demands on daily duties. We learned how safeguarding for front-line staff can be intensive and long-term in terms of the amount of staff time that has to be allocated to supporting them on a week to week basis. Work with clients can last for months

⁸³ See discussion in Levi (2011) which argues that complete awareness is impossible, and that there will always be disputes about recklessness and intention.

or years without satisfactory identification of risk or its resolution⁸⁴. Voluntary organisations carry significant safeguarding responsibilities over the long term but do not always feel they are properly resourced or that their voices are heard sufficiently.

In addition to providing insights into the behaviour of financial abusers and those who are abused, our professional informants also cast light on the environments in which they worked, showing how their involvement with safeguarding was strengthened – or weakened – by the organisation or system within which they were located. Multi-agency collaboration was not the problem-free process that policymakers often proclaim or expect it to be. Competing and contrasting pressures sometimes complicated attempts to build a coherent system of safeguarding and support but improvements have been made and expectations expressed by some informants were optimistic.

Comment on the data

While we met our objective of examining contrasting sources of data, hard and soft, national and local, in order to construct a composite picture of the phenomenon of financial abuse, the amount of direct cross-over between the data sources was limited. In that respect, the findings fall into silos – of level, location and type. Even so, we have learned a considerable amount about financial abuse and efforts to prevent and tackle its occurrence from a multitude of angles. The statistics give some insight into the numbers that come to official attention and we can see that financial abuse – third among the range of possible sorts – is significant. The case studies provide qualitative detail of what it looks like in practice and the Court of Protection analysis gives us a vivid picture of intra-family disputes and, on occasion, abuse. But we are not able to say that the cases that come to the local authorities and which eventually become safeguarding statistics were necessarily like the cases investigated by the OPG or the those heard by the Court of Protection. In respect of the latter, we don't know, for example, if there were LPAs in existence, or, in the safeguarding statistics, whether the persons 'known to the individual' category were, or were like, the family members who appeared as respondents in Court of Protection cases or were the subject of investigations by the OPG. Are they different populations? How often do those who are subject to OPG investigation also appear in safeguarding statistics and later before the Court of Protection?

However, despite these limitations, we think that we have shown from discussions with experts involved at national and local level, in the statutory and voluntary sectors, that the financial abuse of vulnerable people is at least beginning to be officially recognised and may soon be firmly on the public policy agenda.

Literature and theory

In the introductory chapter to this report, we considered the range of theories employed by researchers to explain financial abuse – sociological, psychological and criminological. Strain and caregiver burden theories suggest that people may fall into abusing as a result of the stress they experience in their role as carers. Routine activity theory argues that abuse happens because the opportunity is there and perpetrators of abuse take advantage of available circumstances (in doing so, rejecting socio-psychological explanations of the behaviour). For example, accounts from those working with vulnerable people in supported housing referred to the risk of overbearing tenants taking advantage of vulnerable fellow tenants by the chance opportunity to exploit their dependency and trust. Particularly persuasive was evidence that suggested financial abuse of people lacking capacity can best be understood within the framework of family dynamics theory – but this is probably because much of the evidence available to us relates to intra-family circumstances. For example, analysis of Court of Protection cases clearly reveals the part played by family members in financial misbehaviour. The HCSIC statistics show that most cases of financial abuse took place within the home (the person's own/family's home) and the perpetrator was known to the victim – possibly (but not necessarily) a family member. From what we know from some of these data and from the anecdotal accounts we heard, it is clear that families can be dangerous places rather than the 'haven', 'refuge' or 'hearth' of popular discourse. Of course this has been a lesson well-learned in the context of child abuse. It has also been suggested that where domestic violence

⁸⁴ [This observation raises the question of *how* is risk [assessed in a risk assessment? Is safeguarding chiefly concerned with a specific risk (as it seems to be when the safeguarding statistics are examined) or do those undertaking the assessments look at the whole context, all the circumstances, in which the person being assessed is placed, which inevitably means the whole process of safeguarding is extended and longer term?]

between partners has existed earlier on in relationships, once those people reach old age, the abusive nature of their relationship persists – and may become reclassified as ‘elder abuse’. In relation to financial abuse, we found that within the family, sibling rivalry, jealousy, the greed of sons and daughters – and victims’ misplaced trust – all played a part. Important here are the ‘techniques of neutralisation’ that the family members and carers give to themselves to feel more comfortable with themselves: entitlement because of their status as a family member or because of the unpaid care work they are putting in or because they will inherit anyway and it is of more use to them now than later, if not eroded by care fees or death/inheritance tax duties to come. Some have argued that there might be a ‘culture of narcissism’ rising over time, but the evidence for this is weak: however if so, then in addition to larger populations of older people statistically ‘at risk’, the rate of exploitation of fraud opportunities is a key variable whose prediction is beyond our scope in this study.

Establish a typology - did we?

