HAMPSHIRE SAFEGUARDING ADULTS BOARD

A Thematic Safeguarding Adults Review into ‘cuckooing’ in Hampshire.

Katie, James & Luke

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Glossary

1.1	Hampshire Safeguarding Adults Board. Provides oversight and leadership in adult safeguarding arrangements across Hampshire and oversees and coordinates the effectiveness of the safeguarding work of its member and partner agencies
1.2	The Care Act 2014. Introduced to set out a framework to improve people's independence and wellbeing. Local authorities must provide or arrange services that help prevent people developing needs for care and support or delay people deteriorating such that they would need ongoing care and support.
1.3	Social Care Institute for Excellence (SCIE) Seeks to improve the lives of people of all ages by co-producing, sharing, and supporting the use of the best available knowledge and evidence about what works in practice.
1.3	SAR Quality Markers – a set of standards covering the whole process from initial decision making about whether a case meets the statutory criteria for a SAR, to evaluating the impact of actions taken in response to the learning identified.
2.4	Individual Management Reports (IMR). A single agency review of the circumstances at the time; and to develop an open critical analysis of both individual practice and organisational policy and practice, to see whether the case indicates that changes can and should be made.
2.4	Root Cause Analysis. The process of discovering the root causes of problems leading to the most appropriate and effective solutions to improve outcomes for people.
2.8	Independent Mental Capacity Advocate (IMCA). A person who is appointed to act on a person's behalf when they lack capacity to make certain decisions. (MIND, Advocacy in mental health)
3.1.4	Hampshire Adults Health and Care. In Hampshire, social care professionals (including social workers) and public health professionals working to support adults who need support in leading safe and independent lives.
3.1.4	Multi Agency Safeguarding Hub (MASH). A process where safeguarding concerns to Hampshire AHC are triaged and assessed. The hub brings together professionals from a range of agencies into an integrated multi-agency team.
3.3.2	Management move. Where a tenant of a housing association provider requires an urgent move on the basis that it is not safe to remain in their current home due to reasons of domestic abuse, violence, harassment, intimidation, hate crime, or threats of violence likely to be carried out or other urgent management reason.
3.3.2	Organised Crime Group. Planned and co-ordinated criminal behaviour, conducted by people, groups or networks working together on a continuing basis.
3.3.4	Public Protection Notices. A notice from Police Forces to other agencies such as AHC and GP's where there are concerns about a person's wellbeing and safety.
3.2.3	S9 Care Act 2024. The process within Local Authorities Adult Social Care to assess an adult's need for care and support.
3.2.3	S42 Care act 2014. An adult safeguarding enquiry is to enable the local authority to decide whether any action is required for an adult to support to safeguard an adult in their daily living.
4.1	The National County Lines Coordination Centre. A multi-agency team comprising of police officers, National Crime Agency and Regional Organised Crime Units to develop a national picture of the complexity and threats emanating from illegal drug supply and links to slavery/exploitation.
4.1.1	Cuckooing. A practice where people take over a person's home & use the property to facilitate exploitation'. (Cuckooing. A joint approach – National County Lines Coordination Centre.)
4.1.21	Community Safety Partnership. A long standing statutory multi-agency partnership established to reduce crime and disorder in their local areas.

4.2.23	Social Prescribers. Social prescribers are part of the GP practice or primary care network who connect people to activities, groups, and services in their communities to meet the practical, social and emotional needs that affect their health and wellbeing.

1. Introduction

1.1 Hampshire Safeguarding Adults Board (HSAB) commissioned a thematic safeguarding adults review (SAR) into the circumstances leading up to the deaths of 3 people who had been victims of 'cuckooing'.

1.2 The HSAB Learning Subgroup, a subgroup of HSAB, responsible for overseeing the referral and management of such reviews across Hampshire decided that the circumstances leading up to the 3 deaths met the statutory requirements for a Safeguarding Adults Review under Section 44 of The Care Act 2014.

'A review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if –

there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

the adult had died, and the SAB knows or suspects that the death resulted from abuse or neglect…'

1.3 This review has attempted to follow as far as possible the Quality Markers for Safeguarding Adults Reviews as produced by Social Care Institute for Excellence (SCIE) and the National Network of Safeguarding Adults Board Independent Chairs.

1.4 The independent reviewer is a former Chief Superintendent, Devon & Cornwall Police, and a former Head of Public Protection. There is neither current nor previous connection with HSAB or any of its partner agencies.

1.5 At the time of this review, apart from an outstanding HM Coroner's Inquest, there are no concurrent processes ongoing. This review has not been impacted by this outstanding inquest.

1.6 The HSAB Business Team has made efforts to involve surviving members of each person subject of this review. To ensure their voices and those of the deceased are heard, the review has included non-instructed advocacy.

1.7 It is important to state that, although there are areas of learning for the safeguarding system across Hampshire, no apparent omission nor practice has been identified that could have directly prevented any of the deaths.

2. Review Methodology

2.1 A Safeguarding Adults Review is more than a written report. It is a process which galvanises people & organisations who worked/are working directly with people who needed support to have a 'duty of candour', how they are open to learning, identify where improvements can be made & transparent in recognising barriers to effective practice.

2.2 An analysis of the Care & Health Improvement Programme led thematic work of SARs (2020, Preston-Shoot, Bray et.al) identifies key elements of an effective SAR.

(1) Legal literacy as to when a SAR is required (mandatory) or where it is believed valuable learning is beneficial to the safeguarding system (discretionary)

(2) Open, detailed & timely responses by agencies documenting not only the extent of their engagement with the person, but an openness in identifying learning at an early stage.

(3) Effective communication & involvement with/of family members or those representing the family of the person subject to the review.

(4) A process where the lead reviewer can engage with practitioners and managers, either individually or as a group where systemic analysis can take place.

(5) A review where there is good concordance between rationale for referral, terms of reference & identification of **key areas** through the above analysis.

(6) Drawing on learning from previous SARs where similar issues were identified.

(6) Areas of learning & recommendations that are co-produced, evidenced-based, learning focused & timely. Reviews should not 'shy away' from proposing system improvement regionally and/or nationally where appropriate.

2.3 This review has been identified as a **mandatory** SAR. Although not statutorily being provided with care and support as defined under The Care Act 2014, it is recognised through initial analysis of agencies responses that all 3 individuals were people who required care and support, that their deaths had occurred from abuse or neglect (including self-neglect) & there was reasonable cause for concern about how the SAB members of it or other persons with relevant functions worked together to safeguard them.

2.4 The documentation from agencies, through Individual Management Reports (IMR) or Root Cause Analysis reports allowed the lead reviewer to identify key areas of focus for further analysis, and areas where learning could be implemented.

2.5 To support the independent reviewer in the review process, a panel of local representatives, acting as co-reviewers from a number of agencies was used to provide relevant single agency information, the local context within which the safeguarding system works within, and were intrinsically involved in developing recommendations and questions for the Board. There was openness and candour in how the safeguarding process could have been improved.

2.6 To ensure the review benefitted from the views of practitioners who knew the 3 individuals, a series of 3 practitioners' events were held. The Panel believed that 3 individual events enabled each person to have their case examined in more detail and was more personal.

2.7 A final component of the review process was a line managers' event enabling the independent reviewer to triangulate the agencies responses, practitioners' views with polices, strategies and their expectations. This latter event also enabled a discussion around questions and recommendations for the Board to consider.

