Safeguarding Adults Review
Learning from the circumstances surrounding
'Stanley'

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Dudley Safeguarding People Partnership

Note

The reviewer would like to thank all those who have contributed in any way to this Safeguarding Adults Review for their time, commitment and cooperation, particularly as this has taken place during the Coronavirus (Covid-19) pandemic.

The pseudonym 'Stanley' has been used to maintain confidentiality.

The reviewer would also like to specifically thank Stanley's nephew for his time and contribution.

Contents

1. Introduction

The subject of this Safeguarding Adults Review (SAR), 'Stanley', died in hospital on 11/2/20. Whilst clearing Stanley's flat his nephew (next of kin) came across paperwork that caused him concern about his uncle's care and he contacted the Local Authority requesting a SAR be undertaken to look into the circumstances leading up to his uncle's death.

A cluster of safeguarding concerns had been raised on behalf of Stanley in early January 2020. Previous safeguarding concerns had been raised for Stanley over many years. All of these related to alleged financial abuse and occasionally to self-neglect.

In response to the nephews request for a SAR, a 'Rapid Review'[1] was undertaken. This involved a panel discussion based on analysis of information provided by combining key agencies scoping returns about their involvement with Stanley.

The panel discussion took place on 15/12/20 and involved four designated Safeguarding Leads representing: Dudley's Clinical Commissioning Group (CCG), Dudley Safeguarding People Partnership (DSPP), Dudley Metropolitan Borough Council (DMBC), Adult Social Care and West Midlands Police (WMP).

The panel's conclusion was that although there were lessons to be learnt from Stanley's case, a formal SAR was not needed. However, this decision was overridden by the Chair of DSPP and this SAR was subsequently commissioned.

Section 44 of the Care Act 2014 states that Safeguarding Adults Boards (SABs):

> "must arrange a SAR when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult."[2]

Stanley's death was not related to the safeguarding concern. His death certificate states cause of death as "1A Bronchopneumonia, 1B Decreased mobility and 1C Frailty of old age". However as Stanley was under safeguarding at the time of his death due to suspected serious abuse or neglect the additional guidance is pertinent such that SABs must also arrange a SAR to provide useful insights into the way organisations work together to prevent or reduce abuse and/or to explore examples of good practice.[3] Furthermore SABs are free to arrange for a SAR in any other situations involving an adult in its area with needs for care and support."[4]

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[1] Social Care Institute for Excellence. (2021) *Safeguarding Adults Reviews (SARs) in Rapid Time*. Available online: https://www.scie.org.uk/safeguarding/adults/reviews/in-rapid-time [Accessed 18/8/21]

[2] The National Archives (2021) *The Care Act 2014:44: Safeguarding Adults Reviews*. Available online: Care Act 2014 (legislation.gov.uk) [accessed 17/8/21]

[3] Department of Health and Social Care (21 April 2021) Care and Support Statutory Guidance (updated 21 April 2021). Available online: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1 [Accessed 17/8/21]

[4] ibid

2. The process of the review

Covid-19 and related restrictions meant that all meetings, interviews and learning events for this SAR were either virtual (via 'Microsoft Teams') or over the telephone. Email correspondence was also central.

The time period covered by the review is from April 2019 up to the time of Stanley's death as this is the particular time period when concerns and referrals escalated. The terms of reference were set by the SAR panel with the reviewer.

2.2 Terms of reference: general:

- To establish whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and agencies work together to safeguard adults at risk (including working with referrers, family and procedures).

- To inform and improve local practice by acting on learning (developing best practice) including connecting learning from previous SARs.

Terms of reference: specific:

- To consider whether all opportunities to undertake relevant assessments and conversations were undertaken with Stanley in the two year period up to the time of his death. For example with family; around care and support needs; and capacity assessments (including consideration of executive functioning and possible impact of coercion).

- To review the effectiveness of safeguarding responses (particularly when a case is triaged as meeting the criteria) including around; timeliness; quality; differences of opinion (e.g. between and within agencies, family etc.); feedback to the Local Authority; and closure.

- To consider the response of professionals when engaging with individuals who appear not to want to engage with safeguarding, who appear to have capacity and who appear to be making seemingly unwise decisions about their care that puts them at risk of financial abuse.

- To identify areas of good practice.

2.3 Family involvement

In line with good practice recommendations regarding family involvement in SAR's[5] the nephew was contacted by the reviewer at the earliest opportunity. The views, queries and verbal information he provided was summarised, checked with him for accuracy and circulated to all attendees prior to the two learning events.

This was also used to inform the learning event's analysis as well as for individual, separate explorations and conversations with key staff. The reviewer kept the nephew informed of progress regularly via email and telephone during the process of the review and he was informed on the content of the report before publication.

2.4 Agencies/professionals invited to participate

- Black Country Healthcare NHS Foundation Trust - Dudley and Walsall Division (previously Dudley and Walsall Mental Health NHS Foundation Trust)
- Black Country & West Birmingham CCG (previously Dudley CCG)
- Dudley Metropolitan Borough Council (DMBC) Adult Social Care
- Dudley Group NHS Foundation Trust
- West Midlands Ambulance Service NHS Foundation Trust
- West Midlands Police
- West Midlands Fire Service
- Sage Care (West Midlands) – Care Agency
- Dudley Safeguarding People Partnership
- British Red Cross

2.5 Methodology

The reviewer utilised a mixed, 'systemic' approach for this SAR ensuring that a person-centred, proportionate and outcomes focussed philosophy informed each element of the process in line with safeguarding principles and the ethos of Making Safeguarding Personal.[6]

This approach included a combination of examining the Rapid Review paperwork, additional information from subsequent Agency Involvement Forms, relevant agency records, material from the two learning events including completed SROT analysis tools (strengths, risks, opportunities and threats), individual conversations and correspondence with key staff, information and documentation provided by the nephew alongside conversations with him, and panel meetings.

[5] Department of Health and Social Care (21 April 2021) Care and Support Statutory Guidance (updated 21 April 2021). Available online: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1 [Accessed 17/8/21]

[6] Local Government Association (2021) *Making Safeguarding Personal*. Available online: https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/making-safeguarding-personal#:~:text=%20Making%20Safeguarding%20Personal%20%201%20Implementing%20MSP.,in%20the%20context%20of%20Making%20Safeguarding...%20More%20 [accessed 18/8/21]

3. Case summary, themed analysis with related learning points and recommendations

Alongside the focused time period, this report references previous concerns for context as many of the themes identified have longevity and are cumulative.

