

“There are few more worthwhile endeavours than trying to alleviate the harms caused to people in the places where they are supposed to feel most safe.”

cuckooing-beyond-the-line Mathew Rive 2024

SAFEGUARDING ADULT REVIEW

LEARNING FROM LOUIS' LIFE



WHAT WILL WE COVER?

- Improvements to Safeguarding system in Reading
- Cuckooing took everything from Louis and his story wasn't shared across all the people who were working with him
- How a broken safeguarding system allowed Louis to 'fall through the gap'
- Sharing the need for board improvements such as Safeguarding Adult Boards and Community Safety Partnership and rethinking collaborative working

WHAT HAVE WE BEEN ASKED TO THINK ABOUT?



Did social unconscious bias impact on professionals decision making and management oversight in Louis' case? How do we ensure that it doesn't impact on decision making? - for example, would different decisions have been made if Louis was older/younger, different gender and without substance misuse?

WHAT HUMAN FACTORS MIGHT HAVE
INFLUENCED WHAT HAPPENED?

WHAT HAVE WE BEEN ASKED TO THINK ABOUT?

As a system, what local and national tools and frameworks are available, or required, to enable the system to effectively safeguard people with care and support needs, experiencing or at risk of cuckooing?



WHAT HUMAN FACTORS MIGHT HAVE
INFLUENCED WHAT HAPPENED?

WHAT HAVE WE BEEN ASKED TO THINK ABOUT?



How effective are the use of closure orders in the West of Berkshire to protect people at risk of exploitation?

To also consider: what are the drivers for closure orders? Unconscious bias?

WHAT HUMAN FACTORS MIGHT HAVE
INFLUENCED WHAT HAPPENED?

WHAT HAVE WE BEEN ASKED TO THINK ABOUT?

Has the SAB guidance (*Pathways-for-Multi-Agency-Planning-V.1.0.pdf* (sabberkshirewest.co.uk)) produced in response to the Sandra SAR, supported professionals in calling Multi-Disciplinary Meetings when required?



WHAT HUMAN FACTORS MIGHT HAVE
INFLUENCED WHAT HAPPENED?

WHO WAS LOUIS?

- Sensitive child
- Sometimes obsessive
- Stayed in touch with his family in Wales
- Engineering degree



WHO WAS LOUIS?

- Victim of domestic abuse by his father
- Struggled with this into adulthood
- Drug use led to police contact
- Serious overdoses on a few occasions



WHO WAS LOUIS?

- He struggled with depression and anxiety as a child
- He was homeless and moved into a flat
- He was a victim of cuckooing in his home, finances and life



**LOUIS –
'SEEN' DIFFERENTLY BY
THOSE WHO SAW HIM
FACE TO FACE AND
RECOGNISED
HIS FEAR**

**SAFEGUARDING ADULT REVIEW
LEARNING FROM LOUIS' LIFE**

emotionally unstable personality disorder
terrified
victim
overdoses
vulnerable
son
challenging criminal • isolated
sensitive
traumatised
lies scared lies
obsessive

CUCKOOING - SETTING THE SCENE

WHAT IS IT?

Cuckooing is a highly exploitative and predatory practice named after the nest stealing practices of wild cuckoos. It is a form of exploitation where people are conned, coerced, controlled, or intimidated into providing access to their home to criminals, who then use it as a base for their activity. Such activity may include sex work, storing cash and weapons, or dealing drugs. Perpetrators may also take over a property to financially abuse its occupier

Laura Banbridge -

Cuckooing Research and Prevention Network 2024

CUCKOOING

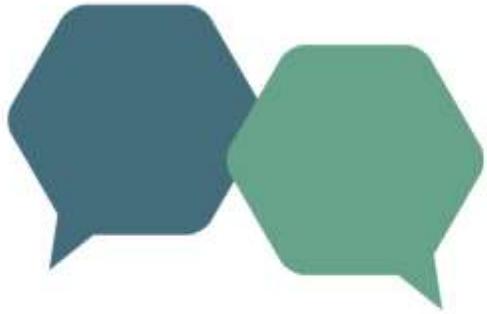
LOUIS' REALITY

A practice where people take over a person's home & use the property to facilitate exploitation'.