One of our early intentions was to develop a typology of financial abuse based on the evidence we collected through the project. By doing so, we argued that it would help clarify the scope of the research and assist in meeting our aims and objectives accordingly.

But as we proceeded, we questioned how useful it would be to develop a typology which strictly focused on the financial abuse of people lacking mental capacity. We spent some time in Chapter 1 identifying the possible characteristics and definitions of financial abuse but did not move beyond that as we gathered and analysed the data. One of the problems that prevented us from doing so was that much of the evidence that we assembled did not provide enough systematic or comparable detail. Safeguarding statistics, as we have seen, use very broad descriptors of the nature of abuse that is reported to them – so that in the safeguarding returns, all financial abuse is classified as “financial & material” risk. As noted earlier, we learn nothing of its precise nature. There is no further breakdown of the category itself, only further details relating to characteristics of the people at risk (age, gender, ethnicity, mental capacity), their existing links with the council and the progress and outcome of the referral as a result of the safeguarding team’s investigation. Other collections of statistics that might be relevant (crime statistics) hardly bothered mentioning the sort of financial abuse we were concerned with. We had to depend on broad categories - in fraud and crime statistics, “abuse of position of trust” was the only relevant category we could identify.

We acknowledge that it might be possible to develop an abstract typology of financial abuse (although developing one which involved only victims who lacked capacity would still be difficult because of paucity of exemplifying data) and which could be applied to the variety of empirical cases that researchers have come across – but to what advantage? The literature is already full of attempts at definition (a step on the road to developing a typology). But terms and definitions often change – for example, from ‘abuse’ to ‘exploitation’ to ‘mistreatment’ – and as noted in chapter 1 we made a decision to set these attempts to one side because we felt the exercise was rather a sterile one. In fact – ironically – the fraud statistics (which help our understanding very little in other ways) might have got it right – the sort of misbehaviour we are concerned with is perhaps fundamentally one which can be labelled ‘abuse of position of trust’ – for that is what probably lies at the bottom of all the financial abuse we are concerned with, given that it involves the abuse of people lacking capacity who are in no way fully able to defend themselves from the abuse, usually committed by people they know.

Another related factor we have had to take into account is the fact that definitions span different discourses and bodies of knowledge which then have different implications for action. From ‘abuse’ to ‘at risk’ in social work terms to ‘fraud’ and ‘financial crime’ in the criminal justice world, definitions and usage may differ – and produce different responses from the state agencies involved (ranging from curtailment of decision-making responsibility to prosecution). We decided to use the term ‘financial abuse’ as a cover-all term for this report, making reference to more specific terms where appropriate. Our concern throughout was to avoid using terms and definitions which through being too narrowly defined might unintentionally limit our understanding of aspects of financial abuse which detrimentally affect the wellbeing of people lacking capacity. This did not mean, however, imposing no limitations. Our focus from the outset was on the financial abuse of people lacking capacity and our aim was to investigate financial abuse in relation to them rather than the population in general. We have tried to be as clear as possible each time we seem to be making definitions by placing them in context and describing their attributes, rather than by trying to construct a typology.

What we can say, at least, in respect of this study, is that financial abuse can be classified according to the following descriptors: *type of behaviour* (abuse of trust; undue influence and pressure; stealing; deception; regularity of its occurrence – single act or persistent behaviour); *scale or the monetary value of the exploitation* (selling a house, or removal of large amounts of cash from bank, to regular spending of small-scale amounts from limited assets); *motive* (feeling of having a right to it because of family ties; sheer greed; greed ‘justified’ by a claim of fairness – such as doing the local authority out of its claim to a portion of the abuser’s ‘rightful inheritance’ or that other siblings have ‘done nothing to help care for the parent’ while the abuser has done); and *emotions* – feelings of power and dominance (an extension of domestic abuse); jealousy; resentment; rivalry; and trust, though often misplaced.

Emerging issues

Three major issues emerged from our work which, although we may not have fully anticipated their significance at the outset, need further consideration here. The first two raise the following questions: how do the safeguarding and judicial systems deal with the problem of undue influence in cases where capacity may not be lacking but the individual is still vulnerable? And how can victims of financial abuse secure redress for what has been done to them? The third issue leads us to ask: is the issue worthy of being placed on the public policy agenda?

