Camden Safeguarding Adults Partnership Board

Safeguarding Adults Review (Paul)

Report

Author: **Eliot Smith, Independent Reviewer**
Date: **February 2025**

CONTENTS

INTRODUCTION

Background

Safeguarding Adults Reviews and the SAR referral

One of the statutory functions of a Local Safeguarding Adults Board is to arrange Safeguarding Adults Reviews. The aim of the Safeguarding Adults Review is to learn from individual cases to produce evidence-based findings and recommendations which are applicable to the whole system. Mandatory Safeguarding Adults Reviews must take place 'when an adult in its area dies as a result of abuse or neglect and there are concerns about how agencies worked together to safeguard the individual' [1].

On 27/09/2023 the Camden Safeguarding Adults Partnership Board's SAR sub-group recommended that a mandatory Safeguarding Adults Review be arranged in the case of Paul. The case had been referred to the SAR sub-group on 12/09/2023 by Camden Mental Health Adult Social Care due to concerns about cuckooing, exploitation and about the effectiveness of periods of multi-agency interventions and safeguarding in the months preceding the discovery of his body in August 2023. The medical cause of his death is unknown with an open verdict issued following a coroner's inquest.

Individuals referred to in this report have been anonymised through the use of pseudonyms and where necessary identifying information has been disguised or omitted to protect confidentiality.

Information about the case

The case of Paul concerns a white British man in his mid-forties who lived in Camden and who was well-known to mental health services with established mental health conditions of schizophrenia, and records of Post Traumatic Stress Disorder. Paul had co-existing conditions of congenital cerebral palsy, epilepsy, and substance misuse including heroin and cocaine. Paul had a good relationship with mental health services, attending well at a depot clinic where he received a monthly injection of mental health medication and working closely with his social worker whom he had known for over 15 years. Paul was also close to his mother and saw her regularly. At the time of his death a safeguarding process was ongoing in relation to cuckooing concerns.

About the Reviewer

This Safeguarding Adults Review has been led by an Independent Author, Eliot Smith, who is an Independent Health and Social Care Consultant with a background in social work, mental and physical health, and safeguarding. Eliot Smith has worked for both Local Authority and NHS services and has no prior connection to the case, Safeguarding Adults Board, or partner agencies.

METHODOLOGY

Principles

Safeguarding Adults Reviews should be conducted in line with principles set out in paragraph 14.167 of the Care and Support Guidance:

- "There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice
- the approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined
- reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed
- professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith
- families should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively" [1]

Assumptions

The Safeguarding Adults Review methodology is based upon a number of assumptions about the purpose and aims of Reviews, the evidence provided to the Review, and about learning and improvement in safeguarding systems.

- Assumptions about the case: It is assumed that the case provides a fair and representative example of practice.
- Safeguarding Adults Reviews are not a reinvestigation of incidents or performance: the purpose of a Safeguarding Adults Review (SAR) is "not to hold any organisation or individual to account" [1].
- Reliability of documentary evidence: It is assumed that evidence provided to the review was contemporaneously recorded and provides a full, honest, and accurate account of events
- Practitioner's views and opinions: The views and opinions of practitioners are taken as heard, and reflect personal subjective opinions and recollections
- 'People come to work to do a good job': It is assumed that most practitioners who work with people with care and support needs are committed, compassionate, and 'come to work to do a good job'.
- Systems-focused learning: Individual practice in health, social care, and safeguarding is influenced by the system within which people work. Effective learning and improvement take place when Reviews adopt a systems focus and generate findings from individual cases that are applicable across the system.

Themes

Using qualitative research techniques and content analysis emerging themes in the case of Paul can be identified. Figure 1 provides a word cloud representation of the emerging themes at the early stage of analysis. Figure 1 was produced using Qualitative Data Analysis software after documentary evidence was analysed using a qualitative research approach.