*(Cuckooing. A joint approach –
National County Lines Co-ordination Centre.)*

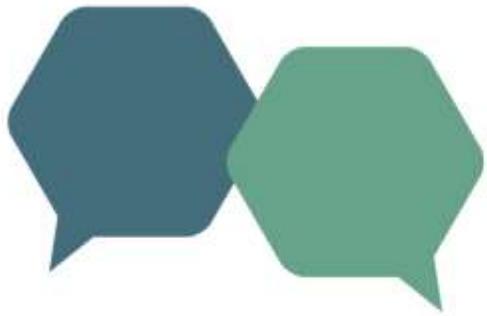
**THIS WAS THE REALITY FOR LOUIS -
AND HOW MANY MORE?**

TO QUOTE LOUIS' FAMILY



“How can you put so many vulnerable people in one accommodation without support?”

TO QUOTE LOUIS' FAMILY



**“Someone took over his flat –
no belongings in his flat.
Large amounts of money was sent
from his account. The same person
was exploiting him a long time”**

WHAT WAS HAPPENING IN THE TIMEFRAME - PARALLEL PROCESSES

	MARCH – MAY 2023		JUNE – SEPTEMBER 2023	
	ACTIVITY	OUTCOME	ACTIVITY	OUTCOME
SAFEGUARDING CONCERNS AND CUCKOOING	<ul style="list-style-type: none"> Housing Association submit safeguarding concern following joint visits with police <ul style="list-style-type: none"> Cuckooing Physical danger No Adult Protection Notice by Police Requests welfare visits by neighbourhood policing team 	<ul style="list-style-type: none"> Closed by Local Authority – no care and support needs Several attempted welfare visits 	<ul style="list-style-type: none"> Joint visits Housing Association and Police Police Adult Protection Notice and two people told to leave Further contact, two weeks later, Louis 'physically shaking'. Seems 'dirty, barricaded in his room, little furniture'. Cuckooing is now recorded. July – Police state Louis is at risk of further exploitation and his mental health is deteriorating and he mentioned he is suicidal He wanted to move back near his mother in Wales 	<ul style="list-style-type: none"> July – Information shared with CMHT and LA safeguarding team July – referral progresses through to S42 Closure order discussions and no strategy meetings organised No discussions about moving back to Wales Occasional welfare visits – but Louis not available
	<ul style="list-style-type: none"> Police concerned about cuckooing following an incident (car stopped driven by man in Louis' flat. Louis has paid for the hire of the car, but he is not in it). Adult Protection Notice and Police MASH refers to LA. Louis is 'skinny' and 'showing signs of paranoia' – says he is at risk when Police leave GP calls Police requesting support as Louis suicidal TVP Adult Protection Notice completed and submitted to Police 'MASH' 	<ul style="list-style-type: none"> No connection made regarding potential abuse and the cuckooing Welfare visits attempted but Louis did not allow access LA – Louis not at risk Closed (only discussed by Customer Fulfilment Centre) Adult Protection Notice sent to Police MASH – closed No safeguarding concern raised by Primary Care Has pneumonia and infection secondary to intravenous drug use 		
MENTAL HEALTH AND PRIMARY CARE	<ul style="list-style-type: none"> Louis is increasingly agitated/not sleeping/isolated and not leaving his home Panic attacks continuing GP concerned about Pregabalin increase All CMHT appointments are by telephone 	<ul style="list-style-type: none"> Appointments continue by telephone No follow up when appointments not attended Pregabalin increased 	<ul style="list-style-type: none"> Primary Care: 'Looks thin, self care not as good', unkempt, long beard Back pain Foodbank referral GP not aware of any safeguarding concerns 	<ul style="list-style-type: none"> BHFT receives Adult Protection Notice via Police informing of safeguarding concerns Safeguarding Team contact AST CMHT had planned to discharge Louis but offered further appointment due to safeguarding. No extra contact offered

MIRROR MIRROR - A BROKEN SYSTEM

- **No guidance on cuckooing or data-** leading to variable responses
- **Relationships matter** and face to face contact is important to be able to 'see' what is happening
- **The mental health trust** did not oversee the clinician's work and spot any patterns

A BROKEN SYSTEM

- **Statutory Adult Safeguarding** – decision making in the wrong hands (not a social worker) and not understanding thresholds
- **Thames Valley Police** – consistency in safeguarding pathways and role of core safeguarding team
- **Housing /homelessness** – how are support needs flagged and assessed ?
Is there potential for supported lets?