○ *Undue influence*

Under mental capacity law, safeguarding or judicial processes are activated when an individual has been assessed as lacking capacity in relation to a particular decision that needs to be made. There are situations, however, where the law on mental capacity does not seem to be applicable and yet there are concerns that inappropriate decisions are made by a possibly vulnerable individual under the ‘undue influence’ of another individual⁸⁵. The experiences of individuals living in supported living accommodation have been mentioned earlier in this report where these situations of ‘mate crime’ sometimes arise. The three case studies in Appendix 2 also display examples of undue influence or pressure being exerted, each in different ways. In one, a stranger insinuates her way into a carer relationship with the victim which enables her to foster his dependency on her over a period of years, gaining access to his money and assets, which in due course is then, apparently, made more accessible through the establishment of LPA as his health declined – although the relative who provided the story is not certain of this. In a second case study, the undue influence is embedded within the family with one of the sons taking advantage of the father even though his sister has LPA at the outset. He ‘persuades’ his father to seek assessment from a second doctor who assesses him as having capacity and the father then revokes the LPA held by the sister – appointing the son attorney in her place who goes on to take advantage of his new power. In the third case, the sisters of an elderly lady feel that her daughter pressurised their sister, when she still had capacity, to move into a poor quality, ‘cheap’ care home rather than a specialised, more costly home they would all have preferred, and was at some point appointed attorney, giving her access to the money deriving from the sale of her mother’s bungalow, with the implication that she is using it on herself. None of these cases, of course, has come to law and the details have not been tested but they depict scenarios that are not uncommon. In practical, everyday situations it can be a serious problem for those making (or failing to make) capacity assessments, and those being assessed, with anxious and concerned family members or carers often looking on in dismay.

The dividing line between the ability to make unwise decisions (as spelled out in the Mental Capacity Code of Practice) and being pressured under the weight of ‘undue influence’ by another individual is often not clear. Depending on which side of the dividing line the judgement is made, the outcome for the person at risk can be significant (protection against being taken advantage of at the risk of losing someone you thought was a friend, perhaps your only friend – or being ‘taken for a ride’). Lawyers and safeguarding professionals and voluntary sector workers all voice concerns about this. In our research, voluntary sector informants described many situations where they had seen clients being taken advantage of but where they felt they had no power to intervene. As noted in the previous paragraph, they regarded tenants living in supported housing whom they supported as being particularly vulnerable to exploitation by overbearing co-tenants. They gave accounts of families who expressed express worries about their vulnerable relatives, especially those living independently

⁸⁵ “ ‘Undue influence’ means excessive persuasion that causes another person to act or refrain from acting by overcoming that person’s free will and results in inequity” (Quinn 2014).

under personalised care plans – but we also heard of families themselves, as well as overbearing ‘friends’, exerting undue influence and exploiting those who are vulnerable.

It is a dilemma which often confronts professionals working directly with clients and who have to make mental capacity assessments which may have long-term consequences for the wellbeing of the individuals concerned. On the one hand, valid pressure to ensure the rights of individuals to autonomy and the free exercise of their decision-making powers bears heavily on them. On the other, their concern that clients may be vulnerable to undue influence may lead them to be overly cautious in their capacity assessments.

There is a view that the law does not give clear enough guidance in this respect – a view shared by lawyers dealing with the same issue in other jurisdictions (Quinn 2014). As noted in chapter 2, Senior Judge Lush has raised it as an issue of major concern, suggesting that any review of the Mental Capacity Act 2005 should include a consideration of the issue of undue influence. Our findings confirm its salience for people working in the field.

○ *Redress or not?*

The more our fieldwork progressed the more we became aware of the lack of information about what happens at the conclusion of cases coming to the safeguarding authorities or the Court of Protection in respect of victims being able to seek redress for what has happened to them – particularly the restoration of assets that have been lost or the punishment of their abusers. The analysis of Court of Protection cases in chapter 4 sharpened up this awareness. We know very little about how often any steps are taken through the civil courts to restore assets to those who have had them wrongly removed. There is much discourse about redress for fraud victims – and a special victim care unit financed by MOPAC – but this is normally focused on card fraud, mass marketing fraud, and Ponzi schemes: the issues here are far more subtle. Can the issue of redress (and retribution in terms of the abuser) be taken up at a policy level? From a different perspective, we also know little about family relationships once the Court of Protection has revoked an attorneyship. The costs of appointing a deputy in such cases are taken from the assets of the person lacking capacity. Does this have consequences for family relationships? Do further tensions and disputes within the family arise, including the ‘family suspects’ leaving the person without capacity to their own devices?

Rather differently, the issue is linked to the contrasting standards of proof required for safeguarding purposes on the one hand and criminal prosecution on the other. Prosecutions for financial misbehaviour seem to be rare (although there seem to be no hard data to quantify this assertion). Reports in the media⁸⁶ suggest that the public finds both the conduct and the lack of prosecutorial action unacceptable but little can be done. This difference between police standards and the safeguarding authorities’ standards feeds into a general feeling of impotence – and perhaps exacerbates the problem noted earlier of collaborative failure between some of the agencies involved in tackling abuse.