Learning points are noted after each themed sub-section and differentiated from recommendations. Where either are applicable to more than one section they are noted within the first relevant section only and then cross-referenced.

3.1 Case summary

Stanley was an elderly gentleman of White British heritage who lived alone. Aged 82 when he died in hospital, Stanley had been admitted on 24/1/20 with a swollen abdomen and leg. There had been a series of five 999 responses over the previous weeks regarding one fall and four catheter issues.

Stanley was the youngest of six children, brought up by his parents in the Dudley area where he continued to live. A diagnosis of paranoid schizophrenia[7] from early adulthood, necessitated involvement with secondary mental health services.

Physical health issues developed for Stanley in later life around arthritis, sciatica and some lack of muscle control and coordination of movements, all of which affected his mobility. Due Stanley's poor mobility, low weight and smoking he was at increased risk of skin breakdown, developing pressure ulcers for which he received regular health care. A prostatectomy in 2002 led Stanley to need to use intermittent self-catheterisation in order to urinate. This method became increasingly difficult for Stanley to manage, causing him pain and discomfort leading to a change to a long term catheter for which he received regular health care particularly as it often became blocked or infected. Stanley was also noted as being agoraphobic in later life. He smoked in bed due to his mobility issues.

There were recorded safeguarding concerns dating back to 2010 about Stanley's relationships with local people around anti-social behaviour (theirs) and financial exploitation (of him). During later years this regarded a particular neighbour 'S' (and sometimes her partner), whom Stanley described as his friends and S as his carer. Several safeguarding concerns were raised alongside calls to the police in the decade or so before Stanley died. These began to include reference to self-neglect from January 2015 with an escalation in the year before he died regarding both categories of abuse. The last few safeguarding concerns clustered around January and February 2020 included an added reference to lack of sufficient agency care. These later concerns were triaged[8] by the Multi-Agency Safeguarding Hub (MASH)[9] as meeting the criteria for a safeguarding response (a Section 42 enquiry)[10] although Stanley's case was still awaiting formal allocation by adult care at the point of his death.

[7] This is a chronic, severe, debilitating mental illness characterised by psychotic symptoms, where the person is often out of touch with reality (unable to distinguish their own thoughts from reality). See https://www.nhs.uk/mental-health/conditions/schizophrenia/overview/

[8] Triage is the process of screening referrals, gathering relevant information in order to make a decision regarding if the subject meets the criteria for a Section 42 enquiry (i.e. a Safeguarding Adults response) or a different response.

[9] See Multi-agency safeguarding hubs (scie.org.uk)

[10] S.42 (Care Act 2014) applies where a local authority has reasonable cause to suspect an adult in its area (a) has needs for care and support, (b) is experiencing, or is at risk of, abuse or neglect, and (c) as a result of those needs is unable to protect themselves against the abuse or neglect or the risk of it. See: https://www.legislation.gov.uk/ukpga/2014/23/section/42/enacted

3.1 Stanley's strengths

Strengths based practice applies to SARs as much as to front-line practice. With that in mind, mirroring the structure of the two learning events, Stanley's strengths are noted first.

Stanley had several jobs during his adulthood before he retired, including one working alongside his father as a carpenter. Stanley sustained a tenancy and lived alone. He articulated that he wished to continue to live at home. Despite ongoing mental health issues throughout adulthood there is no record that Stanley was re-admitted to a psychiatric hospital after his first episode as a young man.

Stanley's nephew talks of his mother (Stanley's sister) being very close with Stanley. She looked out for him and had done since he was little, particularly since his mental health issues developed and his parents died when he was in his early thirties. This close relationship continued and was important to Stanley, as was the relationship with his sister's partner. Both took him out for shopping and supported him generally. Records show Stanley's sister stayed at his home on occasion until her admission to a nursing home in 2014 where she died in early 2018.After admission her partner continued to support Stanley until his own death.

Another relationship that Stanley was able to sustain over a long period of time was with his Care Coordinator, a Community Psychiatric Nurse (CPN) who worked with him for over ten years having taken over his case from a colleague who retired. The Care Coordinator described Stanley as a smartly dressed man who was a keen music fan of the 1950's. Several other professionals who worked with Stanley stated that the fortnightly visits by his Care Coordinator were more than medication visits and he enjoyed them, this relationship was important to him.

Stanley was also accepting of care from agency staff when they started working with him, he was initially able to complete some care needs with prompting.

Stanley regularly over the years told workers about the financial abuse he was experiencing from S. He was able to let trusted staff know that he was unhappy with this situation and asked them to raise concerns and contact the police.

Learning point

Some agencies were unaware of some of Stanley's strengths around family and history demonstrating a lack of sharing of important historical and familial context.

3.2 Mental health

Records and Stanley's nephew state that he had a "nervous breakdown" aged seventeen and had subsequently spent a long period in a psychiatric hospital where he was diagnosed with schizophrenia, in later years refined to paranoid schizophrenia. Stanley's experience manifested in him having episodes of delusional and disorganised thinking. For example he held a long term belief that he needing to stay at home to prevent world war three. Stanley also experienced

a loss of interest in daily activities and self-care which became more apparent in later life exacerbated by his health deterioration. As he aged and his muscle mass lowered it became hard to administer Stanley's anti-psychotic medication via depo injection[11] and he moved to self-administered oral medication.

Older health records mention the possibility of Obsessive Compulsive Disorder (OCD) and a Safeguarding Strategy Meeting in early 2012 queries a Learning Difficulty (LD)[12] "or memory impairment" as Stanley seemed "childlike". In 2015 records query his "understanding" and a safeguarding concern raised in January 2020 ticks LD on the referral and notes concerns around capacity. However these addition labels have been disputed by Stanley's Care Coordinator who stated to the reviewer that there were no signs of OCD, his IQ was not low, there were no issues with language and he was able to manage paperwork including bank work.

In addition to the above labels, there is a query around dementia in later health records with this term also used in reference to Stanley at the learning events by some health professionals. The Care Coordinator also disputed this label and stated to the reviewer that there was no evidence of any symptoms, certainly up to the time of closure by secondary mental health services in November 2019.