2.8 The review and this report also benefits from valuable information gleaned from family members, neighbours and professionals working with Katie, James, and Luke from VoiceAbility, an independent charity providing advocacy and involvement services. Summaries of their Independent Mental Capacity Advocates (IMCA) reports has been included in the below case summaries for each person.

2.9 In line with the review's terms of reference, the narrative of this report and recommendations include learning from previous SAR's relating to cuckooing, national guidance, and local practice elsewhere.

3. Case Summaries

3.1 Katie

3.1.1 Katie was a 52-year-old female who lived alone in a one-bedroom property. Although Katie was found deceased on the 14th June 2022, it is more likely she died a few days before. Due to inconsistencies of Katie's death being reported, a person was arrested on suspicion of causing or allowing the death of a vulnerable person, but released with no further action. Drug use was a key factor in Katie's death as detailed in HM Coroner's cause of death. The Inquest into the death of Katie was heard on the 1st August 2023.

Medical cause of death:

1a. Respiratory Depression. 1b. Morphine (Heroin) and Methadone Toxicity and Chronic Obstructive Pulmonary Disease. 2. Alcoholic Ketoacidosis.

HM Coroner recorded an Open conclusion, meaning that there is insufficient evidence to decide how the death came about, pending any further information that may arise in the future.

3.1.2 Katie had a significant medical history including chronic hepatitis C, chronic type 2 renal failure, Chronic Obstructive Pulmonary Disease, asthma and Thrombocytopaenia due to hep-C diagnosis, and previous deep vein thrombosis. There is also recorded information Katie had ongoing intravenous drug and alcohol use for over 20 years.

3.1.3 Katie was known to several agencies, identified as a vulnerable adult on police records. The Police, through a number of intelligence logs indicated a cuckooing risk over a period of time.

3.1.4 Adults Health and Care (AHC) had minimal involvement with Katie. In 2013, 2018 and 2020, AHC had received notification of incidents that Katie had been involved in, but for each event it was not deemed suitable for AHC follow up. On the 6th June 2022 (a few days before Katie's death), AHC did receive a safeguarding referral from South Central Ambulance Service with concerns around self-neglect, substance use and Katie's refusal of help. This referral was reviewed by the AHC Contact and Resolution Team on 14th June 2022 and referred to the Multi Agency Safeguarding Hub (MASH) on 16th June 2022, however Katie by this date had been found deceased.

3.1.5 Agencies appear to have had knowledge of risks and providing interventions, but no cogent and structured multiagency intervention has been noted at this stage. The circumstances of Katie's death led to the hypothesis that the circumstances leading to her death may have been linked to abuse or neglect. Specific 'cuckooing' risks were not identified in a partnership arena.

3.1.6 Katie had 3 children, 2 daughters and 1 son. They did not have much contact with their mother, as they were taken into care at a young age.

Additional information from Independent Mental Capacity Advocates.

3.1.7 As part of their work, VoiceAbility consulted with Katie's daughter and close neighbour.

3.1.8 The information provided to IMCA suggested that rather than the 3 children being taken into care, they lived with their father. Whatever happened, not living with Katie had a significant adverse effect on Katie and may have been a contributory factor in her later behaviour, including substance use.

3.1.9 Despite her difficulties, Katie was a very clean person and extremely houseproud. It was also felt that Katie empathised with people with similar issues to her. Her natural characteristic was to help people, but this positive trait could have led her to be exploited, including those she was trying to help. This included Katie's previous associates, people she had known in the 'heroin world' who would turn up on her pay day. Katie would let people stay in her house when she was in hospital and have parties. On one occasion she was seriously assaulted in her home.

3.1.10 There were efforts by Katie and others close to her to stop the abuse and exploitation she was experiencing, but Katie, although wanted to remove individuals from her house, she did not have the capacity to do this. There were occasions when neighbours helped Katie in removing individuals from the house because Katie couldn't.

3.2 James

3.2.1 James was a 56-year-old man, who lived in a housing association property. Although the tenancy was for James alone, there is clear information that other people, primarily one person also lived at this address. James died on the 9th June 2022. Although it is believed James died of an intentional drug overdose, James's death has not been subject to an Inquest. When police officers visited James's address on the 9th June 2022 following a report by his neighbour, a note was found with James saying he can no longer deal with people 'knocking on his windows' and specifically referred to 2 people who it is believed were exploiting him. There were no signs of forced entry nor suspicious circumstances.

3.2.2 James had a history of alcohol and substance misuse as well as a diagnosis of Emotionally Unstable Personality Disorder and epilepsy. James had been under a local Community Mental Health Team since May 2019 and at the beginning of 2022 was being seen in a nurse led Community Mental Health Centre being allocated a care coordinator. At the beginning of April 2022 James took an intentional mixed overdose of his medication and was taken to an Emergency Department. Following assessment by the Mental Health Liaison Team, James was admitted to a ward dedicated for those with functional mental health needs. Mental Health Liaison staff identified several safeguarding risks, which included James having been previously set alight, stabbed, and punched by the people in his flat.

The Police in their IMR, identify numerous events where they were involved with James. The majority of these contacts relate to concerns for James 's safety along with numerous recorded contacts with other men in his property. Included in these recorded contacts are allegations that James was assaulted with a knife, and also being found sleeping in the woods as he was fearful of going home. The Police had also received information from other agencies along similar issues where James was assaulted, sleeping in a graveyard as he didn't feel safe at home, and that neighbours had reported to his housing association of anti-social behaviour.

3.2.3 James was not in receipt of any social care support at the time of his death. For a period in 2019, AHC worked with other agencies to engage with James who accepted some support in the form of reablement care calls and befriending service, but after a short time, he stopped engagement leading to no further action for him. Throughout 2020 and 2021, AHC received a number of safeguarding referrals in respect of James. For some of these, the assessment did not reach The Care Act eligibility criteria, but he was referred to other services e.g. Occupational Therapy or Drug and Alcohol Services. In August 2020, a safeguarding referral in respect of 'cuckooing' did meet the S42 enquiry threshold and action was identified to complete a Section 9 Care Act assessment. However James was admitted to Hospital and self-discharged before support could be coordinated and despite attempts to progress the assessment, the community team were unable to contact James and his case was closed in September 2020. Of note, is that this time period coincided with the covid19 pandemic and processes at that time may have hindered attempts to make face to face contact with James.

3.2.4 Hampshire AHC received 2 other referrals in respect of James which met The Care Act eligibility criteria. The first, June/July 2021 again related to James's fear of safety. On the 25th June 2021, a joint visit with AHC and Community Psychiatric Nurse met James, who agreed to a S9 assessment. This assessment took place in July 2021 with James meeting the Care Act eligibility criteria. The assessment identified that James would benefit from a referral to sheltered accommodation, a further occupational therapy assessment, a referral to debt relief services and a review of Argenti telecare. James also indicated he wished to receive support to maintain daily living activities and to receive support to apply for a managed move.

3.2.5 Although initially James wished to receive support to maintain his activities of daily living and to receive support to apply for a managed move, he subsequently decided that he did not wish for AHC care and support. In April 2022, following an intentional overdose, James was again assessed and met the S42 eligibility. Over the following 3 months, AHC staff were engaged with other agencies, particularly Community Mental Health Teams, Homeless Prevention, Police and Hospital in trying to coordinate support for James. This was complicated by James's admission to hospital, and subsequent discharge process where inter-agency communication was imperfect, and a simple issue of James not having a phone as this was previously stolen. Although a joint visit had been arranged for the 9th June 2022, James had already died by this time.