Figure 1: Emerging themes in the case of Paul

From themes to case context

The themes identified can provide valuable insights into the case context for the professionals and agencies working with him. Organised using the emerging themes and initial SAR information, the case context is represented in figure 2:

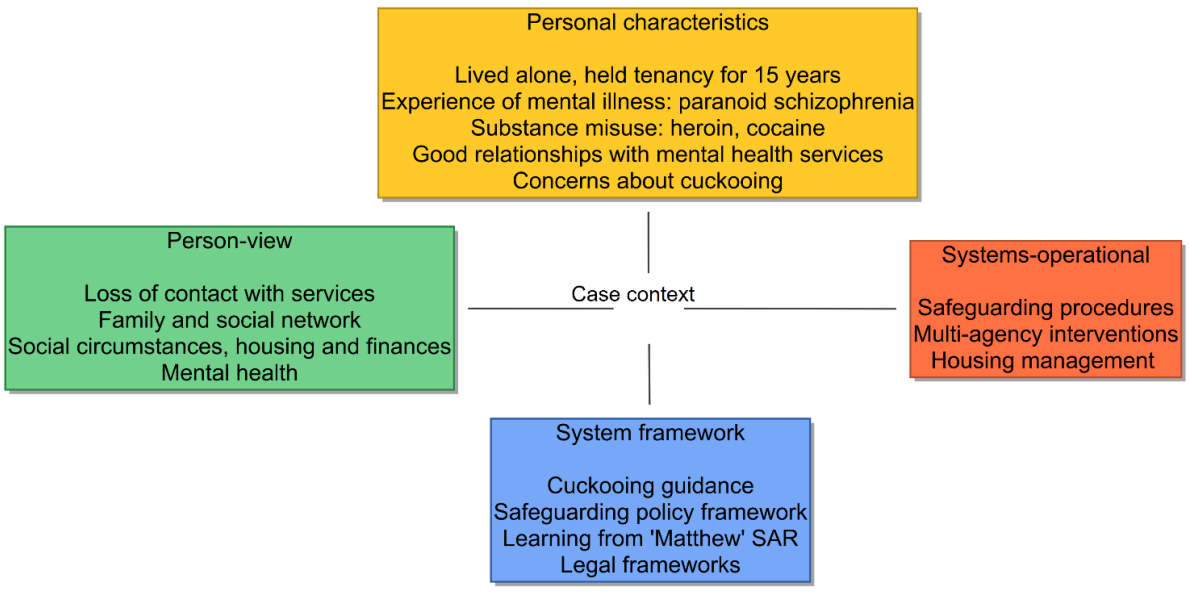

Figure 2: Case context for Paul at early stage of analysis

SAR questions

By linking emerging themes and the case context, it is possible to identify learning about the system in the context of individual experience, operational systems, the wider frameworks that guide policy and practice and learning from previous safeguarding adults reviews, in particular the 'Matthew SAR', which also concerned a case of cuckooing in the Borough which is addressed later in the report. In the case of Paul, the practice context used is as follows:

- Person view: What can we learn about the safeguarding system through Paul's experiences?
- Systems-operational view: Objectively, what was the impact of 6-9 months of safeguarding activity with Paul?
- System frameworks: How well does the system in Camden work in the context of policy, guidance, and legal frameworks?

Terms of reference for Safeguarding Adults Reviews are agreed by Safeguarding Adults Boards for any review they arrange. Terms of reference provide clarity from the outset about what questions the Safeguarding Adults Review is going to address. Specific terms of reference can provide structure to the collection, organisation, and management of evidence gathered for the review. Using the structure of a person-view, system-operational view, and analysis of the system framework, this Safeguarding Adults Review was based upon the following Terms of Reference:

SAR question	**1. Person-view: What can we learn about the safeguarding system through Paul's experience as an adult with co-existing mental health and drug use, exploitation and cuckooing, and vulnerability to others?**
Potential areas of interest	• Mental health / drug use • Experiences, social history • Engagement with services • Mental capacity • Social relationships • Exploitation, cuckooing • Financial circumstances • Accommodation
SAR question	**2. Systems-operational view: Objectively, what was the impact of 6-9 months of safeguarding activity with Paul? How did services respond to concerns and risks in the case of Paul?**
Potential areas of interest	• Safeguarding procedures • Multi-agency intervention • Impact and outcomes • Decision-analysis • Risk assessment • Escalation
SAR question	**3. System frameworks: How well does the system in Camden work in the context of policy, guidance, and legal frameworks, in particular the Camden Cuckooing Guidance (2023) and Matthew Safeguarding Adults Review (2023)**
Potential areas of interest	• Cuckooing Guidance (2023) • Learning from Matthew SAR (2023) • Policy, procedures and local guidance • Legal frameworks