There are no formal diagnosis logged on any health or mental health systems of any of these additional conditions. As a consequence, it is difficult to ascertain if Stanley's long-term mental health diagnosis of paranoid schizophrenia was overlaid with other complications through his life and if new conditions (i.e. dementia) developed after secondary mental health services closed his case. However, what is apparent is that he was recognised as vulnerable throughout his adult life evidenced by formal monitoring, medication administration via fortnightly visits and six monthly outpatient appointments with the Consultant Psychiatrist.

A meeting was held to review Stanley's mental health on 14/11/2019 with a view to closure as he was deemed mentally stable, medication was now self-administered and he had a social care package of support. His Care Coordinator was absent from work for a few months prior and post this meeting so was not able to be present. A Senior Clinical Lead along with the Consultant Psychiatrist and one of Stanley's paid agency care workers was present as was Stanley.

The meeting noted Stanley continued to have delusions, however they were not a risk to him or others, safeguarding issues were "resolved" and he had capacity to make treatment decisions. He was therefore discharged to the care of his GP the next day. Whilst there was still risk from S at this time, the level of ongoing input from various health professionals and care agencies was deemed adequate to ensure monitoring of risk and escalation if necessary. The option to transfer Stanley to the Older Adult Mental Health Team was not considered necessary given his stability and there being no sign of dementia or any other degenerative condition at that point.

[11] A depot injection is a slow-release form of medication.

[12] Although the term 'learning difficulty' was used it is unclear if this or 'learning disability' is meant. The first is where a person has specific difficulties around learning but their intellect is unaffected (e.g. dyslexia). The second is where a person has reduced intellectual functioning. Both are on a scale. See https://www.mencap.org.uk/learning-disability-explained/learning-difficulties?gclid=EAIaIQobChMI8L_vxLTC8gIVFIBQBh24BAggEAAYASAAEgI_2_D_BwE [accessed 20/8/21]

From the point of discharge, the GP would have needed to re-refer as there is no other direct access into secondary mental health services. Also from that point, any safeguarding concerns Triaged by MASH would be sent to adult care and not back to mental health as at the point of Stanley's discharge from secondary mental health services the S.75[13] agreement that was in place would have formally ceased.

However, despite this closure, several involved agency records and safeguarding referrals continued to name the Care Coordinator as a point of contact or assume he was still involved, including for safeguarding concerns. Consequently there seems to have been a lack of robust information sharing and updating of records as well as a possible confusion over systems and thus roles and responsibilities.

Learning points.

If any professional believes or suspects a client may have additional conditions that may involve or lead to a cognitive impairment (e.g. dementia and learning difficulty) rational must be recorded and a referral for a specialist assessment must be considered. Outcomes must be sought out, recorded and shared so that any change to vulnerability, risk assessment and capacity assessment can be initiated.

As changes occur within local arrangements these need to be made clear to all staff at all levels and logged on client records so that roles and responsibilities are transparent and current key staff easily identified.

Recommendation.

Adult Social Care need to develop a standard operating procedure (SOP) for feedback, information sharing, recording and coordination regarding safeguarding cases where S.42 responsibilities (full or partial) have been delegated to other agencies and professionals in order to quality control and for governance purposes.

3.3 Self-neglect

Stanley's nephew lives in Scotland and would visit him when he visited his mother in Dudley. His last visit was in 2018 to relay his mother's death. At that point he was shocked at how his uncle was living, stating there was no food in Stanley's house and living conditions were much neglected which he says was unlike Stanley and not how he had previously lived.

Records from frontline health as well as safeguarding referrals all feature various elements of self-neglect[14] for Stanley in the years leading up to his death, the first

[13] Section 75 of the NHS Act 2006 allows partners (NHS bodies and councils) to contribute to a common fund which can be used to commission health or social care related services. Dudley commissioned the Mental Health Trust to undertake their Care Act duties which included Section 9 assessments for care and support, Triage and Section 42 enquiries. See: Integrated commissioning and provision | Local Government Association

[14] 'Self-neglect is defined as 'the inability (intentional or non-intentional) to maintain a socially and culturally accepted standard of self-care with the potential for serious consequences to the health and well-being of the self-neglecters and perhaps even to

mention in 2015 where he was described as “unkempt”. All of the referrals in 2019 refer to self-neglect in various forms as a feature. For example neglect of personal hygiene, unclean clothes, weight loss, issues with faeces on clothes, Stanley’s body and his bedding, a dirty environment, lightbulbs missing, lack of food in the house, unpaid bills, the telephone landline cut off, lack of clean bedding and flannels. These descriptors of self-neglect interlink with concern about financial abuse and neglect by S as the ‘carer’ who Stanley said he was paying to attend to most of these needs. The reviewer established during the course of this SAR that S did claim Carers Allowance for Stanley and this was paid directly to her. This is significant and brings the additional category of ‘neglect and acts of omission’ to the fore due to the position of trust which would have needed to have been included in any safeguarding enquiry as well as impacting on police actions regarding formal investigation.

Care agency and health records show that in the year leading up to his death Stanley was spending almost all of his time in bed, leading to serious pressure sores and cigarette burns on his chest and legs as he smoked in bed and would fall asleep smoking. A ‘safe and well’ visit from Fire Support Services took place in April 2019 after a referral by Home Care. Safety advice and fire-retardant supplies were provided (a smoke alarm, bedding and a throw). Later that year Stanley needed a particular pressure relieving mattress. However it’s composition increased risk of fire. Stanley refused to give up smoking and by then was unable to smoke away from the bed due to lack of mobility. The mattress could not be sanctioned whilst fire risk remained. A referral was made to Fire Support Services by the Duty Social Worker on 2/1/20. There is no record of if a visit took place or any follow up around this. However, although there is no official recording, Fire Services are logged on their own system as attending on 7/1/20 with suggestion that further bedding was provided. Despite the presenting vulnerability of Stanley and detail of this on the referral, Fire Support Services did not refer him to their complex needs officer/service.

The SAR highlighted a difference in perception of self-neglect relating to Stanley between frontline health and care agency staff and the Care Coordinator. In one-to-one conversation with the reviewer the Care Coordinator acknowledged a gradual decline in Stanley’s appearance as he aged (i.e. “weight and how smart in appearance he was”) but felt that was part of “growing older and frailer”. However they did identify Stanley needed prompting to bathe and wash as he didn’t always want to.