3.2.6 James has 1 surviving daughter who was in contact with him. She felt that her father lived in fear, scared of the people who were controlling his life, and although he wanted to leave the area to feel safe again, he felt trapped by the situation he had found himself in.

Additional information from Independent Mental Capacity Advocates.

3.2.7 The primary source of information from the IMCA report comes from professionals who worked closely with James or had knowledge of their agency's involvement with him.

It is clear that James had a close relationship with his daughter, and this may have led to certain decisions that exacerbated the ongoing harm and exploitation that he was experiencing. For example, although he recognised the need for him to move to different accommodation, he did not want to move too far away from his daughter.

3.2.8 Protecting his daughter was also a driving factor in not reporting certain events to the police as he 'did not want to grass on those who were causing him harm, because he was fearful of repercussions, in particular placing his daughter at risk'.

3.2.9 James's care coordinator developed a close relationship with him, who describes James as, 'a really nice person who wanted to help people …... but was very afraid and this overshadowed any hobbies or interests he had.'

3.3 Luke

3.3.1 Luke was a 48-year-old man who lived in a housing association property. Luke died on the 17th October 2021. The inquest into Luke's death stated that cause of death was:

1a. Central Nervous System Depression, b. Tramadol Overdose and Promethazine and Olanzapine Toxicity, 2. Severe Alcoholic Fatty Change of Liver. Although Luke was found deceased on the 17th October 2021, due to a number of reasons, it is believed that he died some time before this date.

Luke was born in Northampton and both parents were from Jamaica. There is information, particularly from the police information that Luke was a victim of hate crime.

3.3.2 In January 2021, Luke was subject to a management move through his housing association provider to Hampshire from another local authority area. This move, which happened quickly, was as a result of Luke being a victim of cuckooing, the perpetrators being an organised crime group based outside of Hampshire. Although there is no evidence that Luke was a victim of cuckooing in Hampshire, the ongoing impact of being a previous victim of such a crime, and the subsequent move to another area has led to wider learning in respect of cuckooing when such moves take place.

3.3.3 Although AHC received a steady number of referrals from other professionals, housing, and police in relation to Luke over the latter part of 2021, particularly in September 2021, no S9 assessment had been carried out, nor were any AHC services in place at the time of his death or since he had moved to Hampshire in January 2021.

3.3.4 From July 2021 to his death in October 2021, the police recorded numerous incidents and crimes in respect of Luke, as a victim of crime, including hate crime, an alleged perpetrator, and concerns around his mental health. Allegations of anti-social behaviour against Luke and by him against his neighbours were also recorded. Not only did the police record these crimes and incidents they submitted a number of Police Protection Notices (PPN's) to AHC. Specifically, between the 13th and 29th September 2021, five PPNs regarding Luke's behaviour, including apparent distress, mental health concerns, stripping and running in the street on being released from police custody, substance misuse, threats to kill, racial abuse were received. At that time, Police only forwarded PPN's to the relevant AHC. It was recognised that this led to missed opportunities for sharing of important information to other key people such as GP's. This process has now changed so that such PPN's will be shared with GP's and if relevant with AHC.

3.3.5 It is clear that Luke's mental health was significantly deteriorating in the last few months leading up to his death. He reported to Police that the people who exploited him in his previous address knew where he lived in Hampshire and threatened to kill him. This turned out to be an unsolicited text message from a local pizza company. Furthermore, Luke entered a shop and undressed, threw his clothes in a bin, and redressed with clothes from the shop. Linked to this deteriorating mental health was an increase of anti-social behaviour incidents being reported either by Luke or his neighbours.

3.3.6 Luke leaves a surviving mother and sister, but when informed of his death, neither had any contact with Luke for about 3 months prior to this.

Additional information from Independent Mental Capacity Advocates.

3.3.7 The primary source of information from the IMCA report comes from professionals who worked closely with Luke or had knowledge of their agency's involvement with him.

3.3.8 Of note, in VoiceAbility's report are comments made by a community police officer who worked directly with Luke. The police officer who first met Luke when he moved into Hampshire stated that the covid19 restrictions limited Luke's ability to forge new relationships. Initially, when moved into Hampshire, he lived in Bed & Breakfast accommodation. On first encountering Luke in his new permanent accommodation, the police officer found Luke to be well motivated, took care of himself physically and his flat was tidy and well ordered.

3.3.9 A key factor in Luke's mental health appears to be his unfounded fear that his new neighbours had connections with those who had harmed him in his previous accommodation.

3.3.10 Being a victim of hate crime also became a regular feature of Luke's life, and over half of the incidents that Luke reported to the police involved racist abuse.

3.3.11 Both his unfounded fears of his neighbours being in contact with his previous abusers and persistent hate crime led to Luke not wanting to stay in his home, with him stating that 'he would prefer to walk the streets at night rather than being at home.'

4. Key lines of enquiry findings.

4.0.1 Although more recently, there have been a number of SAR's commissioned due to the harm caused by cuckooing, the number is extremely small in the context of the overall number of SAR's. This thematic review is the first HSAB has commissioned into cuckooing. Although cuckooing and adult exploitation is not in itself a new challenge, this review allows HSAB to reflect on how it is achieving it's 3 strategic priorities in respect of cuckooing specifically and wider adult exploitation.

The agreed terms of reference principal aim was to '*understand how the local safeguarding system is working together to identify cuckooing and whether there are strategies in place to effectively support individuals.'*

4.0.2 This review has identified some good local practice in Hampshire, both in single agencies and existing partnership mechanisms such as the MARM to prevent or minimise risk to adults. However, what is missing is a coordinated and formalised multi-agency adult exploitation strategy, including cuckooing in which partner agencies can coalesce around. The questions and recommendations for the Board have been intentionally produced to enable HSAB to develop a strategic approach to cuckooing, particularly in respect of priority 3 within the 2022-2025 strategic plan. This approach needs to consider how understood cuckooing is across the partnership beyond the standard definition, and how different relationships between victim and perpetrator are effectively identified, assessed, and safeguarded in a way that is tailored to that relationship.

4.1 Developing an understanding and approach to Cuckooing within a limited legislative framework and different relationships between victim and perpetrator.

4.1.1 'Cuckooing' is described as:

… a practice where people take over a person's home & use the property to facilitate exploitation'. (Cuckooing. A joint approach – National County Lines Coordination Centre.)

4.1.2 In essence, criminals will use a person's home for drug dealing, but other criminality such as violence, including sexual violence & theft are often associated with this form of adult exploitation.

4.1.4 There is no specific offence for 'cuckooing' and in their report, entitled '*Cuckooing. The case for strengthening the law against slavery in the home.*', The Centre for Social Justice highlight the local challenges in prosecuting offences of this form of exploitation. The report highlights the evidential difficulties that police forces face in applying existing legislation to cuckooing. Section 1 of the Modern Slavery Act is the legislation that investigators are frequently signposted to, but unless there is tangible evidence of 'servitude, then 'mere occupancy' is inadequate to pursue a charge under s.1 of the Act.