Table 1: SAR Questions

Methods

In order to organise, structure and analyse data collected for this Safeguarding Adults Review the author has used qualitative research tools, including qualitative data analysis (QDA) software, to provide a rigorous approach to learning lessons from Paul's case and to ensure findings are evidence-based and free from hindsight and outcome bias. The Safeguarding Adults Review process involved gathering evidence from organisations and practitioners who worked with or had significant involvement with the Paul. The following agencies provided information, or were invited to contribute to the Review:

- Camden Council Adult Social Care, Community Mental Health Services (integrated with NHS services under a section 75 (NHS Act 2006) agreement
- Camden Council Housing Services
- Camden Council Community Safety Team
- GP Practice
- Police

Documentary evidence
The Safeguarding Adults Review focused on the period from 1 August 2022 to 10 August 2023, when Paul's body was found at his home. This includes a period of time when he was working well with services, before concerns about exploitation and cuckooing were identified, the subsequent safeguarding response, and specific actions leading up to his death when his whereabouts had become unknown.

Practitioner Event
A practitioner event was held on 09/12/2024 to gather the views and opinions of individuals working with the Paul. The event was structured around the specific questions and areas of enquiry set out by the Safeguarding Adults Board.

Family involvement
Paul was close to his mother who offered him support and who in the latter stages of his life acted as a point of contact for him with services. Paul's mother has been contacted in relation to the Safeguarding Adults Review and offered the opportunity to participate. At the time of writing, she has not taken up this opportunity.

Other learning and research
Learning from previous Safeguarding Adults Reviews in Camden, in particular the 'Matthew' SAR, national learning from Reviews, and research was also be used to support the analysis and to generate evidence-based findings.

Safeguarding Adults Review (SAR) Panel
A Review Panel of representatives from organisations and members of the Safeguarding Adults Partnership Board was convened to provide expertise on the design of local safeguarding systems, clinical pathways, and processes, and to support an iterative process of sense-checking the draft overview report for relevance and accuracy.

FINDINGS

This section takes events and examples of practice in the case of Paul and considers them in the context of the wider system. The aim of findings in Safeguarding Adults Reviews is to enable "lessons to be learned from the case and those lessons applied to future cases to prevent similar harm occurring again" [1].

This section applies theoretical frameworks to practice in order to generate findings that can be applied to the safeguarding adults system. Findings are structured around the SAR questions and areas identified for the Review to address. A representation of themes in each area is shown in figure 3:

Figure 3: Representation of themes by SAR question in the case of Paul

Review findings are based upon the case evidence gathered through the Safeguarding Adults Review process, views and opinions shared by practitioners in the case, and are informed by previous Camden Reviews (notably the Matthew SAR), national learning and research.

The case of Paul demonstrates the challenges that safeguarding systems and professionals face when individuals with multiple vulnerabilities are targeted for exploitation, and the limitations of existing frameworks to tackle the issue of exploitation and cuckooing of adults at risk. That an adult such as Paul, who was so well known and well-supported by services could be subject to cuckooing shows just how significant these challenges can be.

SAR question 1: Person-view

What can we learn about the safeguarding system through Paul's experience as an adult with co-existing mental health and drug use, exploitation and cuckooing, and vulnerability to others?

Paul had an established diagnosis of paranoid schizophrenia and a known history of substance misuse. Paul had a history of inpatient psychiatric history, including compulsory admission and treatment under the Mental Health Act 1983, including in the two years before moving to his flat in the community. There is evidence of good practice within mental health services in relation to the consistency of care and treatment, and the quality of relationships formed between mental health staff and Paul and his mother. By the beginning of the period under review Paul had an established pattern of treatment and support that he depended on to maintain community living. Paul had worked with his mental health social worker for over twelve years and regularly attended the depot clinic[1] for an injection of anti-psychotic medication once per month. Paul had held his tenancy, in a flat above a café, for over fifteen years and he was well-known to housing officers and in the local community. Paul also had regular contact with his mother who offered support, and who also provided a useful point of contact for services. Throughout this time there was evidence of Paul's vulnerability which were well-documented, and protective factors which for many years maintained a degree of balance and equilibrium.