A BROKEN SYSTEM



Referrers did not challenge when a safeguarding referral was closed – and no further multiagency pathways followed

THE SIMPLE FACTS

- **No multiagency discussion or strategy meetings** as per section 42 requirements as incorrectly stated that Louis did not have care and support needs
- **No follow up of referrals** into safeguarding to ask questions
- **No links made** with health partners
- **No full understanding** of cuckooing - or its prevalence

WHY IS THE RELIABILITY OF SAFEGUARDING IN QUESTION?

- A pattern of working based on 'this is the way we do things here'
- The role of enforcement vs safeguarding – not an either/or
- A semblance of working together well and yet perpetuating silo working

WHY IS THE RELIABILITY OF SAFEGUARDING IN QUESTION?

- The plethora of Strategic Boards with their own way of doing things
- A multiagency safeguarding framework in place and the key statutory partners not all working as one

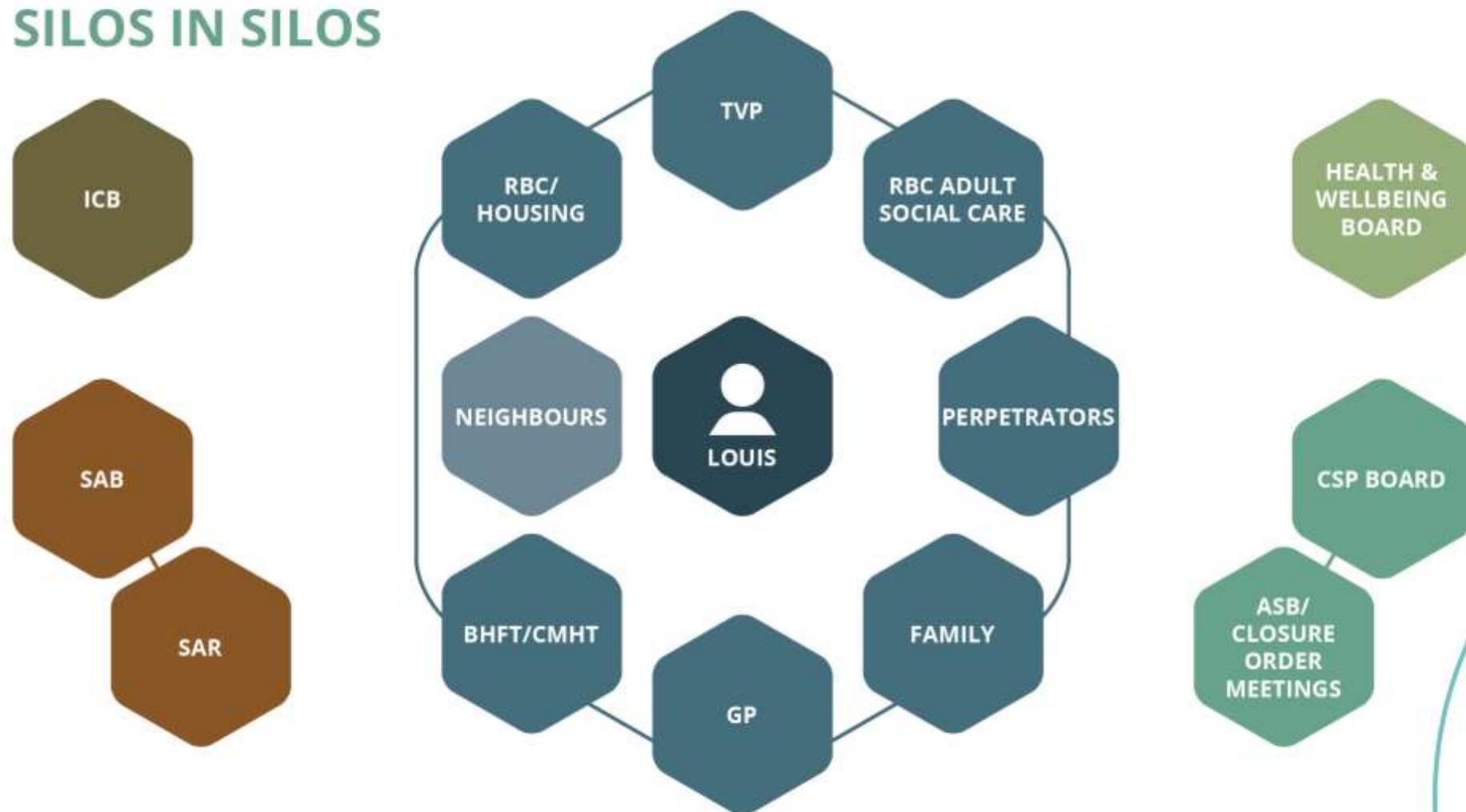
IMPROVEMENTS ARE COMING....