4.1.5 Section 45 of The Serious Crime Act 2015 is another piece of legislation commonly identified as pertinent to cuckooing. However, this offence requires a minimum of 3 people acting in concert as part of an organised gang. Again, prosecuting in relation to this offence would not be applicable in Katie's and James's case as no more than 2 people at most were acting together.

4.1.6 This review has identified that there are different forms of 'cuckooing', from associates (mate crime), local drug dealers through to organised crime groups. Both Katie and James knew those that were exploiting them. These people were not members of any gang, nor were they associated with county lines. The aforementioned legislation may be sufficient to prosecute the organised element of cuckooing as in Luke's case, but where the perpetrators are associates of their victims or local drug dealers, the criminal justice framework is not robust enough to safeguard adults at risk of such exploitation and associated harm.

4.1.7 Luke was a victim of cuckooing of an organised crime group, who hid drugs and weapons in his house. Violence and threats of violence including weapons was a feature of this exploitation. The prompt action taken by the police and other agencies reflected this level of risk and ultimately led to Luke being moved to another area. Perpetrators were arrested and subject to the criminal justice system. In Luke's case, the legislation and level of risk allowed a more direct approach in keeping him safe.

4.1.8 The responses from agencies in this review and from the practitioner's workshops demonstrated a clear understanding of the standardised definition of cuckooing. What was not so clear was an understanding of the specific nature of the cuckooing taking place, and how the response needs to be tailored to the relationship between victim and perpetrator. It is apparent that this awareness of the nuances of cuckooing across Hampshire needs to be more clearly understood. Locally there has been a reliance on the police to disrupt and enforce perpetrators. Given that many people believe cuckooing is a crime and supported by legislation this is an understandable position. However, where this is not possible, a wider, more multi-agency approach, utilising a wider base of skills, experience, non-criminal justice legislative opportunities are required.

4.1.9 The National County Lines Coordination Centre has identified a number of specific heightened risk factors that make people vulnerable to cuckooing.

(i) Lack of safe/stable home environment.
(ii) Social isolation or social difficulties.
(iii) Economic deprivation.
(iv) Insecure accommodation status.
(v) Physical or learning disability.
(vi) Mental ill health.
(vii) Substance misuse.

4.1.10 A major reason for such a multi-agency approach is that for many cases, victims are those with multiple and complex needs and often require specialist support from a number of agencies. All 3 individuals in this review had long standing drug and alcohol use, other significant medical issues, mental health challenges and it was difficult for agencies to get a consistent level of engagement to support them. On a number of occasions, they contacted the police for help, but after that initial fear of feeling unsafe had passed, they did not wish to pursue any subsequent investigation. This is common in many victims of cuckooing.

4.1.11 Notwithstanding the absence of a specific crime of cuckooing, the investigations of recorded crimes relating to Katie, James and Luke did not lead to any prosecution of any perpetrator. There were examples where Police Officers on visiting the victims, spoke to potential perpetrators and provided some safeguarding support, but no perpetrator was brought to justice for any crimes against any of the 3 deceased.

4.1.12 This is not uncommon, as in addition to the legislative gaps, relying on people who are vulnerable as primary witnesses in cases of this type of exploitation will always prove challenging for investigators and prosecutors. Criminals, particularly organised crime groups will target people such as Katie, James and Luke to exploit for their own benefit as they can prove to be unreliable & reticent witnesses against them. All 3 were inconsistent in their wish for support from agencies, and it is also clear that they were committing criminal offences themselves, particularly the taking of illegal drugs, adding another layer of why they may not want the police or other agencies involved past that initial reporting of feeling unsafe.

4.1.13 Given that it is unlikely in the foreseeable future that the legislative framework will be strengthened to support victims of cuckooing, it is vital that victims are supported either by way of improved investigation outcomes within the current law and/or protected through a multi-agency framework to support them and to disrupt perpetrators.

4.1.14 Investigations and criminal justice system processes are an integral part of safeguarding and in the absence of specific cuckooing legislation, it is imperative that investigations of crimes against victims of cuckooing are timely, thorough, and attempts to safeguard the victim through prosecution and/or disruption of perpetrators. The National Police Chiefs Council, in August 2023, published its Vulnerability Action Plan. One of 7 key themes to support this plan is ‘effective outcomes and investigations.’ This document identified that investigations, particularly involving vulnerable victims need improving.

4.1.15 Specifically, there are 3 areas where Police Forces can improve on this area:

(i) Improving the service offer by listening and understanding the victim’s perspective and seeking feedback from victims to plan future service design.
(ii) Developing competent front-line police and staff responders who use professional curiosity to ensure that the early investigation is maximised to gather best evidence.
(iii) Develop and utilise in more effective ways early evidence gathering techniques and the use of 'evidence-led' prosecutions in all appropriate cases.

4.1.16 An additional challenge for partnerships to clearly understand both the level of cuckooing and its associated risk is the absence of data. Given that there is no specific crime, Hampshire Police cannot record cuckooing as a specific crime. Nor are there any ‘cuckooing incident’ markers on its Command-and-Control system. This is not just a local issue, but one for many police forces across the country.

4.1.17 The practitioner events and single agency discussions as part of this review identified an emerging risk to vulnerable adults from cuckooing, albeit anecdotally. The Board may want to consider how it gains a better understanding of the level of risk and harm posed to adults through cuckooing and wider adult exploitation.

4.1.18 In its 2022-2025 Strategic Plan, the HSAB has the strategic priority of:

Supporting the effective identification, assessment and coordinated management of risk in a way that balances different perceptions of risk whilst preventing or reducing the impact of harm.

4.1.19 The 5 key elements as to how the HSAB will do this e.g. testing and challenging practice, the effectiveness of the MARM framework, championing effective information sharing, and promoting key principles and core ingredients to enable effective identification, assessment and coordinated management of risk are relevant to the wider theme of adult exploitation and also cuckooing.

4.1.20 The review has identified that there are different types of 'cuckooing' ranging from associates (mate crime), local drug dealers to organised crime groups. The differing relationships between victims and perpetrators requires different multi agency approaches to support victims. Although there is no set data to give a clear picture of 'cuckooing' across Hampshire, this review has identified that 'cuckooing' is becoming/an increasing risk to people with care and support needs/vulnerable adults prevalent across Hampshire.

Question 1. How might the Board assure itself that there are systems, policies, and frameworks in place both within single agencies and in partnership to be confident that its partnership is doing what it set out to do within its strategic plan, specifically in relation to people who are being harmed from cuckooing and wider adult exploitation. This assurance to include an understanding of the limited criminal justice framework, and how different relationships between victim and perpetrator requires a multi-faceted approach including trauma informed practice, impact from substance misuse and mental health, and challenges surrounding victims who can be perceived as perpetrators.

Question 2. In the light of the NPCC Vulnerability Action Plan, how does Hampshire Police assure itself and its partners that there is an effective investigative response to crimes perpetrated against victims of cuckooing from first report through to subsequent investigation? Are they viewed as single occurrence low level crimes with limited investigation and supervision or are they seen as a course of conduct which increases the risk and harm caused to a vulnerable person? How are Hampshire Police taking the responsibility of investigation away from vulnerable victims to using more 'evidence led' prosecutions?