Stanley had been offered a formal care package several times in the years leading up to his death, however he refused, insisting he could wash himself and S was his carer and he wanted that to continue as she was his friend. He did accept care for his pressure ulcers and weekly catheter care from health staff. Finally in April 2019, Stanley accepted a care package when S herself stated that she was finding caring for him harder, and she was uncomfortable with providing personal care (bathing and washing). The SAR established that this was part of a ‘safeguarding plan’ from mental health services to relieve stress on S and to ensure monitoring of risk to Stanley from S. However it also appears mental health had established

their community.’ See Gibbons, S. 2006. ‘Primary care assessment of older people with self-care challenges.’ Journal of Nurse Practitioners, 323-328.)

Stanley did not meet the criteria for a S.42 enquiry. So there is evidence of professional confusion around exactly what 'safeguarding' meant and what was being undertaken under which legal jurisdiction.

Stanley's situation was complex with layers of concern about different categories of abuse interlaced with different types of self-neglect. Intentional (active) self-neglect was apparent, for example, around his rejection of formal packages of care, not taking opportunities to pursue criminal proceedings against his alleged abuser, continuing to be friends with her and continuing to smoke in bed. Non-intentional (passive) self-neglect was apparent, for example, due to several significant bereavements, health issues, physical/mobility issues, paranoid schizophrenia and possible dementia. Both types of self-neglect indicate possible issues with Stanley's insight (and thus capacity) as does the possible impact of coercion and undue influence (from S). However, as stated there was a difference of opinion or understanding around self-neglect and related risk to Stanley.

As demonstrated, self-neglect is a complex mix of personal, mental, physical, social, health, environmental and historical factors. Analysis of these issues alongside presenting behaviour is essential in order to move from reactive responses to proactive root cause analysis and appropriate practice to address these. However if self-neglect is not properly recognised, particularly by a lead agency or professional this would not then be explored and this seems to have been the case for Stanley.

Plainly there are competing demands between and within organisational systems regarding workloads and skills sets. Additionally there are ethical dilemmas and a respectful balance to be achieved between the values of autonomy and self-determination and the duty to protect from harm and promote dignity. It would seem the professionals involved in Stanley's life were trying hard to achieve a balance between the Mental Capacity Act's principles[15], human rights,[16] their duty to protect[17] and their duty of care[18] all of which is good practice.[19] What is not apparent is if any of this was conscious or active as recording does not include rationale around, or reference to, these laws and concepts.

Furthermore, this lack of recorded legal literacy extends to engagement with established policy and procedures around self-neglect. For example, there are no records of the Self-Neglect Policy[20] being referred to or actively utilised with regard to Stanley. Worryingly, what became apparent during the course of the SAR and in particular within the learning events was that some staff at all levels of all systems within various agencies were unaware that Dudley actually had a Self-

[15] A person is not to be treated as unable to make a decision merely because he makes an unwise decision. See: https://www.legislation.gov.uk/ukpga/2005/9/section/1 [accessed 19/8/21]
[16] Article 8 of the Human Rights Act relates to a person's right to respect for private and family life. See https://www.legislation.gov.uk/ukpga/1998/42/schedule/1
[17] See : https://www.legislation.gov.uk/ukpga/2014/23/section/42/enacted
[18] Duty of care is a legal obligation for professionals to: always act in the best interest of individuals and others, not act or fail to act in a way that results in harm, act within your competence and not take on anything you do not believe you can safely do. See https://www.scie.org.uk/workforce/induction/standards/cis05_dutyofcare.asp
[19] Braye, S, Orr, D, and Preston-Shoot, M. (2015). *Serious Case Review Findings on the Challenges of Self-Neglect: Indicators for Good Practice.* In Journal of adult Protection. 17. 2.
[20] DSPP had a Self-Neglect Policy in place from 2017, this was updated in 2019. Both versions were available on their Safeguarding webpages and both outline tools (such as risk-assessment and advice around mental capacity) to help practitioners when working with complex people such as Stanley anywhere on the self-neglect spectrum whether that be at a safeguarding level or lower.

Neglect Policy. Alongside this policy, there was free multi-agency training available on self-neglect. Furthermore, the reviewer notes that in June 2019 Dudley Safeguarding Adults Board signed off a Multi-Agency Risk Management Protocol (MRM). This is for use when working with a fully capacitated adult who is at risk of serious harm or death through self-neglect, risk taking behaviour or refusal of services. It would seem that this useful protocol was also not utilised for Stanley.

Whilst health staff were discussing Stanley's self-neglect amongst their own MDT meetings regularly and both health and agency care staff were recognising that his self-neglect was not a lifestyle choice, taking the situation seriously and persistently raising concerns including safeguarding concerns, there appears to have been a lack of systems integrating and collaborating. For example although multi-agency meetings are said to have taken place around the financial abuse this does not seem to have addressed the self-neglect or include all health and agency workers. There appears to have been a lack of proper coordination (of the safeguarding strands, issues and key parties). It appears as if the situation drifted, worsened over time and became entrenched.

Many professionals felt helpless and frustrated at the apparent lack of action from 'safeguarding'. In Dudley at the time (as with other Local Authorities[21]) there seems to have been an absence of effective multi-agency risk assessment and case management and interagency collaborative working. Collaborative working moves beyond cooperation and coordination between agencies into teamwork, sharing resources, skills and knowledge, multi-agency discussion, analysis, risk assessment and respectful challenge. Collaborative working should be at the heart of multi-agency safeguarding (and work that falls outside that remit yet remains high risk) and include preventative elements. All those involved seemed to have been attending to their remit, talking within their agencies, responding to incidents as they arose, however nothing seems to have been joined up, and safeguarding concerns seem to have been responded to as individual rather cumulative or concurrent concerns.

It would seem that mental health services were the agency who (at that time) were best placed to coordinate such work. However the Care Coordinator does not appear to have fully recognised self-neglect as an issue, was absent from post during parts of 2019 and it is unclear what happened to Stanley's case in their absence. What is known is Stanley's case was closed in November 2019 and self-neglect was not recorded as an issue during that meeting. It would seem that the 'rule of optimism' prevailed around the issue of self-neglect for mental health services, when in fact root causes had not been addressed (a care package could not address them) and risk remained.

Stanley's health rapidly deteriorated after discharge from mental health services and just two months later he was admitted to hospital (on 24/1/20) where he remained until his death.