○ *Is it a public policy issue?*

Underlying this research has been the question of how significant a public policy issue is the financial abuse of people lacking capacity. We have been unable to establish its scale, but the level of anxiety among professionals we have interviewed suggest that this is more than a mere suspicion or a moral panic which has little real foundation. Arguably, the fact that financial abuse ranks third in the seven types of risk reported to safeguarding authorities – above sexual, institutional and discriminatory abuse (all of which are well-recognised as public policy and human rights issues with legal penalties when proven) – strengthens claims about its importance. Similarly, the detailed evidence from the Court of Protection demonstrates the reality of financial abuse within legal structures designed specifically to protect very vulnerable people. Findings of this sort (statistics and case analysis) triangulate with the anecdotal evidence from professionals in the field which suggests that financial abuse is not rare amongst the client groups they support.

Theories of policy development – especially in terms of how problems become accepted as public issues requiring official attention (by government or other institutions) – generally agree on the need for at least some of a range of legitimacy criteria to be present. Blumer (1971), for example, argued that collective, societal recognition was all-important for an issue to become a social problem around which action is required. Despite

⁸⁶ Headlines listed in Appendix 3 from articles in national and local newspapers over a period of 12 months, often sensational, suggest that there is a public appetite for these stories and that, along with this, there is strong moral disapproval of the exploitation of vulnerable old people by their relatives.

recognition of objective conditions warranting action, nothing may happen until society deems it to be a problem requiring action. Lowenstein et al (2009) argue several points: that a problem becomes a legitimate candidate for public action when it results in suffering to individuals or groups or threatens society itself in some way; its resolution requires a need for social solidarity; it fits in with prevailing norms and values as to the solution; or it is of a scale that demands attention. Others have framed the argument that for a problem to become a public issue requiring attention it should meet a threefold set of propositions: that it is legitimate for it to be addressed (in terms of public opinion, prevailing interest group acceptance, professional concern); it is feasible for it to be tackled (in terms of knowledge, mechanisms, technologies to deal with it); and it has support (from those occupying positions of influence in relation to the issue) (Hall, Land, Webb and Parker 1978).

The issue of abuse, we argue, meets many of these criteria.

Conclusion

Focusing on people lacking capacity meant we had to explore the meaning and nature of capacity, not just the nature of financial abuse. This led us to the work of the safeguarding agencies, the OPG and the Court of Protection and the preventive and protective mechanisms that exist specifically for people lacking capacity. It also pointed to the hidden nature of the financial abuse which they experienced – embedded so often within the family or the closed networks of their social relationships. It also pointed to the deficiencies in existing ways of making it public and at the end of this process of obtaining appropriate redress.

We think we have persuasively argued the case for recognising the financial abuse of people lacking capacity as significant enough to become a public policy issue. At the same time we acknowledge that more needs to be known about it although it is a social problem which is often difficult to track down and fully understand. Nevertheless policymakers should recognise the pressing need to do so.

Recommendations

1. Improve the range and detail of information readily available from the wide range of agencies involved in the protection of the interests of people vulnerable to financial abuse

At the centre of this recommendation is the view that there needs to be more sharing of information between agencies in ways which are complementary and systematised. In this way, public and policymaker awareness of emerging social problems will be enhanced. The data held by the HSCIC are extensive and over the next few years as they build up, it will be possible to plot trends and identify change where it occurs. However, at present, HSCIC publishes only a selection of tables, for England as a whole and the regions (although it will respond to specific requests for unpublished data).

If voluntary organisations working in the same field were to adopt similar methods of classification and recording (as some have), there might also be some opportunity to build a broader picture of the phenomenon of abuse in relation to safeguarding encompassing this sector as well as statutory agencies. But even if this were the case, the statistics would only relate to higher level categories (i.e. no breakdown of the financial & material category itself).

The OPG and Court of Protection holds information which if made readily available would inform us in greater detail of the nature and scale of those issues which concern us. This could be in both numerical (statistical analysis) and descriptive (case analysis) form.

Given the difficulties in getting organisations to take data seriously, especially in times of austerity and public sector cutbacks, it might be helpful to have a 'data summit' to discuss how this greater complementarity could be facilitated.

2. Knowledge sharing (across silos)

Inter-professional and inter-agency differences in attitudes, language and terminology on policy and practice issues hinder successful joint working (an observation frequently made). More opportunities could be provided for knowledge-sharing between professionals in statutory and voluntary agencies to promote greater understanding of their differing perspectives and the problems they encounter. This could be achieved through:

- National or regional conferences to share knowledge.
- Practical seminars at local level to build inter-agency relationships.
- Reflective lesson-learning from the experience of those participating in existing collaborative structures (e.g. SABs) in their attempts to share knowledge and build relationships.

3. More opportunities for improving training and knowledge

This could be achieved on the back of knowledge-sharing activities. Where examples of good practice in different parts of the country or within different professions are identified, training could be developed as a follow up.