- Complete changes within Adult Safeguarding Team including reporting and recording
- BHFT has introduced a new 'One Team' approach, significantly strengthening staff supervision and enhancing oversight of clinicians' caseloads – *Amendment May 2025 by West of Berkshire Safeguarding Adults Board.*

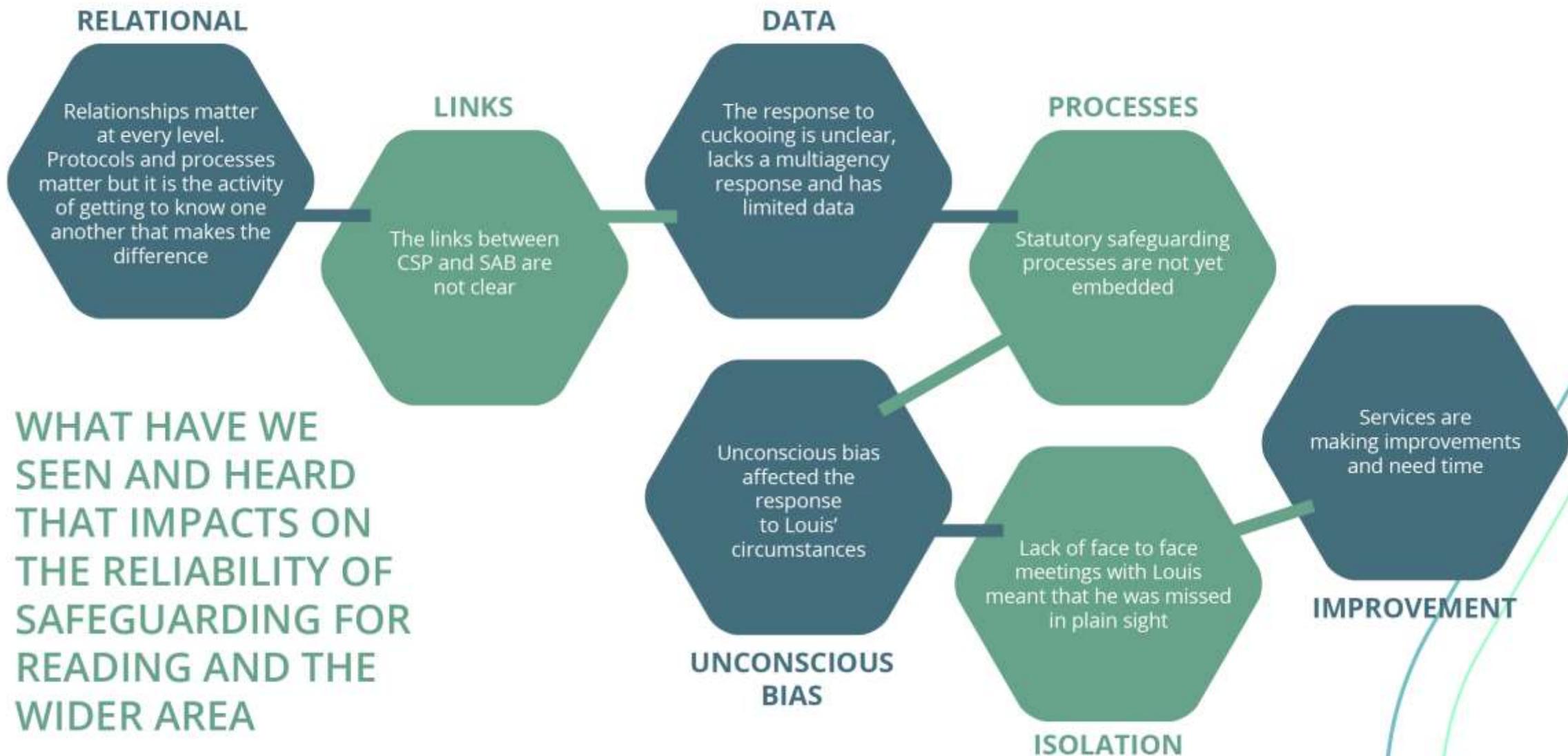
IMPROVEMENTS ARE COMING....