Learning points

[21] See: Braye, S., Orr, D. and Preston-Shoot, M. (2015) 'Learning lessons about self-neglect: An analysis of serious case Reviews.' Journal of Adult Protection (2015) 17 (1), 3-18.

Additional categories of abuse (such as 'neglect and acts of omission') that may be masked by the presenting category need to be explored in order for any safeguarding enquiries to be robust and thorough. Accurate recording, dutiful information checking and clear sharing of information is crucial regarding people who care for adults with care and support needs.

Longevity of professional relationship is useful for consistency and relationship. However fresh eyes can offer differing perspectives and may be useful where a client's behaviour is entrenched and where there is difference of opinion between agencies.

Case transfer is vital when workers are absent from post where risk is ongoing.

Managerial oversight regarding decision-making, access to and use of policy, protocols and law that informs practice is crucial along with reflective supervision.

While there was much individual and agency good practice, and some multi-agency meetings, there is a question as to if the right people were present at the right meetings and whether the right policy and procedures were utilised (i.e. formal Safeguarding and/or the Self-Neglect procedures and protocols). It would seem that truly collaborative working was absent.

Keeping up-to-date regarding policy, protocols and procedure alongside robust recording of use of legal systems is vital for legally defensible practice. Absence of records indicates absence of thought and action.

Referral to services (e.g. Fire Service, Safeguarding) needs to be followed up by the referring agency and outcomes clearly recorded.

Escalation to be considered where there are differences of opinion.

Recommendations

Where there is mention of a 'carer' formal checks with DWP etc. (via an established standard operation process, SOP) need to be made by the lead agency and information then recorded and shared with relevant agencies. Where there are concerns about possible financial abuse, or any type of abuse, by a paid carer (whether via Carers Allowance or a formal care agency) a referral should be made to the MASH.

West Midlands Fire Service to undertake an annual audit of referral to their Complex Needs Officers and Safeguarding.

DSPP to develop an Escalation Policy as a matter of urgency to ensure partnership agencies, and staff at all levels, understand they can challenge within and outside of their systems and know how to do this.

A review of the DSPP Self-Neglect Policy is needed as a matter of urgency. Likewise the Multi-Agency Risk Management protocol. The revised versions need to be owned by all partners so that all partners are utilising the same policy.

Once updated a clear dissemination strategy needs to be implemented, including regarding transfer of knowledge to practice (i.e. to all partnership agencies and between all levels of their staff).

Understanding of and commitment to truly collaborative, multi-agency and preventative working needs to be endorsed and promoted by all agencies as a way of moving beyond silo working. DSPP to measure this with an annual audit.

3.4 Financial abuse

The earliest record citing finances as a concern for Stanley is from a Housing Officer in Autumn 2010 concerned that he was giving money away to strangers and women. Over the following year, police and housing received several calls from neighbours about related anti-social behaviour and alleged financial abuse by young people targeting Stanley for money.

Safeguarding meetings were held in late 2011 and early 2012 where the neighbour S was discussed in relation to financial abuse for the first time. The outcome was that Police Community Support Officers (PCSO's)[22] would visit and do a 'walk-by' regularly. Stanley was also offered a move to be nearer his sister and to warden assisted housing. He refused and the case was closed as he wanted no help, was deemed to have capacity around all decisions, was independent and mobile. Details of how Stanley could ask for help if he changed his mind were provided.

No further concerns were raised until early 2014 when a neighbour contacted the police worried about Stanley who they said had bought a car for his neighbours who they thought were financially abusing Stanley although they also said he needed these neighbours as friends.

The Care Coordinator confirmed that over the few months after S and her partner moved into the flat below Stanley they befriended him and S started to assume a caring role. The couple appeared to help Stanley by putting carpets in his flat and with refurbishments. The Care Coordinator has said he felt "uncomfortable", his gut telling him things were benefiting S and her partner more than Stanley, particularly financially, yet when he raised this with Stanley, he always stated he was happy with the arrangement with S, and enjoyed talking and sharing a cup of tea and a cigarette with her.

However, at the same time, Stanley made several complaints to professionals that S was misusing his bank card, taking his money and otherwise financially abusing him. At one point he asked them to call the police which they did. These health and care professionals made safeguarding referrals about this from 2015 until the

[22] See: Police Community Support Officer (PCSO) - College of Policing

very last referral in February 2020 when Stanley was in hospital. At this point items had gone missing from his flat and a woman (suspected to be S) claiming to be a relative of Stanley contacted the ward and the home he was possibly moving to demanding his post office card.

Over the years suggestions of respite or moving to supported warden facilitated accommodation were offered to Stanley as a way of helping to move him away from the source of risk (i.e. S). However he continued to insist he wanted to remain at home and that he wanted S to continue to care for him and be his friend. The Care Coordinator is clear Stanley had full capacity to make all decisions regarding his life including around care, support, where he lived and finances during the whole time he worked with him. The nephew believes Stanley was targeted because he was lonely and vulnerable, he said that his uncle "wasn't daft, it came to a point he did know he had been duped. But he was scared".

An oscillating pattern of Stanley making allegations, not taking things forward criminally and appearing to remain friends with S continued over years. This is not unusual in such cases and can be due to coercion and grooming as has been learnt from work around domestic abuse[23] and child sexual and criminal exploitation.[24] 'Mate Crime[25]' is the term that would seem to describe this situation where S (and her partner) used their knowledge of Stanley's vulnerable characteristics to target a relationship that was ultimately used to manipulate and steal from him. Certainly this was the consensus established during the course of this SAR. However, this is a concept applied in retrospect, at the time it was never mentioned or logged and so does not seem to have been considered by any of the agencies involved despite work that West Midlands Police had already accomplished on Mate Crime[26] and transferrable knowledge with other vulnerable victim groups.

In addition to Mate Crime as a concept being overlooked, it would appear that 'Special Measures'[27] and consideration of an Intermediary were not explored for Stanley to facilitate the gathering and giving of evidence from the onset of any of the police investigations. Furthermore, S could have been investigated as a person working in a formal position of trust negating the requirement for Stanley to make a complaint.