Vulnerability factors included:

- **Mental health:** diagnosis of paranoid schizophrenia and history of Post Traumatic Stress Disorder. Paul is reported to have suffered from mental health problems from the age of 21 years old.
- **Physical health:** Diagnoses of cerebral palsy and epilepsy
- **Substance misuse:** known history of drug use, including heroin and cocaine
- **Self-neglect:** evidence of domestic self-neglect including concerns about cleanliness and clutter
- **Employment:** Paul was unemployed and dependent on income and disability related benefits
- **Accommodation:** Paul lived alone in a social housing tenancy
- **Limited social network:** Paul lived alone and had contact with his mother and mental health services

Protective factors included:

- **Treatment:** For many years, Paul was established on treatment for mental illness
- **Relationships (family):** Paul was close to his mother who he saw regularly
- **Relationships (services):** Paul had worked with his Social Worker for over twelve years, and they had developed a positive relationship. Paul attended the depot clinic regularly and had a good rapport with staff
- **Communication:** There is evidence of good communication between staff, and also with Paul and his mother. Later in the review period Paul's mother offered a vital channel of communication

[1] Depot clinics are often part of community mental health services. They are used to administer long-acting antipsychotic medications for individuals with mental health conditions, such as schizophrenia or bipolar disorder, to help with medication adherence.

A vulnerable adult, or an adult at risk?

The language of vulnerability and risk in safeguarding changed following the enactment of the Care Act 2014. The previous definition of a 'vulnerable adult' has been replaced with the concept of an 'adult at risk': "a person aged 18 or over who is in need of care and support (whether or not those needs are being met), who is experiencing or at risk of abuse or neglect, and because of those needs is unable to protect themselves against the abuse or neglect or the risk of it" [2].

This definition, and criteria for a statutory safeguarding enquiry, focuses on the *experience* of the adult (of abuse or neglect) and their *ability* to protect themselves (linked to care and support needs) rather than a concept of inherent vulnerability. In the context of safeguarding decision-making, there is often an emphasis first on assessing an individual's experience of abuse, and then on their ability to protect themselves from it. Statutory guidance, and local policy, also stress the importance of prevention: the safeguarding principle that states that "it is better to take action before harm occurs" [1].

Proactive preventative work on resilience is an important element in good safeguarding practice and should be incorporated into the general support offered to individuals with care and support needs who could be classed as 'adults at risk'. Prevention is about taking action before harm occurs. The London Multi-Agency Safeguarding Policy & Procedures [2] provides an example of visiting staff identifying a 'combination of characteristics', in this case in relation to a fire risk, leading to an intervention: a referral to the fire brigade. While not everyone with a particular combination of characteristics will experience harm, the analysis of risk factors can help services identify who would benefit from preventative work for specific types of abuse, neglect, or self-neglect.

Preventative actions may include community awareness campaigns, training for frontline workers, routine enquiry and targeted support for at risk individuals, education, and a relationship-based approach with adults at risk. Early intervention and open conversations about risk, safeguarding, and where to go for support, may give potential victims the resources and confidence to seek help and potentially avoid harm.

Risk factors for cuckooing and exploitation

Cuckooing is "the practice of taking over a person's home, usually in order to establish a base for criminal activities. It is the term used when a person alleged to be causing harm uses the home of an adult at risk to handle cash proceeds of crime, to store and/or supply drugs, weapons or engage in other criminal activities, and is a form of criminal exploitation. It involves utilising the accommodation as a place to stay and involves safeguarding issues of coercion and control of the person, which may often begin under the guise of befriending" [2].

Cuckooing has been linked to organised crime, county lines, and perpetrators may target multiple or consecutive individuals: when one accommodation or victim-exploitation breaks down, they may move on to the next. Research into the experience of cuckooing has identified a number of common risk factors among victims [3] [4] [5] [6] [7]. Table 2 represents an aggregation of risk factors identified in recent research on cuckooing.