- TVP have a sub-category of cuckooing on their recording system
- A workshop is planned January 2025 with Strategic Boards including Health and Well Being Board to think about working better together

COMPLEX SYSTEMS AT WORK SILOS IN SILOS



SAFEGUARDING ADULT REVIEW | LEARNING FROM LOUIS' LIFE



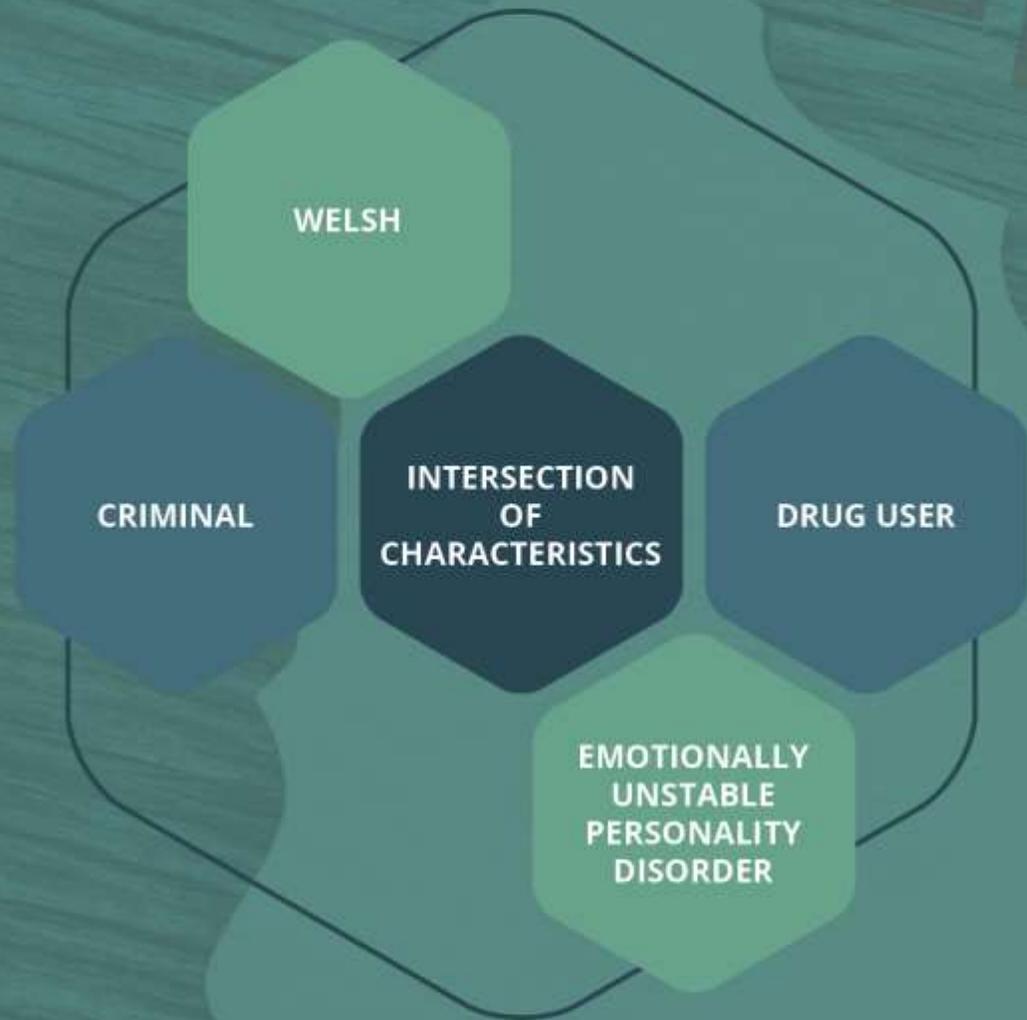
WHAT HAVE WE SEEN AND HEARD THAT IMPACTS ON THE RELIABILITY OF SAFEGUARDING FOR READING AND THE WIDER AREA