[23] See section 76 of the Serious Crime Act 2015. Coercive control. Available online: https://www.cps.gov.uk/legal-guidance/controlling-or-coercive-behaviour-intimate-or-family-relationship [accessed 25/8/21]
[24] National Crime Agency (2021) *Child Sexual abuse and Exploitation*. Available online: Child sexual abuse and exploitation - National Crime Agency [accessed 6/4/21]
[25] Mate Crime is linked to Hate Crime as vulnerable people and/or people who are different (e.g. they have a learning disability, a mental health condition or a physical disability) are befriended or groomed for exploitation and abuse. See: https://www.communitycare.co.uk/2017/02/22/social-workers-need-know-mate-crime/ and https://www.cps.gov.uk/legal-guidance/disability-hate-crime-and-other-crimes-against-disabled-people-prosecution-guidance
[26] See: https://www.bbc.co.uk/news/uk-england-birmingham-22272893
Deputy PCC publishes review of vulnerable victims services - West Midlands Police & Crime Commissioner (westmidlands-pcc.gov.uk)
Layout 1 (westmidlands-pcc.gov.uk)
[27] S16 Special Measures were introduced through legislation in the Youth Justice and Criminal Evidence Act 1999 (YJCEA) and include S.16 (vulnerable) and S.17 (intimated) witnesses for which Stanley met both criteria. See Special Measures | The Crown Prosecution Service (cps.gov.uk)

Appointeeship [28] was never considered by any agencies for Stanley. The SAR revealed there was a general lack of knowledge around using Appointees with adults with capacity. Additionally, civil actions (such as Stanley or Housing applying for an Injunction[29]) do not seem to have been considered or discussed as an option with him during the periods of opportunity when he was clearly stating he was being financially abused and wanted help. Furthermore, it is unclear if any professional accessed Dudley's specific training and resources around financial abuse.[30]

The reviewer discovered during the course of this SAR that police records had noted the Care Coordinator commenting that sometimes Stanley made things up. If this was factual, there should have been evidence to back this statement up from the Care Coordinator. Even with evidence, this should not influence the perception of a potential victim or any investigation.

Learning points

Opinion needs to be professionally substantiated and also differentiated from fact in relation to commenting on a person's character or ability.

Recognising signs of coercion and fear in adults at risk of abuse and understanding related concepts such as 'Mate Crime' is crucial particularly when the vulnerable person concerned is making decisions that puts them at greater risk. Learning from related SARs (see [31]) and utilising resources would help with this.

Proactively utilising windows of opportunity to discuss options with those oscillating between expressing they want help and withdrawing statements is needed in cases of Mate Crime.

Disruption of crime is more than conviction focussed. It can be preventative (a key safeguarding principle). It can include civil options. Multi-agency collaboration is key to gaining understanding of options, even if those options are not taken or able to be taken.

Recommendations

All partnership agencies to ensure that learning and resources regarding financial abuse, Appointeeships, Mate Crime and civil options are accessible to all staff, they have the time and reflective space to absorb them in order to enable transfer of learning to practice and this needs to be monitored.

3.5 Mental capacity

[28] An Appointee can act on someone's behalf who has capacity regarding finances and is in receipt of benefits, this can be a commissioned service from an organisation, for example around direct debits, management of money such as loading set amounts onto cards - all with the agreement of the person.

[29] An Injunction is a legal order for a person to do or to cease doing something for example to preserve or prevent the loss of an asset,

[30] Financial Abuse Toolkit https://safeguarding.dudley.gov.uk/media/12854/dudley_financial_abuse_toolkit.pdf

[31] E.g. The case of Derrick which led to a Mate Crime Thematic Review by Bristol City Council in 2018. See https://bristolsafeguarding.org/adults/safeguarding-adult-reviews/mate-crime-thematic-review/ And Martyn Welcome to the Keeping Bristol Safe Partnership website. (bristolsafeguarding.org)

Discussions of mental capacity have been integrated within the other sections of this report as appropriate. Here, further elements and learning are considered.

Whilst the Mental Capacity Act 2005 (MCA) was intended to protect and empower people who lack (or may lack) mental capacity to make decisions about their care and treatment, it can also be used for people like Stanley who appear to have capacity although there may be issues around fluctuation, and/or their ability to enact decisions to lower risk. Being unable to enact decisions relates to the persons executive capacity.[32]

Fluctuating capacity is particularly common in situations of self-neglect.[33] For Stanley this may have been the case due to undue influence, control and exploitation by S, and/or when he had health issues such as an infected catheter, and/or when he had not eaten or drunk due to no food being in the house. Fluctuation can take place in the course of a day, or over days or weeks, which is why capacity must be seen as a film and not a photograph. As a manager stated at one of the learning events, "mental capacity assessment is an aide not a destination".

In situations of fluctuating or disputed capacity and when someone with care and support needs is consistently making high risk unwise decisions (such as Stanley refusing support services that could have lowered risk to him) mental capacity assessments, especially of executive capacity should form part of risk assessment. Research[34] recommends that this should include practitioners moving beyond 'tell me' (verbal assessment) to 'show me' (functional) assessment of capacity. And NICE recommends taking a 'real-world', practical and longer term perspective rather than assessment at a point in time.[35] Furthermore in such situations of high risk sometimes more than one practitioner, more than one assessment for each decision and 'fresh eyes' to undertake such assessments needs to be considered as an option.

This sort of professional curiosity needs to be coupled with robust recording. Evidence of capacity is just as crucial as evidence of lack of capacity particularly where clients are making ongoing risky decisions and professionals have no power to intervene. If this is the case they need to consider going to a higher power for judgement (for example via Inherent Jurisdiction).[36] The learning events demonstrated a lack of knowledge around this concept from some attendees. For Stanley, it would seem that legal advice was not considered or sought and there are no formal capacity assessments recorded indicating either a lack of legal literacy or lack of robust recording.

Learning points

[32] Executive capacity is the ability to put the decision that has been made into action. This element of capacity assessment should be included when considering the person's ability to use and weigh information.
[33] See: Braye, S., Orr, D. and Preston-Shoot, M. (2015) 'Learning lessons about self-neglect? An analysis of serious case reviews.' Journal of Adult Protection (2015) 17 (1), 3-18.
[34] ibid
[35] See Recommendations | Decision-making and mental capacity | Guidance | NICE
[36] Inherent Jurisdiction entitles the High Court to make a decision where there is no existing law available (i.e. the MCA or MHA are not pertinent). For example to override a person's Article 8 rights in order to protect their Article 2 rights.