4.1.21 From the information provided in the IMR's, single agency discussions and workshops, there is both a need and enthusiasm to raise the profile and understanding of 'cuckooing' across Hampshire. Review participants were keen to use this thematic review to be a catalyst for a strategic, structured, and stronger multi-agency approach. The general view is that there is a gap at both strategic and operational levels which needs to be addressed if adults at risk of exploitation are to be effectively safeguarded.

Recommendation 1. The HSAB, together with community safety partners consider a joint event to draw out the learning from this thematic review acting as a catalyst for a joint strategy and operational plan to further support those of its citizens who are being harmed or at risk of being harmed through exploitation.

4.2 The Care Act and people who are experiencing abuse or harm.

4.2.1 The Care Act 2014 set out a legal framework for how local authorities and other parts of the health and care system should protect adults at risk of abuse or neglect. In these cases, local services must work together to identify those at risk and take steps to protect them.

4.2.2 Sections 3.2 and 3.3 sets out a summary of referrals and action taken by AHC in respect of James and Luke.

4.2.3 Care Act provisions were considered for James and Luke, particularly an assessment of their care and support needs under S9 of the Act and a safeguarding enquiry under S42.

4.2.4 A review of AHC response to this review identified that following referrals, 'opt in' letters were sent to both James and Luke, visits and phone calls made to James and attempted phone calls to Luke.

4.2.5 Although efforts were made to provide support both, no enquiry was carried out, nor was any support services provided at the time of their deaths. The primary reason given for this was non-engagement and lack of response for contact.

4.2.6 Hampshire Adult Health & Care have changed and/or introduced a number of processes since Katie's, James, and Luke's deaths.

(i) The sending out of 'opt in' letters have now stopped as it was recognised that this wasn't an effective way of identifying and managing risk.

(ii) In the Autumn of 2022, an internal risk escalation process was introduced. This allows practitioners and line managers to raise concerns around risk and challenges around engagement to senior management. The benefit of this process is that senior managers can support practitioners in actioning certain activity, not only internally but to partners also.

(iii) The AHC Social Care Practice manual has been updated to incorporate safeguarding practice around cuckooing. This was highlighted in a recent practitioner safeguarding conference.

(iv) An Enhanced Support Project which has been established to work with service users who are self-neglecting or hoarding and focuses on service users who are difficult to engage. This has been seen as a helpful tool in supporting people with mental health issues to engage with services.

4.2.7 This review has identified 3 areas which AHC may wish to consider in improving safeguarding practice for people who have care & support needs and whether there is a need for bespoke risk management for people who are experiencing or at risk of harm or abuse, including exploitation.

4.2.8 s9 Care Act – assessment of an adult's needs for care and support.

Although attempts were made to carry out care act assessments for James, it is apparent that there were delays in carrying these out. S12 of the Care Act adds further provisions to the assessment process including, 'specify steps that the local authority must take for the purpose of ensuring that the assessment is carried out in an appropriate and proportionate manner'.

4.2.9 In both James' and Luke's cases, timeliness of assessment and action was important. Delays can lead to frustration, and for victims, enables the perpetrator to coerce their victims into refusing help from 'the authorities' whether that is social care support or police investigation.

4.2.10 Although the sending of 'opt in' letters has stopped, should there be consideration of how the term 'appropriate' is relevant to people with complex needs, who are victims of crime, and may be being coerced into behaviour that undermines efforts to support them.

4.2.11 S11(2b) of the Act also stipulates that, 'the local authority may not rely on subsection (i) (and so must carry out a needs assessment) if:

(b)the adult is experiencing, or is at risk of, abuse or neglect.

4.2.12 There is no suggestion that where they believed criteria were met, AHC did not make attempts to carry out an assessment. The area where AHC may wish to review, is the system of contact and ongoing engagement with people such as Katie, James, and Luke to ensure they maximise the opportunities for an assessment to be carried out, particularly around timeliness of assessment, methods of engagement and processes around case closure.

4.2.13 James was the only person out of the 3 where it was believed by AHC that S42 criteria had been met. There were 3 occasions where it was believed these criteria were met, August 2020, January 2021, April 2022. None of these referrals led to any tangible action by AHC or partners. The primary reason for these referrals being closed was seen as James's lack of engagement. There is no information that AHC, despite long standing involvement with other agencies and James, used its powers under S42 to 'cause to be made' enquiries of its partners to decide if any action should be taken.

4.2.14 It is clear that a number of agencies tried to provide support to Katie, James, and Luke, whether that was through a criminal investigation, care & support needs, mental health, and recovery support. The risk escalation process now adopted in Hampshire AHC will hopefully strengthen and provide a more coordinated response to statutory provisions under both S9 and S42 of the Care Act, but along with other action recommended in this report, a key element of Hampshire improving its safeguarding practice to

people with care and support needs who are being harmed through exploitation is a more rigorous and personalised approach to the Care Act statutory requirements.

4.2.15 In their reports, VoiceAbility state that Katie, James, and Luke would have been entitled to independent mental capacity advocate support from a S9 assessment or S42 enquiry if there was no family member or friend willing or able to support them. For James and Luke, if assessed as lacking capacity, this entitlement would have been extended to ongoing safeguarding concerns even if family members or friends had been available to support them.

4.2.16 S9(5)(c) states that:
A local authority, in carrying out a needs assessment, must involve:
(c)any person whom the adult asks the authority to involve or, where the adult lacks capacity to ask the authority to do that, any person who appears to the authority to be interested in the adult's welfare.

4.17 In recognising the challenges faced by professionals in maintaining consistent and meaningful engagement with people with multiple and complex needs, together with being harmed or abused, the involvement of advocacy may support opportunities to maximise efforts to enable more sustainable support.

Question 3 – How does HSAB seek assurance from AHC that the processes it has introduced in 2023/2024 to supporting people with care and support needs, particularly S9 and S42 of The Care Act and advocacy, provides the rigour and quality of practice that is tailored to people who are being harmed or at risk of harm through exploitation.

4.3 A multi-agency risk framework in preventing or reducing the impact and/or risk of harm.

4.2.1 Hampshire has an existing and long-standing multi agency framework that seeks to reduce risk of harm where statutory or other formal mechanisms are not applicable, commonly known as MARM.

4.3.2 The MARM is a process where partner agencies work together to identify, assess, and manage risk to people who are not assessed as meeting the s42 criteria.

4.3.3 In March 2022, the HSAB published a thematic SAR into self-neglect. In that review, the MARM process was subject to a specific learning point. Key issues from that review were:

(i) organisations who participated in the learning events and who contributed to this SAR do not appear to be confident in either a) using MARM or b) knowing when to use MARM or when the s42 duty applies.
(ii) Using a MARM instead of section 42 means that statutory duties are not engaged, neither the duty to cooperate including information sharing, nor to enquire, nor the duty to commission advocacy in specified circumstances.
(iii) The use of a multi-agency forum outside of s42 for people who meet the s42 criteria is contrary to legislation and will contribute to a culture that thinks of self-neglect as 'less serious' than abuse by a third party. The MARM should not be used regarding self-neglect that carries a high risk to a person with care and support needs.

4.3.4 This review has examined the MARM process specifically in relation to cuckooing. Although safeguarding referrals were made in respect of Katie, James and Luke, and attempts were made to carry out s9 assessments, ultimately none of the 3 received care support from AHC.

4.3.5 This review has identified some positive progress in respect of the learning from the aforementioned self-neglect thematic review.