UNCONSCIOUS BIAS

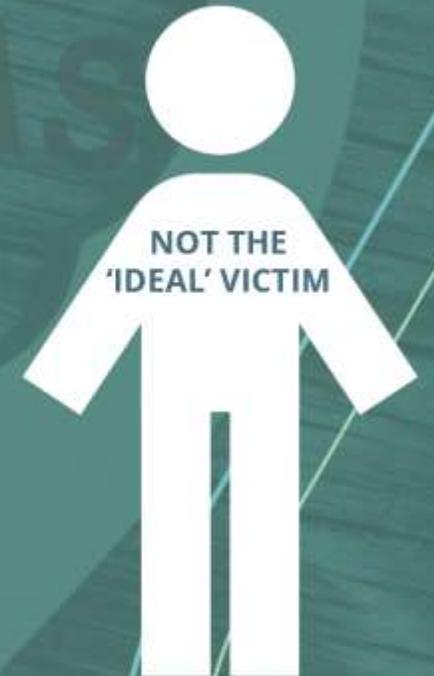
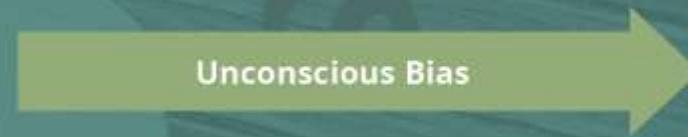
Unconscious bias refers to a bias that we are unaware of, and which happens outside of our control. It is a bias that happens automatically and is triggered by our brain making quick judgments and assessments of people and situations, influenced by our background, cultural environment, and personal experiences.

UNCONSCIOUS BIAS

A major finding for the system is the need to further explore the impact of unconscious bias in practice. Previous SARs such as SAR Issy have documented the impact of bias on delivery of person centred and compassionate care. SAR Issy found that practitioners developed 'tunnel vision' in pressured environments which prevented them from fully 'seeing' the person and family in front of them. (SAR Anna Southampton) 'Professionals who are perfectly sensitive and compassionate in other settings, failed to respond with compassion'. (SAR Issy Southampton)



The intersection of specific characteristics may have created an unconscious bias which resulted in Louis being viewed as, 'not the ideal victim'.



THE SYSTEM IN READING, RESTORING

Tackling cuckooing needs to become everybody's business across Reading and the wider area



THE SYSTEM IN READING, RESTORING



- There is no agreed process/understanding of cuckooing across Reading.
- The strategic structures do not enable an operational response that addresses vulnerability and complexity.
- Improvements in AST are not complete and business as usual.