When there is a possibly that an adult at risk is scared or coerced and they are self-neglecting the possibility of this impacting on elements of capacity needs to be explored, capacity assessments undertaken formally, robustly recorded and legal advice sought.

Concepts such as 'executive capacity' and legal routes such as 'Inherent Jurisdiction' need to be understood by all agencies.

3.6 Safeguarding

Safeguarding has been discussed within other sections of this report where pertinent. Consequently this section will identify only additional safeguarding elements, learning and actions. These will be separated into before mental health services closed Stanley's case and afterwards.

3.6a Safeguarding whilst open to secondary mental health services:

The documents supplied by Stanley's nephew do not detail the decisions made at Triage by mental health services. Mental Health Leads have stated that safeguarding concerns at the time did not meet the criteria for a safeguarding enquiry. However the Care Coordinator is clear 'safeguarding strategy meetings' took place. And various professionals working with Stanley recorded over a long period of time that he was 'under safeguarding'. There is no evidence of referrers being communicated with regarding the outcome of their referrals, various staff attending one of the learning events expressed their frustration around this and lack of action.

Clarity of legal framework when working with a situation of risk is essential for transparency and governance as is related recording for legally defensible practice. Robust recording should include details around assessment, decision-making, action and intervention as well as who has oversight and gave guidance in order to demonstrate that a proper process has been followed and that practitioners and managers have acted reasonably and proportionately. There should be a clear audit trail of what options were considered and why certain actions were or were not taken to demonstrate governance.

The Making Safeguarding Personal (MSP)[37]agenda (incorporated into the Care Act 2014) establishes Independent Advocacy as a part of good practice with regard to Safeguarding. The SAR established Advocacy was never considered or offered to Stanley. When Advocacy was discussed at the learning events some professionals across all agencies at all levels did not understand the need for Advocacy if a Social Worker or Care Coordinator was involved with a case, or the duty to offer Advocacy regarding those finding it difficult to be part of safeguarding, or the difference between using Advocacy for those without capacity (non-instructed) and those with capacity (instructed). In fact, one professional thought

[37] Local Government Association (2021) *Making Safeguarding Personal*. Available online: https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/making-safeguarding-personal#:~:text=%20Making%20Safeguarding%20Personal%20%201%20Implementing%20MSP.,in%20the%20context%20of%20Making%20Safeguarding...%20More%20 [accessed 18/8/21]

you could not use Advocates unless a person lacked capacity. Another stated it was good when a person has no family as it makes decision making for them easier. There was confusion amongst some regarding the difference between the use of advocacy skills and Independent Advocacy. Conversely, some professionals were clear about Advocacy and felt that collaborative safeguarding meetings would have been a space to explore this as an option. These individuals aside, the lack of understanding around Advocacy is concerning and points to a lack of knowledge base and/or application of the ethos and aim of the MSP agenda.

Recommendations

Mental Health services in particular, and other single agencies, would benefit from signing up to the 'Care in Health and Improvement Programme' (CHIP), a joint initiative by the Association of Directors of Adult Social Services (ADASS) and Local Government Association (LGA) which has developed a framework to help untangle the Safeguarding criteria and provide resources and recommendations as to how to do that.[38]

All agencies to re-establish the MSP agenda and ensure related concepts such as Advocacy are central considerations within any safeguarding work. DSPP to measure this with an annual audit.

3.6b Safeguarding after closure by secondary mental health services:

Within this latter timescale, six safeguarding concerns were raised regarding Stanley, the first on the 31st December 2019 and the last on the 10th February 2020. During this acute episode, Stanley was refusing offers of respite, treatment and at one point for the GP to come into his flat. All referrals listed self-neglect and financial abuse. One also cites neglect and acts of omission.

All referrals were Triaged by the Multi-Agency Safeguarding Hub (MASH) as meeting the criteria for a S.42 enquiry and each sent to the relevant adult care team stating urgent allocation was needed. However, at that time the community team could not allocate the case due, in part, to lack of available staff over the Christmas and new year period. It would seem there was no arrangement in place within Dudley at the time to ensure that a S.42 enquiry takes place when the team that has been tasked, cannot perform this Care Act duty adequately due to a lack of staff. As an alternative the case was given to Duty staff to undertake various urgent actions while it awaited formal allocation. One instructed action was for a Duty Social Worker (DSW) to undertake an urgent home visit. This did not take place until 6/1/20.

Another action was for a DSW to commission additional care to that already in place as Stanley now needed two people to move and handle him and the current

[38] See: Understanding what constitutes a safeguarding concern and how to support effective outcomes | Local Government Association and for tools see: https://www.local.gov.uk/understanding-what-constitutes-safeguarding-concern-and-how-support-effective-outcome-appendices

provider could not meet the increased need. The Local Authority Urgent Care Team were contacted. A workflow email referral took place but the DSW did not follow this up with a call. This was a breakdown in systems and communication, with one team thinking a referral had been made, the other awaiting a telephone call to confirm it before allocating care staff. As a consequence Stanley was left with inadequate care between 31/12/19 and 2/1/20. This led to the care agency instigating a safeguarding referral that included neglect and acts of omission on the part of the Local Authority in addition to financial abuse and self-neglect that was ongoing. The adult care team also raised a safeguarding concern about this.

Stanley was allocated a Senior Social Worker on 27//1/20, by which time he was already in hospital. It was usual practice for hospital discharge to be effected before starting safeguarding enquiries unless safeguarding issues directly impacted on discharge. As Stanley's plan was to move to a nursing home the safeguarding concerns were to be looked at once he was there and settled. However S had reacquired a key to Stanley's property and on the 10/2/20 there was another safeguarding concern submitted due to items going missing from his home. There was no sign of forced entry and only S and two professionals had a key. There was clearly a missed opportunity to safeguard Stanley financially by changing the locks and securing his property when he was admitted to hospital, although this was done after the thefts.

There seems to have been a misguided assumption from the adult care team that MASH was holding Stanley's case open until they could allocate. This is incorrect and points to a level of confusion around the role of MASH and necessary limitations to its remit at the time. This, a lack of staff, and piecemeal allocation of elements of the case to the Duty system that seems to have had no thorough oversight from management led to missed opportunities regarding safeguarding Stanley financially and ensuring he had adequate care to meet his needs.

Once Stanley died, the S.42 enquiry was not completed. The police investigation ceased. The remit of the enquiry had not been fulfilled and the alleged crimes had not been fully investigated.