4. Better information and instructions for those appointed as attorneys under LPAs

Individuals do not always remember the information that has been provided to them, but there seems to be too little information provided to them about their role as attorneys when LPAs are first registered. Better information – *including warnings about the implications of failing to exercise their duties properly* – might head off difficulties that crop up when LPAs are put into effect. Discussions with the OPG would provide an opportunity for this recommendation to be considered. Consultation with voluntary organisations who work closely with individuals lacking capacity and their families could inform this process.

5. Protected space for reporting concerns/dilemmas

Members of different professions vary in their decisions about what constitutes risk and the thresholds that need to be reached before action to refer cases of suspected abuse is taken. In addition, individuals may sometimes be inhibited from reporting concerns if they feel that the system is too rigid in dealing with them. Given the numbers of staff involved and their turnover, some cascading would be needed, but a seminar could be organised to discuss the issue of discretion and how far professionals feel they need more (or less) guidance in their decision-making around risk.

6. Redress and retribution

Could the lack of access to redress for victims and retribution for abusers be discussed at a policy level with a view to looking at the possibility of changing the current position? These issues could initially be raised in a public debate.

Areas of possible future research

1. An examination of how different professionals understand and apply the meaning of 'lack of mental capacity' especially in cases where undue influence might be involved. Despite clear procedures being laid down in the Mental Capacity Act Code of Practice about assessing mental capacity, professionals are often confronted with difficult cases where the distinction is problematic often with practical consequences.
2. A mixed methods study of decision-making about safeguarding referrals in relation to thresholds for making decisions to refer examining the role of discretion in deciding to refer or not (this could be linked to the first suggestion).
3. A survey of people named as attorneys under LPAs (at point of registration) to find out what they knew about future duties as well as a survey of those already acting as attorneys
4. A study of popular discourse on financial abuse – press reports analysis, focus groups, surveys.
5. Further case analyses - using OPG and Court of Protection data (as in chapter 4).
6. Survey of financial institution staff (STEP) (re-try, after our initial lack of success).
7. An exploration of the nature of family dynamics leading to cases of financial abuse, with a focus on abusers and their characteristics and motivation.
8. A study of discretion in decision-making.
9. A study of how the competence of professional advisers can be improved.

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Appendices



APPENDIX 1

The issue of prevalence

Our view that it would not be feasible to attempt to undertake a prevalence study was contained in our original proposal submitted to the Dawes Trust in 2014:

“The specification lists a number of aims for the research and suggests a mix of possible research activities to achieve them. The title of the specification refers to “a study of the prevalence and nature of financial abuse of those lacking mental capacity”. The body of the document goes on to suggest a range of potential research activities that could be undertaken. In relation to prevalence, we feel that it would not be fruitful to attempt to conduct a prevalence survey similar in methods to the one conducted by KCL/NatCen (2007) because of cost and the problems of constructing a sampling frame from which individuals with the required characteristics [lacking mental capacity, having suffered financial abuse] could be sampled; moreover, agreeing what constituted experiences of financial abuse committed by relatives or carers for the purpose of the survey is similarly problematic. Essentially, would they be based on hard or anecdotal data? Would ‘financial abuse’ be defined consistently across the survey – evidence may be woolly, anecdotal or based on surmise; or restricted (e.g. referred to safeguarding, having been subject to legal process).”

Further, the Brunel team’s previous research on financial abuse points to some of the methodological difficulties that may be associated with anecdotal or hearsay accounts of abuse taking place – it found that one of the problems facing financial professionals was distinguishing between genuine cases of financial abuse and allegations which could be shown to be untrue (*Decision making in detecting and preventing financial abuse of older adults*, New Dynamics of Ageing Programme, Findings, 2011).

APPENDIX 2

Case study 1

The details of this case were provided by AK, a great-niece of K

The case concerns K, the 91-year old great uncle of the informant AK (he was AK's mother's uncle), and was married to E. The husband and wife (K & E) had one child who died at the age of 10 but who was never far from their minds throughout their married life together. Extended family members (siblings, nieces and nephews and their partners across three generations) were close, some of them living in the same area and visiting each other regularly – they saw themselves as “a strong, caring family.”

As the couple grew older, E began to suffer from an Alzheimer's-like condition. K was determined she should stay at home and, though in his eighties, cared for her at home (a hospital bed was installed) until she died. As E grew more infirm, in 2006 K decided to employ a companion to sit with E so that K could get out of the house periodically. Social services told them to expect a possible companion would come to the house one Thursday to discuss the role. On Tuesday a caller came to the door, from Social Services to take on the role of companion. However it turned out there had been a mistake with the address and she had in fact gone to the wrong house. They began to chat and she told them that she, too, like them, had lost a child. She suggested to K that he ring Social Services and ask for her instead of the person due two days later. She was called M. He informed social services of his decision.