Category	Specific Risk Factors
Victim Vulnerabilities	**Mental health issues:** people with mental health conditions are more likely to be isolated making them easier targets **Substance misuse:** Individuals with drug or alcohol addictions are often targeted. Criminals exploit their need for substances in exchange for the use of their property. **Social isolation:** Those lacking strong social or family networks are at greater risk, as their absence of support makes them easier to control. **Age or disability:** Age, frailty, physical or cognitive impairments increase susceptibility to coercion and exploitation. **Self-neglect:** Studies on exploitation identify that adults who self-neglect are often targeted for exploitation.
Socioeconomic Factors	**Poverty:** Individuals living in financially deprived areas or in low-income households are often targeted due to their limited resources. **Unstable Housing:** People in temporary or insecure housing situations, such as hostels or social housing, are frequently victims. **Unemployment:** Financial vulnerability stemming from unemployment can lead individuals to engage with or succumb to criminal exploitation.
Criminal Networks	**County Lines Drug Operations:** Cuckooing is a tactic used in county lines, where drug networks exploit vulnerable individuals to establish local distribution hubs. **Community Dynamics:** Areas with high levels of gang activity or organised crime see increased rates of cuckooing. **Trust Building and Grooming:** Criminals often befriend vulnerable individuals or provide small financial incentives, which evolve into coercive control.
Lack of Awareness	**Limited Knowledge of risk factors:** Professionals in housing, healthcare, and community support sometimes lack training on recognising the signs of cuckooing. **Under-reporting:** Victims may fear retaliation or feel ashamed, leading to underreporting of incidents. **Fragmented Support Systems:** A lack of coordinated responses from social services, police, and housing providers can leave victims without adequate protection.
Community-Level risk indicators	**Transient Populations:** Areas with high tenant turnover are attractive to criminals as they are harder to monitor. **Urban Deprivation:** Poorly resourced urban areas often serve as hotspots for criminal exploitation. **Rural Isolation:** Rural and semi-rural areas are increasingly targeted due to less visible police presence and community resources.

Table 2: Risk factors for exploitation and cuckooing in the UK

Sources: Spicer (2021); Robinson et al. (2022); Bainbridge & Loughery (2024); Fawell et al. (2024); Neaverson (2024).

Cuckooing, also known as 'forced home invasion' is a tactic used by criminals, typically drug dealers, to take over the homes of vulnerable individuals. Once befriended, vulnerable individuals are subjected to coercion, control, and exploitation. Cuckooing is a multi-faceted issue and there are often significant challenges to overcome to effectively intervene and protect victims who have been befriended, and who may resist actions to extract them from their exploitation or be reluctant to support criminal action against their exploiters. Evidence-based measures and responses to individuals subjected to cuckooing focus on prevention and community education, early intervention, and multi-agency collaboration.

Finding 1: Targeted prevention

Context

Cuckooing is "the practice of taking over a person's home, usually in order to establish a base for criminal activities. It is the term used when a person alleged to be causing harm uses the home of an adult at risk to handle cash proceeds of crime, to store and/or supply drugs, weapons or engage in other criminal activities, and is a form of criminal exploitation. It involves utilising the accommodation as a place to stay and involves safeguarding issues of coercion and control of the person, which may often begin under the guise of befriending" [2]. As with many other forms of abuse and neglect, the risk factors for cuckooing are well known and based in evidence and research.

Rationale

Cuckooing is a multi-faceted issue, and cycles of exploitation can be difficult to break. Prevention is a key principle in effective safeguarding – "it is better to take action before harm occurs" [1]. Preventative interventions may be targeted at individuals deemed to be at risk, or towards communities and may include community awareness campaigns, training for frontline workers, routine enquiry and targeted support for at risk individuals, education, and a relationship-based approach with adults at risk. Prevention and early intervention may give potential victims the resources and confidence to seek help and potentially avoid harm.

Recommendation or questions for the SAB

The Safeguarding Adults Partnership Board and Community Safety Partnership should work together on the provision of preventative actions to support existing Cuckooing Guidance:

- Community awareness campaign
- Training for frontline workers
- Targeted support and routine enquiry

Impact and measurement

Organisational and cross-Board presentations of community awareness material can evidence actions. Training may be provided by agencies, or through organised multi-agency events, evidenced by training materials and compliance data. safeguarding networks could oversee routine enquiry based upon risk factors. Impact may be measured through feedback from participants.

SAR question 2: Systems-operational view

Objectively, what was the impact of 6-9 months of safeguarding activity with Paul? How did services respond to concerns and risks in the case of Paul?

Safeguarding concerns were raised by Paul when he called the police to report a male living in his flat and refusing to leave. Police spoke to neighbours who reported that the male may be dealing drugs or using drugs. A safeguarding concern was raised and within one month a multi-disciplinary team meeting concluded that Paul was experiencing cuckooing.

Expected practice in multi-agency safeguarding

The safeguarding system responded well to initial concerns about cuckooing, taking a multi-agency approach and communicating well as a system. There was evidence of effective communication between mental health, housing officers, community safety and police colleagues. Interventions were discussed in multi-agency meetings and evidence showed a balanced approach to decision-making. Later in the review time period, just nine days before his death Paul was reported as missing. The safeguarding network was used to try to locate him including a joint visit to his home. A decision was made not to force entry. The lack of response from his property was not unusual and Paul had gone missing before. In the context of risks: previous behaviours, risk of rough sleeping, cuckooing, vulnerability, and previous injuries sustained by Paul when attempting to access his flat after locks had been changed, forcing entry was a balanced decision. Had entry been made, Paul may have been located if he had been at home – it is only with hindsight that this appears to have been an opportunity to have prevented his death, it is not knowable whether he was at home on that day, nor was the likelihood of his body being found nine days later knowable to the professionals at the time.