(i) There is more confidence in use of the MARM for people at risk of hoarding and self-neglect.
(ii) A number of agencies have invested time and effort in improving awareness of the MARM process.

(iii) Likewise, a number of agencies have trained staff in leading MARM meetings.
(iv) There is a positive link between outcomes and attendance.

4.3.6 Review participants felt there were further improvements to be made in the MARM process.

(i) There can be an over reliance on AHC staff both in terms of leading meetings and decision making.
(ii) Attendance can be sporadic, leading to fewer outcomes.
(iii) On occasions, sharing of information was not timely or not shared.

4.3.7 The concerns identified in the self-neglect thematic review around the use of the MARM for people where the s42 criteria was met was not evident in this review. Assessments were made in all 3 cases but were either not assessed as meeting the eligibility criteria or attempts were made to carry out assessments, but these were unable for a number of reasons to be completed.

4.3.8 Where the s42 eligibility criteria has not been met, there is a need in Hampshire for a clearer tailored framework to support people such as Katie, James and Luke who are at risk of harm through exploitation. This is not to suggest an additional mechanism to the MARM, but a process that is specific to the needs of people with multiple complex needs who are being exploited through various forms of criminality which requires a bespoke safeguarding response.

4.3.9 This tailored approach should look to include the basic elements of safeguarding practice such as identification and assessment of risk and how that risk is prevented or reduced.

4.3.10 Hampshire has in place a number of elements that would be key to a structured response to adult exploitation. Hampshire Police has a specific named operation Fortress which is specific to people who are being cuckooed. Katie was subject to some work from Operation Fortress in 2016/17. Although Operation Fortress seeks to improve communication between partners, this does not lead automatically to a MARM. Discussions with drug and alcohol teams gave reassurance that every effort is made to maintain contact with their patients, with a number of creative actions to minimise the risk of people disengaging. There are also opportunities through this review to involve advocacy and volunteer groups to support agencies in maintaining contact and communication with victims of cuckooing.

4.3.11 It is recommended that the HSAB work with the Community Safety Partnership to draw together the specific learning around the MARM from the self-neglect thematic review, the positive elements from Operation Fortress, the NPCC Vulnerability Action Plan and learning from other partnerships to develop a bespoke toolkit to safeguard people at risk of harm from exploitation within the existing MARM framework.

4.3.12 The Leicester/Leicestershire & Rutland SAB has a specific guide on cuckooing, together with legal definitions, meeting templates which HSAB may wish to consider in developing their toolkit. (*https://www.llradultsafeguarding.co.uk/guidance-for-working-with-adults-at-risk-of-exploitation-cuckooing)

4.3.13 Nottingham Community Safety Partnership has introduced a Slavery and Exploitation Risk Assessment Conference (SERAC). The SERAC in Nottingham has been highlighted by the Home Office as an example of best practice in bringing together partner agencies to share information, risk assess and manage potential victims in a multi-agency forum. The Partnership is now looking at extending the SERAC into Nottinghamshire.

4.3.14 Although a number of partnerships nationwide are looking at how they can strengthen their multi-agency forums outside of statutory processes, Plymouth's long standing Creative Solutions is one that is seen as the most effective. This model focuses on people 'with highly complex and extreme mental and social vulnerabilities who fall between the gaps. They do not fit into standard care settings and often present in a way that allows care services to support them, many of whom do not present at all because they resent or fear authority. This forum is a mixture of practitioners, managers and commissioners to promote co-operation, build relationships of trust and better support the management and mitigation of risk.'

Recommendation 2. The HSAB works with community safety partners to establish a time limited Task & Finish Group to develop a multi-agency 'cuckooing' strategy and associated toolkit, building on existing mechanisms and previously successful work in Hampshire to provide frontline practitioners with an effective and coordinated framework to safeguard adults at risk of becoming exploited through 'cuckooing'.

4.3.14 There are 3 elements that the partnership may wish the above group to provide assurance on in any strategy/operational plan.

(i) How will agencies and multi-agency forums endeavour to maintain communication and engagement with people who are victims of crime, being exploited and at risk of harm, but do not see themselves as victims and will present as 'difficult', non-engaging and at times aggressive.

Some of the comments from agencies highlighted the difficulties faced by agencies when dealing with Katie, James, and Luke:

'.. had a history of poor engagement with the service and sometimes presented as hostile and unwilling to engage in consultation with staff….'

'… reached out for support when in immediate crisis, but then disengaged.'

'… there were challenges due to lack of engagement.'

4.3.15 Health and social care providers are facing increasing demands for their services with growing waiting lists and resources not meeting that demand. This will naturally lead to decisions as to how the specific service can demonstrate effective outcomes. Where there are difficulties around engagement, this can lead to decision making processes that cancel the offer. Many people who are victims of cuckooing will present as 'difficult to engage' and if the system is not nuanced enough to adapt, a number of these people will continue to be at risk of exploitation or that risk heightened if support is stopped.

4.3.16 Many victims of cuckooing will display aggressive behaviour, procrastination, continued drug and alcohol use and self-harm which can all impact on agencies when trying to support people such as Katie, James, and Luke.

4.3.17 Therefore, a shared understanding of and embedded 'making safeguarding personal' approach is fundamental to promoting and delivering safeguarding practice in the most 'person led' way. The focus should be on agencies 'achieving engagement' instead of victims being seen as 'difficult to engage.'

4.3.18 In June 2023, the HSAB published a briefing learning brief in relation to 'Alex'. A key learning point from this review:

It is important to ensure that statutory advocacy eligibility is not overlooked as it is important in hearing the voice of the adult with care and support needs. Professionals need to be knowledgeable regarding matching the right advocacy service to the person's need/requirement.

4.3.19 This learning point is equally relevant to improving the support for people who are being exploited and can provide a value to safeguarding practice.

4.3.20 The most recent 'Making Safeguarding Personal' toolkit, co-developed by The Local Government Association and Association of Directors of Adult Social Care is a useful framework for single agencies and partnerships to benchmark their current approach to the effective application of safeguarding practice.

4.3.21 This framework would be a useful resource if the Hampshire Safeguarding Adult Board were to develop a toolkit in relation to improving their support of victims of cuckooing.

(ii) How will agencies ensure that the right information is shared at the right time, with the right person to prevent or reduce the impact of harm?

4.3.22 There is evidence from this review that information that would have supported a multi-agency response was not shared in a timely way or not at all. Some agencies were overly reliant on emails and leaving phone messages which were not followed up. There is no indication that this was due to caution about sharing of information. Furthermore, some of the dates within the review timeframe parameters was within the covid19 pandemic, and therefore working processes would have been different. However, the partnership needs to reassure itself that when information is requested, the response is timely and if not followed up, escalated if necessary.

4.3.23 Effective information sharing outside the MARM should also be considered. Learning from a previous SAR led to the police forwarding Police Protection Notices to GP surgeries as well as AHC. However, gaps in information sharing still remain, particularly with wider teams such as Social Prescribers. Social prescribers are part of the Primary Care Network Team, based within GP practices.There appears to still be nervousness in sharing information with the wider GP practice teams other than GP's. Given the value that social prescribers and others may have in supporting victims of cuckooing, there needs to be a reflection on how information can be shared with a wider professional audience in an effort to further support individuals. Furthermore, Inclusion, the drug and alcohol team supporting Katie was not aware of the cuckooing concerns being reported by the police.