As the months and years proceeded, relationships between K and some of his family began to suffer. In particular one niece of E, D, who along with her late husband were K and E's closest friends over 70 years used to visit regularly. Over time, it was felt by the family that M was turning K against them. M repeatedly suggested to K that D did not show him enough care and mentioning this to K caused the relationship of 70 years to be broken with D. The rest of the family were particularly upset by this. M gradually got closer to K and family members more distant. When E died in 2007, K said that M should go in the funeral car, which meant displacing a family member. This upset the family. Around this time, K told AK her he was thinking of giving part of his estate (D's share) to M and what did she think about this. AK knew that D was a very wealthy woman in her own right told him he should do as he feels was appropriate. K told her that he would go to the solicitors with M to sort things out.

After E's death, M continued visiting K and being involved in his life. Having pushed D out of the picture, the rest of the family also felt pushed away. M set up a shrine to K and E's dead child and sent cards to K, saying he was like a father to her. K also informed family members that he had opened up a joint account with M so that small sundries such as food could be paid for when she went shopping for him. She was taking on a daily caring role as K got older and becoming frailer. The family had to accept this, though still remaining unhappy about the friction she was causing. M then moved on to criticising other family members to K. This resulted in them seeing less of their uncle/great uncle. M did not inform them when he was in hospital several times and she refused to tell them the code to the key-box set up outside the door at home for carers' access.

On one occasion in 2011 AK did manage to see him in hospital. K told her that M had said the hospital and social services wouldn't let him go home without him making M a power of attorney being arranged (although AK's uncle had been appointed attorney sometime previously) and that a solicitor would be coming to the ward. K was ill and very confused (later verified by ward medical records) AK went home after the end of visiting and was so concerned she went back to speak to the night sister who was shocked – and said she would not permit any legal advisor on her ward. The ward sister put AK in touch with Social Services and she spoke to them at length the next day before going on holiday. M were angered by the fact that AK had spoken to the staff. Once back home K told AK that she had got M in trouble, the hostility grew between family and M, with neighbours also turning against the family. This was clearly a stressful situation for K so the family decided to not criticise M to K because they did not want to add to his stress and were also concerned that their contact with him would be stopped as they were reliant on M and neighbours letting them into the house to visit.

By November 2011, K became very ill. M had stopped coming in as often as before to undertake the caring. He had a carer from social services coming in every morning and one in late evening but was left alone during the day without food and water. One carer said she thought M was fed up with looking after him. During this time AK visited when she knew the carer would be there so she could gain access to the house

He was taken to A&E on 2nd January 2012. AK visited to find the carer had called an ambulance. M did not want to come over to the house but did when she knew AK was there. AK's sister brought her mother (K's niece) over from Canada to step in. She stayed until late February and got him back to good health. They got M to find a care home for him (it is on record that she said she was his next of kin and that he had no blood relatives – n.b. AK's mother is related to K through his wife E, now dead. There was also D and two other nephews who were blood relatives of E). He went into a care home and died in November 2013.

AK's mother was notified she was a beneficiary of K's will. It transpired that K had made his last will in November 2011. He had done this through a will writing company not the solicitors who had looked after K and E affairs for many years. Eventually it transpired that several wills were made one in 2007, that was not signed and then 6 other versions between 2010 and his final will in 2011. The last will K gifted M his house and possessions. This was a scrappy piece of paper hand written and signed by K. The executors of the will were M, another beneficiary who had been a friend of K's late son, and a director of the will writing company. The family have since found out that XB, the director and executor from the will-writing company, was linked to another company that had been mentioned in a Panorama programme in 2010 looking at will writers and suspected malpractice. M and the family friend gave up their roles as executors and XB remained executor of the estate. It appears that K had also made a power of attorney (i.e. Lasting Power of Attorney - LPA) in August 2011 when he was in hospital – a financial advisor had come to the bedside. It was signed on 4th August 2011 the day after AK had visited the ward and when K was confused and under the impression that he needed this in place to be discharged from hospital. It was granted in November 2011. It took over 18 months after K's death for the family to obtain this. Eventually they received copies of the PoA (LPA) application (which was very sparse with little information in it).

After K's death AK's mother asked XB several times for a copy of the will and excuses were made that they were not allowed legally to send a copy by email. She only received one shortly before probate was granted – too late to question it. The executor, XB, was slow to keep the beneficiaries informed nor answer questions in respect of the estate. He however very quick in winding up the estate (in retrospect they should have asked for him to be removed).

With difficulty but over time, the family have now acquired copies of bank statements relating to K's affairs. It appears that there were two relevant accounts – one with NatWest (joint account – K and M) and one with the Co-op (K's own personal account which M took over in her LPA role when K went into the care home).