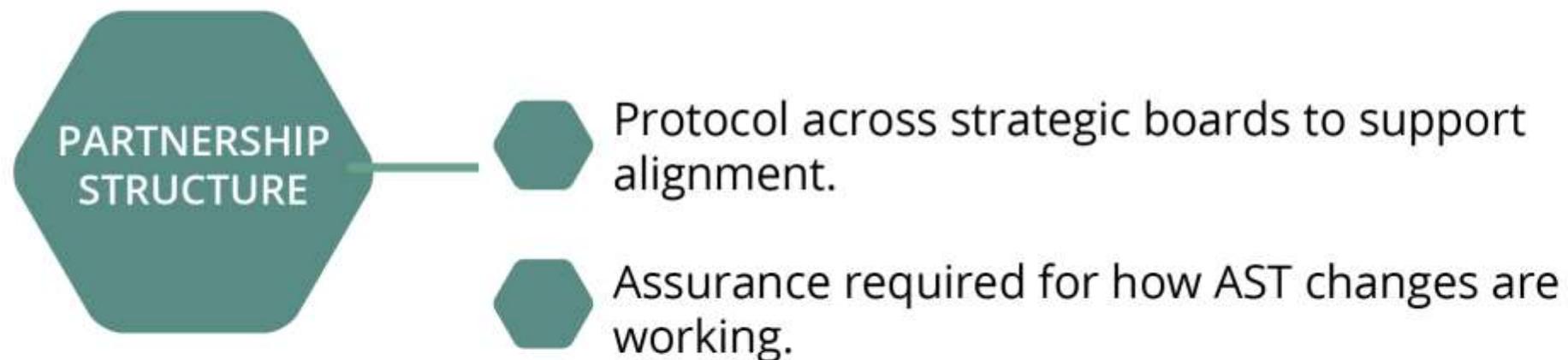
THE SYSTEM IN READING, RESTORING



PARTNERSHIP STRUCTURE

-  All groups and agencies need to play their role in helping to deliver a whole system response to exploitation and cuckooing.
-  Stronger multi agency working arrangements should be developed building on existing arrangements. Consider a taskgroup to review prevalence.
-  Explore national contacts such as SERAC Nottingham and make links.

THE SYSTEM IN READING, RESTORING



THE SYSTEM IN READING, RESTORING



-  The system currently lacks a data collection framework.
-  Consistency about flagging cuckooing on agency recording systems.
-  Agreeing a common language.
-  Audits will be required.

EXPLORING THE BEST EXAMPLES

Co-operative
Councils
Innovation
Network



SERAC
Nottingham
Slavery &
Vulnerabilities
Communities
Nottingham City
Council

Cuckooing
Research &
Prevention
Network



Preventing &
Disrupting Cuckooing
Victimisation:
Professional
Toolkit



LEARNING FROM BEST PRACTICE NATIONALLY

- **Remember** the person at the centre
- **Gather** the data and scale of what's happening – agree a lead
- **Legal** departments do not sign off closure orders if no assessment of vulnerability and risk of cuckooing
- **Must have** links with the Housing Front Door and DWP

LEARNING FROM BEST PRACTICE NATIONALLY

- **Best processes** have learnt from Domestic abuse services and a public health approach
- **Best practice** does not have thresholds in a conventional way (Rag Rating)

ADAPTING A DOMESTIC ABUSE MODEL

What could you apply?



PROMPTS CUCKOOING



**DO YOUR STAFF KNOW
WHAT TO LOOK FOR?**



**DO THEY KNOW WHAT TO DO IF
THEY HAVE A CONCERN?**



**DO YOU HAVE THE RIGHT
RECORDING MECHANISMS?**



**DO YOU NEED TRAINING TOOLS
OR RESOURCES?**



**DO YOU NEED TO DEVELOP
YOUR POLICY AND PRACTICE?**

NOTTINGHAM SERAC

'It's not either or...

You do not have to choose between safeguarding and cuckooing processes (enforcement) but be clear that the victim is not held responsible '

THE BIG QUESTIONS



How will agencies and multi-agency forums maintain communication and engagement with people who are victims of crime, and also engage in crime, are 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?

THE BIG QUESTIONS



What is the potential for a multiagency strategy/guidance to include cuckooing and closure order process?

THE BIG QUESTIONS



Do we need to remind ourselves of
Making Safeguarding Personal?

THE BIG QUESTIONS



What assumptions might you be making about people you are working with that prevents you from understanding them and hearing their voice?