(iii) How will trauma informed practice be used to develop a tailored safeguarding response to support victims of cuckooing.

4.3.24 Many victims of cuckooing will have experienced trauma in their lives, whether this is historical or current. Katie, James, and Luke had all experienced trauma, including very recent trauma immediately prior to their deaths.

4.3.25 There are variations on the term 'trauma' within the context of how certain events impact on a person as they develop. The following has been taken from the Trauma Informed Practice Toolkit, Scotland Government, (https://www.gov.scot/publications/trauma-informed-practice-toolkit-scotland/)

'Individual trauma results from an event, series of events, or set or circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional or spiritual well-being.'

4.3.26 The same document highlights that recognising & understanding how trauma impacts on a variety of life outcomes is well established & understood. How that understanding leads to embedded practice,

'…requires a multifaceted, multi-agency approach that includes awareness-raising and education, upstream working, and effective trauma focused assessment and treatment. To maximise impact, all of these efforts will need to be made in a context that is trauma-informed, based on a sound understanding of trauma and its far-reaching implications.'

4.3.27 The Scottish Government partners recognised that services needed to adapt to maximise the engagement & involvement of service users who struggle to effectively manage their time:

'The principle of choice was most commonly referred to in the context of appointment scheduling, issues relating to non-attendance, or the application of discharge policies. Most services highlighted the need for maximum flexibility, with some services responding to high rates of nonattendance by modifying their practices and procedures multiple times. One service described a practice of operating "under the radar", keeping clients on the books when formal policy dictated that they should be discharged due to non-attendance.'

4.3.28 In discussions with agencies as part of this review, there were pockets of trauma informed awareness or training that had taken place. Others were confident that practitioners understood how trauma can affect behaviour. Basingstoke and Deane Housing Team had gone further, initially working with Southampton University and now commission Outcome Homes to provide psychological & peer mentoring services. There was clear evidence that within agencies, staff did recognise that Katie, James and Luke had suffered from trauma and responded to it. For example, Inclusion did all that they could in maintaining contact with their clients and use a number of ways in order to do this. However, within the multi-agency

arena it was not clear how this influenced a coordinated response to support people whose behaviour was affected by trauma.

Question 4. How might the Board assure itself that for victims of adult exploitation, there is effective information sharing systems within the wider health systems, including information shared by partners and internally, to ensure not only medical support is timely and bespoke to the individual, but also information is shared to enable wider support such as mental health, substance recovery, and facilitates multi-agency activity.

4.4 The role of housing providers in supporting victims of cuckooing.

4.4.1 The Local Government Association in conjunction with the Association of Directors of Adult Social Care in 2017 published a document entitled, 'Making Safeguarding Personal. What might 'good' look like for those working in the housing sector?'

4.4.2 In that document it quotes from the College of Social Work: Skills for Care 2014,

'Housing providers have a key role in adult safeguarding, particularly as their staff may be in the best position to spot signs of abuse or neglect at an early stage…'

4.4.3 In its document on 'Council guide to tackling modern slavery'*, The Local Government Agency identifies housing as an important factor in supporting people who are being exploited or at risk of being so, and due to their complexities and lack of social networks they pose a higher risk of becoming homeless. Although the report focuses on Modern Slavery, cuckooing is seen within this definition, and many of the areas covered in the guide applies to cuckooing.

4.4.4 The guide identifies 2 key elements in this support:

(i) How councils and housing providers, right from the first contact and risk assessment, takes account of potential trauma and the impact this might be having on individuals. Staff therefore need to be familiar with indicators of cuckooing and know how to respond to such cases.

(ii) The importance of considering housing provision where the person may need rehousing to disrupt exploitation and keeping them safe.

4.4.5 There are certain challenges facing housing providers when faced with residents who are victims of cuckooing.

(i) Often linked to the address, in addition to exploitation (may be unseen) is visible anti-social behaviour being reported by neighbours, with the expectation that this will be addressed by Housing providers. This was evident with Luke where both he and neighbours were making allegations and counter allegations of anti-social behaviour.

(ii) It can be difficult for housing staff to differentiate between a person who is being exploited and someone who is actively involved in criminality e.g. drug use.

(iii) As in the case of Luke, deteriorating mental health, and counter allegations with neighbours can hide potential exploitation and victimisation.

(iv) James reported on a number of occasions of feeling unsafe, but at other times did not want to pursue any follow-up investigation. On one occasion he requested a move for a larger property so that the person exploiting him could move in with him.

4.4.6 There is evidence of good practice operating in Hampshire Local Authority Housing Teams regarding cases where there are victims of cuckooing.

LA Housing Team 1.

- Have a training module specifically around cuckooing.
- Good liaison with Police around potentially vulnerable adults which can lead to regular 'knock on' by neighbourhood teams.
- A Housing Officer, who is designated as a safeguarding lead.

- Housing Officers referring victims of cuckooing to the MARM.

LA Housing Team 2.

- Good links with Southampton University, Outcome Home.
- All staff trained in trauma informed practice.
- Have invested in senior Officers MARM Chair training.

Both Housing Teams identified areas for improvement.

- The MARM can be overly reliant on Adult Social Care, and at times it has been difficult to progress referrals due to key agencies not being present.
- Staff made decisions on information from other partner agencies rather than developing their understanding of the individual by speaking directly to them.
- Focused on one or 2 elements of the process e.g. management moves rather than consider wider options.
- Allowing focus and action to be on Anti-social behaviour rather than victimisation and not recognising that behaviour was a consequence of current or past trauma.

4.4.7 Two cases, 2 different housing approaches

(i) Luke – In May 2020, Luke visited a police station outside of Hampshire to report that people were living in his home and had hidden drugs and weapons in the walls. Follow up action by the police found both drugs and weapons and identified that those who had taken over Luke's homes were part of a county lines gang. Due to continuing threats, Luke was moved to temporary accommodation outside of that area for his own safety. In July 2020, Luke's existing housing association provider arranged a permanent move to one of their properties in Hampshire. The level of risk to Luke led to prompt direct action to safeguard him. There were prompt referrals to the Community Mental Health Team on Luke arriving in Hampshire, but comments made by Luke put into context how he may have been feeling on a move to a new area. Although he initially felt safe in Hampshire, he felt 'lonely at times', with his anxiety triggering aggressive behaviour. Couple this with allegations of hate crime against him and neighbourly disputes, potential financial challenges, and restrictive living due to the pandemic, Luke would have been under extreme pressure.

(ii) James – In March 2020, James became a customer of a housing association provider following a nomination from the Local Authority. He was placed in a 1 bed flat under a 'general needs' property, meaning no designated support was provided by that housing association. Over a lengthy period of time, there were a number of incidents reported both to the police and housing association including reports of anti-social behaviour, violence, theft, and cuckooing. On at least 2 occasions James was found sleeping in a graveyard and woods due to his fear of returning home. In January 2021, James contacted the Local Authority Housing Services following a violent assault on him. There were ongoing discussions between the Local Authority and housing provider, including efforts to identify risk factors to establish grounds for a potential management move. Due to a lack of evidence from supporting organisations that James was at risk, a move did not take place.

4.4.8 The above contrasts are not to apportion blame or criticism but to outline the different challenges that are faced in dealing with different types of cuckooing, and also the ongoing impact of either a move to another area or remaining in a property with the exploitation continuing.