A resume of the funds that were spent (excluding direct debits for regular bills and payments) over 5 years follows:

2009	2010	2011	2012	2013 (midway)
£4,718	£5,739	£27,230	£86,189	£32,708

This shows expenditure increased dramatically once K had gone into the care home (accounts don't show care home fees) as his actual needs decreased. M transferred money from the NatWest account when funds in the Co-op account ran low. She also cashed in National Savings when the NatWest account ran low. It is clear that the spending on the Co-op account around £64,000 in 18 months in various clothes shops and supermarkets was not in relation to K who was in a care home

AK, having informally consulted the police (via a friend), believes that it appears the police would not investigate a case like this because the level of evidential proof would be too low.

Issues that emerge:

- Where there is undue influence being exercised over a long period – how can individuals slowly being cut off from family and friends be protected?
- Lack of information about LPA status. Was it registered? Had any other members of the family been informed about it?
- Why were banks not alert to questionable activity on the bank accounts over a period of time?
- How did the original arrangement via social services when M became carer come about?
- How can people be protected from unscrupulous will-makers, giving unsound advice?
- Is there really no redress if the evidence of proof is insufficient to warrant a police investigation?
- How can someone be stopped from taking advantage of a frail elderly person as in this case?

Case Study 2

Profile provided by the advice team of a national voluntary organisation supporting people living with dementia and their carers.

1. *Possible perpetrator: J* (daughter of D who has a dementia). J is approximately aged 40 and works full-time. She never had great relationship with mother and feels her aunts (mother's sisters) are interfering; she has never liked them. She has a brother and a sister who play little part in their mother's care.
2. *Possible Victim: D* has a dementia which sounds in advance stage now. Age 75. Her husband died 4 years ago. Currently in a residential care home which is 50% funded by NHS. Placed there 7mths ago by daughter J. D has £1 million assets according to sisters, as her husband use to deal in stocks & shares and left her well off.

3. *Domestic arrangements:* as above, D currently in care home, part funded by NHS. Sisters visit when they can. D's daughters and son don't visit often.
4. *Caller:* C is the sister of D and is aged 84. 'I'm a policeman's daughter'. She is an ex-nurse, RMN/ RGN. C is the person who has been emailing the advice line.

J gained lasting Power of Attorney (LPA) for mother D, who lived in her own bungalow. J moved D into a residential care home 'against her wishes', according to C. At the time, D had capacity but daughter arranged the move 'secretly', and the sisters were not initially informed of where she'd been moved to.

D always confided in her sisters that she wanted to remain in her bungalow with privately funded home carers. She has a lot of money. Sisters also accused the care-home manager of being aware that the move was against D's consent and knowledge. D has since lost capacity to decide on such a move. Her dementia has worsened and she is very dependent on care from others.

Daughter J gave the care home instructions not to let sisters take her out doors, therefore, she has not been outside in 5mths. D currently agitated and distressed. D's sisters recently visited 'unannounced' and saw her with bruises. They are unhappy about the placement; want her to be in a small care home with 1:1 care, 'because she can afford it'. C and her sisters feels that D, their sister, has been let down by J, D's daughter.

C's main concern as noted by the advice line:

She is upset and frustrated that J won't communicate with her. Feels that Lasting Power of Attorneys betray the donor's trust for financial gain. C wants D to be in a smaller care home specifically for dementia. 'She can afford it' and feels patient's daughter J, is out to get her mother's money as she went bankrupt a few years ago. 'Now she has control of her mother's money'; she has sold her bungalow for £343,000, and is keeping her in an inadequate care home because its 50% funded by NHS. C says family are concerned about care received in residential care home; D had bruise on her face, caught her hand in a door, hurt her bottom. She went to hospital after hurting her hand, but J did not share any info with family and they are kept in the dark. Care home refuses to listen to family's concerns and say feedback should only come from daughter J who has POA. J won't let mother go out with her sisters, but they do visit. Patient sleeps all day, 'she needs stimulation'.

D keeps saying she wants to go home, 'can you take me home? Patient has deteriorated. Her bungalow has since been sold.

Sisters have contacted the following and found:

- Court of Protection - 'they're too expensive;
- the OPG - 'no help from them';
- the police: 'won't get involved';
- CQC: they said 'you're doing the right things';
- Social services: 'don't want to know';
- local MP: 'waiting to hear from him';
- GP - 'useless'
- the advice organisation - the only one that is listening and supporting..

C is not happy with the support they have received from anyone so far. Her quote: 'As with all these big organisations others cover for them and no one is ever held accountable for their failure in what should be their legal duty. The Office of Public Guardian also have such low standards of care - they pass the buck and no one there is ever held accountable'. 'All have not adhered to the Mental Capacity Act 2005 - the code of practice - ; the best interests checklist was not adhered to'.

Possible abuse? Financial abuse; ?movement of property; influencing person at risk to make financial decisions; stealing.

[n.b. advice line's own terminology used e.g. POA]

Case study 3

Profile provided by the advice team of a national voluntary organisation supporting people living with dementia and their carers.