THE BIG QUESTIONS



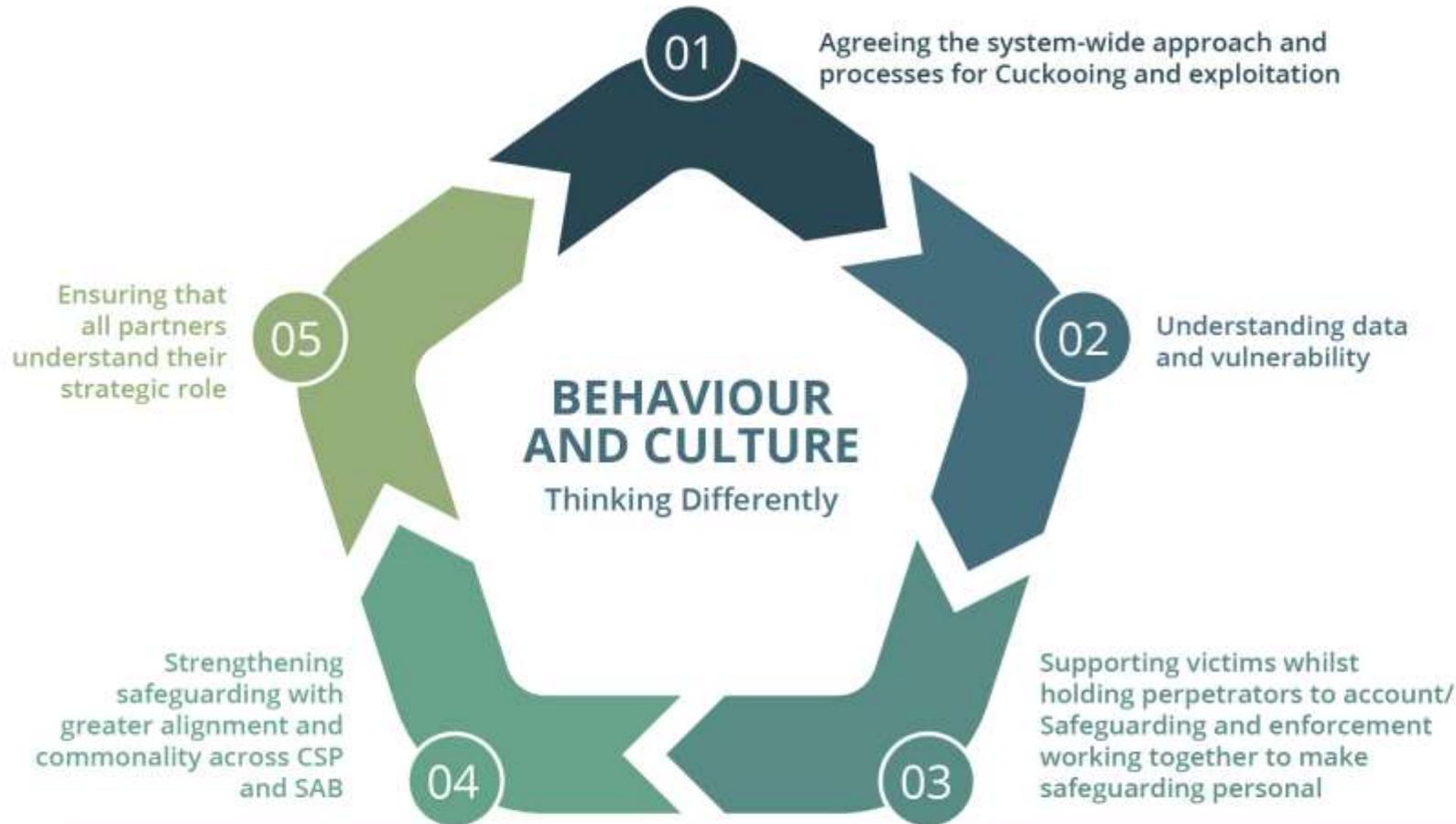
Take time to reflect on 'intersectionality' and how a greater understanding helps to understand how you respond and react to people and how this might make it harder for them to seek help or engage with support.

What if there was a simpler way and everyone worked together to tackle exploitation and cuckooing?



Safeguarding the golden thread

A SYSTEM SAFEGUARDING THE MOST VULNERABLE



Insights from national practice and research combined with learning from the review identify a way forward

Embedding the right behaviour and culture across all partners is central to successful delivery

RECOMMENDATIONS

01

Protocol between Strategic Boards with review of roles and responsibilities, exploring a public health approach

02

Balance between enforcement and safeguarding processes – learning from SERAC

03

Review of data to scope out the people experiencing/at risk of cuckooing

04

Seeking assurance that improvements are working

SYSTEM CHANGE - HEART OF THE ART

This means the real activity that encourages systems change is not analysis, or programme planning or project management. It is a **RELATIONAL ACTIVITY** that asks us to **ENGAGE WIDELY** and **OPENLY**, including with those who trouble us. It asks us to **ENQUIRE** into their **MOTIVE AND MEANS**. It means we must be **READY TO LISTEN** more than to tell, to connect and not to direct, to propagate and not to control.