4.4.9 This review has identified a number of key areas which may have adversely impacted on both Luke and James.

4.4.10 Although there were multi agency meetings in respect of Luke, particularly the Community Mental Health Team and Housing provider, there does not appear to be a wider coordinated multi agency approach. The Police did submit Police Protection Notices to AHC, and there were attempts to contact Luke by AHC, but ultimately no care needs assessment was completed. From the information in the IMR's there was no consideration of a MARM from any agency. There was a long delay in the police being informed of Luke moving into the area from his housing provider. Given the level of risk that Luke had been

exposed to outside of Hampshire, and the makeup of organised crime groups, there was a potential gap in how Hampshire Police could assess ongoing risk to Luke from wider members of the organised crime group even though he had moved areas, as this information was not shared with Hampshire police. Trauma informed practice is not evident in agencies responses to Luke, and this was a person who suffered extreme threats to his life only a few months prior to moving to Hampshire.

4.4.11 Both Luke and James's housing providers received reports of anti-social behaviour from neighbours. Both providers have anti-social behaviour and safeguarding policies. On speaking to one of the housing providers, anti-social behaviour is dealt with by one team, safeguarding by another. It is of concern that despite the number of police incidents to Luke's house and appointments with NHS teams, the first safeguarding referral to the housing provider was on the 10th September 2021, a month prior to his death. Anti-social behaviour is commonly linked to properties occupied by people who are being exploited. If the response is process driven there is a risk that the harm being caused is not prevented or minimised but exacerbated.

4.4.12 In a SAR commissioned by the Torbay and Devon Safeguarding Adult Partnership into Erik (April 2023), the housing provider along with the police issued the victim with an anti-social behaviour letter, in their attempts to deter the perpetrators. This only had a detrimental effect on the victim. There is no suggestion that either the Police or housing provider in either case considered this, but there is a potential gap in housing providers risk assessment. For ASB reports, the housing provider will carry out a risk assessment on the complainant, but not the perpetrator. Hence, when a referral was made by Luke's neighbour, although they would have been subject to a risk assessment, Luke would not have been. This could lead to missed opportunities in assessing the risk to alleged perpetrators who are being abused or exploited.

4.4.13 The relationship between housing providers and Local Authority Housing Teams is fundamental to safeguarding adults at risk of harm. On reflection, both housing provider and Local Authority Housing Team recognise that they were overly reliant on emails rather than phone calls and were not timely in following up requests. Furthermore, on occasions it was left to James to be proactive in his dealings with agencies rather than being supported. Given the harm and abuse he was experiencing at that time, this would have proved problematic for him, leading to perceptions that he was disengaging when he had more immediate risks to deal with.

4.4.14 Many victims of cuckooing and adult exploitation live in social housing/housing associations. This review has identified the important role that housing associations and Local Authority Housing Teams in safeguarding victims of cuckooing, and how, if the response is process driven, rather than person led, the harm being experienced by victims can be exacerbated rather than prevented or reduced.

4.4.15 It is recommended that a housing strategy for adults who are being exploited is developed as part of the cuckooing toolkit. Furthermore, it is proposed that the HSAB seeks assurance from the Hampshire Housing subgroup that the learning from this review is considered as part of their future workplan.

Question 5. The HSAB seeks assurance from the Hampshire Senior Housing Group that the needs of victims of cuckooing in all its forms are supported in a way that 'makes safeguarding personal' for them in line with the LGA/ADASS document 'Making Safeguarding Personal. What might 'good' look like for those working in the housing sector', with particular reference to timely information sharing, wrap around support for those requiring management moves, and how policies ensure the safeguarding of victims when they may also be perceived as perpetrators of anti-social behaviour.

5. Summary

5.1 The detailed reports from VoiceAbility have been used in this review and report. Included in their reports are some questions for agencies to consider in respect of their engagement with Katie, James, and Luke. Furthermore, a number of agencies in their Individual Management Reports have identified specific learning for their agencies. The type of questions and recommendations in this report endeavour to support Hampshire partners to develop a strategic approach to cuckooing. Given the effort and time taken to compile these reports, together with identified learning or further questions for single agencies, it is recommended that the Board seeks to gain assurance from partners as to any action they have taken in respect of these reports.

5.2. This review and report has involved not only an independent reviewer, but a number of partner agencies and advocacy. There has been openness to change and a recognition that this review into cuckooing has given partners across Hampshire a focus on which to start a strategic approach to cuckooing and wider adult exploitation.

Appendix 1 Table of Questions and Recommendations.

	Question/Recommendation	Owner
Q1	How might the Board assure itself that there are systems, policies, and frameworks in place both within single agencies and in partnership to be confident that its partnership is doing what it set out to do within its strategic plan, specifically in relation to people who are being harmed from cuckooing and wider adult exploitation. This assurance to include an understanding of the limited criminal justice framework, and how different relationships between victim and perpetrator requires a multi-faceted approach including trauma informed practice, impact from substance misuse and mental health, and challenges surrounding victims who can be perceived as perpetrators.	HSAB
Q2	In the light of the NPCC Vulnerability Action Plan, how does Hampshire Police assure itself and its partners that there is an effective investigative response to crimes perpetrated against victims of cuckooing from first report through to subsequent investigation? Are they viewed as single occurrence low level crimes with limited investigation and supervision or are they seen as a course of conduct which increases the risk and harm caused to a vulnerable person? How are Hampshire Police taking the responsibility of investigation away from vulnerable victims to using more 'evidence led' prosecutions?	Hampshire Police
Q3	How does HSAB seek assurance from AHC that the processes it has introduced in 2023/2024 to supporting people with care and support needs, particularly S9 and S42 of The Care Act and advocacy, provides the rigour and quality of practice that is tailored to people who are being harmed or at risk of harm through exploitation.	Hampshire AHC
Q4	How might the Board assure itself that for victims of adult exploitation, there is effective information sharing systems within the wider health systems, including information shared by partners and internally, to ensure not only medical support is timely and bespoke to the individual, but also information is shared to enable wider support such as mental health, substance recovery, and facilitates multi-agency activity.	Hampshire Health Partners
Q5	The HSAB seeks assurance from the Hampshire Senior Housing Group that the needs of victims of cuckooing in all its forms are supported in a way that 'makes safeguarding personal' for them in line with the LGA/ADASS document 'Making Safeguarding Personal. What might 'good' look like for those working in the housing sector', with particular reference to timely information sharing, wrap around support for those requiring management moves, and how policies ensure the safeguarding of victims when they may also be perceived as perpetrators of anti-social behaviour.	Hampshire Senior Housing Group
R1	Recommendation 1. The HSAB, together with community safety partners consider a joint event to draw out the learning from this thematic review acting as a catalyst for a joint strategy and operational plan to further support those of its citizens who are being harmed or at risk of being harmed through exploitation.	HSAB/Community Safety partners.
R2	Recommendation 2. The HSAB works with community safety partners to establish a time limited Task & Finish Group to develop a multi-agency 'cuckooing' strategy and associated toolkit, building on existing mechanisms and previously successful work in Hampshire to provide frontline practitioners with an effective and coordinated framework to safeguard adults at risk of becoming exploited through 'cuckooing'.	HSAB/Community Safety partners.