1. *Possible perpetrator:* R, son of B (person with dementia). R is mid 50's and is unemployed; had been sacked from 3 previous jobs due to his confrontational personality. Divorced 7yrs previously and has 2 children age in their early 20s; no contact with ex-wife nor children (they're abroad). Wants to be a successful business man, and is extremely preoccupied with investing in oil and gold trade overseas. Grandiose, self-centred, angry personality type. History of clinical depression and threatening behaviour to family members and especially threatening towards his sister. No close friendships. Refuses to engage in mental health services for himself.
2. *Possible Victim:* B, has vascular dementia (moderate). Age 82yrs. Ex-dentist. Had 3 children. 2 living children, R and A - and one son committed suicide 8yrs ago. B was a successful dentist and wealthy. Married, but wife lives overseas with B's brother. The brother and B's wife visit twice yearly. B has investments in country where his brother lives and brother is POA for him there. B is described as a caring father who wants his children to get along and also always wants to please wife. He can attend to own personal care. Needs help with shopping, cooking, socialising and making daily decisions about his care and finances.
3. *Caller:* A – B's daughter. She is his main carer. Anxious and fearful of brother. 'He is a bully'. She is married with 2 young children. She has held POA for father in UK for many years. She is caring and protective of father, looks out for his best interest. She is the peacemaker in family and feels very stressed. Does all shopping, pays carer etc. Feels unsupported by services except by the advice organisation, who she phones regularly.
4. *Domestic arrangements:* R lives with his father B in the family home. R doesn't provide any help or care. A privately paid home carer visits 3 days weekly; she is B's old family friend, and is described as 'interfering' with little understanding of dementia. She often sides with R, and seems to be taking financial advantage of B.
5. *Substance of concern:* R has been pressuring/demanding money from his father in large amounts for a few years. He asks for and receives between £800 to £3000 plus each time, to invest in his 'businesses abroad, or to buy cars.' B gives money to him reluctantly as he doesn't want arguments. R is angry that A has POA and not him. Feels she controls the money to keep him at a disadvantage. If money is not given to him, he threatens everyone. Also says he will commit suicide (as his brother did). Family are fearful of the suicide threats and feel they are real. B's capacity to give this money away has been questioned. Memory Service psychiatrist said that he 'does not have financial capacity, but with support from daughter, he is able to have some control over his finances'. R reads into this that he has capacity.

When A went on holidays for 2 weeks this year, R took his father to see a new GP who certified that B had full capacity to decide on his finances. R then took father to a new solicitor and got B to revoke the POA from A. Currently no one has POA for B in the UK, but R is encouraging father to give him POA now. Bills are going unpaid. R continues to pressure father for large amounts of money. B is very upset and anxious. R is threatening when A or her husband visits the house, therefore they are unable to support B **NOW**. R plans to take father to Australia soon, and A fears that he will try to access B's money in Australia also.

6. *Possible abuse?* Financial abuse. Influencing person at risk to make financial decisions.

[n.b. advice line's own terminology used e.g. POA]

APPENDIX 3

Media interest in financial abuse

Headlines in newspapers reveal how the press perceives and represents intra-family financial abuse – as a mix of exploitation, class, ‘shock/horror’, visceral jealousy, repugnancy:

- Gardener took £200,000 from woman of 89 Daily Telegraph 17/3/14
- ‘elderly couple forced to give son their home’ Islington Gazette
- ‘ailing RAF veteran 91 wins court battle to keep ‘witch’ niece away from his £750,000 estate Tottenham & Wood Green Journal 12/06/14
- ‘Man loses control of mother’s funds’ [‘which he used to subsidise his lifestyle’] Belfast Telegraph 9 June 2014
- Aunt’s money ‘used as private bank’ Daily Mail 9/7/2014
- ‘Pensioner with Alzheimer’s ‘padlocked into a onesie by his partner’ Daily Telegraph 26/11/14
- ‘Retired businessman’s dementia ‘brought on by drinking three litres of wine a day in Spain’ Daily Mirror 13/3/15
- ‘Warring sisters lose control of mother’s fortune: Judge strips pair of right because of their hatred of each other means they would not be able to make rational decisions’ Daily Mail 22/4/15
- Siblings at war lose rights over sick mother’s bank account: Judge rules brother and sister’s loathing of each other means they cannot be trusted Daily Mail 6/5/15
- Woman spent ‘sick mother’s money’ Daily Mail 7/5/15
- Judge censures son who used vulnerable mother’s money to buy own house Belfast Telegraph 2/9/15
- The ‘repugnant’ son who charged his own MOTHER £400-a-day for visiting her care home Daily Mail 27/10/15
- Britain’s most heartless son? Man charges elderly mother £400 a day for VISITING HER Daily Express 28/10/15

Our thanks to Senior Judge Lush who provided these newspaper headlines.

Financial Abuse of People Lacking Mental Capacity

A Report to the Dawes Trust

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