Learning points

Since the time in question, systems have been changed within the Local Authority in terms of referrals between adult care teams and Urgent Care with the aim of avoiding a repeat of Stanley's experience.

Proactive safeguarding and risk assessment needs to continue after hospital admission. Protective measures should be put in place regarding property, possessions and finances. Information about sources of risk needs to be shared with key hospital staff, potential care homes and other relevant professionals as appropriate.

Duty systems need robust managerial oversight to ensure actions are undertaken.

Complex cases (in particular Safeguarding cases) should not be managed on Duty.

Recommendations

Adult Social Care to establish an agreed timescale for allocation of Safeguarding cases along with a backup system for this where staff shortages within systems are apparent in order to provide opportune protection.

Adult Social Care to establish a clear protocol on proceeding with S.42 enquires once a subject has died in order to establish if there is ongoing risk and/or risk to others.

Adult Social Care to develop a task and finish group to consider establishing a Safeguarding Adults Team in order to provide advice and information to professionals alongside a role with oversight and coordination of some cases.

3.7 Good practice

We learn from acknowledging and sharing good practice as well as from when things could have been done better or differently. Validation is important for morale. The SAR identified the following areas of good and/or effective practice:

- Professional relationships with Stanley were positive, he engaged with staff from several services regularly and over a long period of time (e.g. the Care Coordinator, District Nurses, Community Health Professionals and agency care staff).
- Stanley's 'voice' was present within agency care workers documentation, his views were listened to.
- The police attended on several occasions and began to investigate crimes against Stanley. They took him seriously.
- Fire services attended on two occasion and provided safety advice and fire reducing supplies.
- Care agencies and health staff consistently and regularly completed safeguarding referrals. They did not see self-neglect as a lifestyle choice and showed persistence and vigilance.
- There was recognition of fire risk to Stanley and referral to Fire Services.
- Triage decision making by the MASH team was consistent and legally robust.

4. Recommendations

In summary, good practice has been identified throughout the process of this SAR. There has been recognition that balancing complex concepts of empowerment and protection is challenging particularly when working with an adult making decisions that puts them at risk.

However, there were missed opportunities and omissions. Some responses (including safeguarding responses) could have been more robust, demonstrated a lack of legal literacy (law, policy and research), system breakdowns and a lack of joined up, truly collaborative 'whole system' working. Consequently there are lessons to be learnt with regard to professionals and agencies that can inform and improve local practice.

Learning and recommendations have been listed at the end of each themed sub-section within the previous section in order to provide context. Recommendations are re-listed here specific to the partnership agencies who will need to take actions forward with detail of where they can be found in the body of the report.

Recommendations

Adult Social Care

4.1 Adult Social Care need to develop a standard operating procedure (SOP) for feedback, information sharing, recording and coordination regarding safeguarding cases where S.42 responsibilities (full or partial) have been delegated to other agencies and professionals in order to quality control and for governance purposes. (Taken from section 3.2, mental health)

4.2 Adult Social Care to establish an agreed timescale for allocation of Safeguarding cases along with a backup system for this where staff shortages within systems are apparent in order to provide opportune protection. (Taken from section 3.6b Safeguarding after closure by secondary mental health services).

4.3 Adult Social Care to establish a clear protocol on proceeding with S.42 enquires once a subject has died in order to establish if there is ongoing risk and/or risk to others. (Taken from section 3.6b Safeguarding after closure by secondary mental health services)

4.4 Adult Social Care to develop a task and finish group to consider establishing a Safeguarding Adults Team in order to provide advice and information to professionals alongside a role with oversight and coordination of some cases. (Taken from section 3.6b Safeguarding after closure by secondary mental health services)

Dudley Safeguarding People Partnership

4.5 DSPP to develop an Escalation Policy as a matter of urgency to ensure partnership agencies, and staff at all levels, understand they can challenge within and outside of their systems and know how to do this. (Taken from section 3.3, self-neglect)

4.6 A review of the DSPP Self-Neglect Policy is needed as a matter of urgency. Likewise the Multi-Agency Risk Management protocol. The revised versions need to be owned by all partners so that all partners are utilising the same policy. (Taken from section 3.3, self-neglect)

Once updated a clear dissemination strategy needs to be implemented, including regarding transfer of knowledge to practice (i.e. to all partnership agencies and between all levels of their staff). (Taken from section 3.3, self-neglect).

West Midlands Fire Service

4.7 West Midlands Fire Service to undertake an annual audit of referral to their Complex Needs Officers and Safeguarding. (Taken from section 3.3, self-neglect).

All agencies

4.8 Where there is mention of a 'carer' formal checks with DWP etc. (via an established standard operation process, SOP) need to be made by the lead agency and information then recorded and shared with relevant agencies. Where there are concerns about possible financial abuse, or any type of abuse, by a paid carer (whether via Carers Allowance or a formal care agency) a referral should be made to the MASH. (Taken from section 3.3 self-neglect).

4.9 Understanding of and commitment to truly collaborative, multi-agency and preventative working needs to be endorsed and promoted by all agencies as a way of moving beyond silo working. DSPP to measure this with an annual audit. (Taken from section 3.3, self-neglect).

4.10 All partnership agencies to ensure that learning and resources regarding financial abuse, Appointeeships, Mate Crime and civil options are accessible to all staff, they have the time and reflective space to absorb them in order to enable transfer of learning to practice and this needs to be monitored. (Taken from section 3.4, financial abuse)

4.11 Mental Health services in particular and other single agencies would benefit from signing up to the 'Care in Health and Improvement Programme' (CHIP), a joint initiative by the Association of Directors of Adult Social Services (ADASS) and Local Government Association (LGA) which has developed a

framework to help untangle the Safeguarding criteria and provide resources and recommendations as to how to do that.[39] (Taken from section 3.6a, Safeguarding whilst open to secondary mental health services)

4.12 All agencies to re-establish the MSP agenda and ensure related concepts such as Advocacy are central considerations within any safeguarding work. DSPP to measure this with an annual audit. (Taken from section 3.6a, Safeguarding whilst open to secondary mental health services)

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6. Reviewer

Michele Winter is an Independent Social Worker with a PGCE in adult learning. She has no personal or professional connections with Stanley, his family, or with any agency or individual participating in or connected to this SAR.

Signed and dated by:
Reviewer: 14th February 2022