Practical approaches to cuckooing and exploitation

During the time that the case was under safeguarding, professionals attempted to protect Paul from cuckooing including practical solutions to help Paul to regain control of his property. Practical interventions included changing the locks to the communal area and front door, the exploration of alternative accommodation, consideration of a warrant to remove Paul to a place of safety for an assessment for admission to hospital using section 135 (1) (Mental Health Act 1983), and ultimately action to intervene in Paul's occupation of his flat to disrupt the cuckooing and use of his flat for criminal activity using a closure order.

A closure order, issued under section 80 (Anti-social Behaviour, Crime and Policing Act 2014) is used to prevent 'disorderly, offensive, or criminal behaviour being carried out on the premises'. The effect of a closure is to prohibit access to the premises for a period of time no greater than 3 months in the first instance. Closure orders are usually prepared and applied for without the knowledge of the tenant and are often accompanied by an application for a Notice to Seek Possession (an eviction order); tenants usually find out about the closure order on the day it is served and are offered alternative accommodation to avoid street homelessness. Closure orders, due to the impact on the victim of exploitation are considered as a last resort, and only after the case has been heard at a vulnerability panel within the Housing Authority which considers the vulnerability of the tenant and the proportionality of the Closure Order. For this reason, a closure order in the case of Paul was not considered early in his case and he had died before his case was heard at the vulnerability panel.

Autonomy, self-determination, and mental capacity

One area that attracted less discussion in Paul's safeguarding process was that of mental capacity, autonomy, freedom of choice and degree of self-determination. Paul was well-known and in general was believed to have mental capacity to make most decisions in his life. Evidence from the SAR Practitioners Event confirmed that he was assumed to have mental capacity in relation to his tenancy, social relationships, and decisions about his relationship with the primary alleged exploiter; however, there were significant concerns about his experience of duress and undue influence – while having mental capacity Paul was unable to exercise autonomy and freedom of choice due to the influence of his exploiters. The inherent jurisdiction of the High Court was not considered as a legal option. Discussion during the SAR Practitioner Event revealed that while some agencies had an in-depth knowledge of this option, for a number of others this was an unfamiliar concept.

Inherent Jurisdiction

"Inherent jurisdiction is the ability of the High Court to make declarations and orders to protect adults who **have** mental capacity to make relevant decisions, but are vulnerable and at risk from the actions (or sometimes inactions) of other people." [8]. In particular the courts have stated that

> *"the inherent jurisdiction* [of the High Court] *can be exercised in relation to a vulnerable adult who, even if not incapacitated by mental disorder or mental illness, is, or is reasonably believed to be, either (i) under constraint or (ii) subject to coercion or undue influence or (iii) for some other reason deprived of the capacity to make the relevant decision, or disabled from making a free choice, or incapacitated or disabled from giving or expressing a real and genuine consent"*[2]

While to focus remains on protecting an individual who has been deprived of their capacity to make decisions by a third party, the High Court through declarations and powers set out in legislation is also able to grant an injunction (a judicial order compelling a party to refrain from certain acts) or appoint a receiver (s.37(1) Senior Courts Act 1981). Recent cases before the Court of Protection and the Court of Appeal have confirmed that the Court of Protection also has powers to grant injunctive relief[3]. Inherent jurisdiction may have provided an additional legal remedy for Paul had it been considered earlier during safeguarding processes.

Acting against perpetrators / persons alleged to have caused harm

Protective interventions under safeguarding are often focused on the victim, such as increased support and encouragement, advocacy, moving accommodation, or closure orders. There are fewer powers available to use against alleged perpetrators. There are no specific offences against cuckooing, with agencies relying on related offences, typically drugs offences, threats, and violence [9] [10]. One of the challenges for professionals working with Paul was his protection of criminal exploiters that had been able to build his trust, isolating him from professional support. Paul was

[2] Re SA (Vulnerable Adult with capacity: Marriage) [2005] EWHC 2942 (Fam).
[3] SF (Injunctive Relief) [2020] EWCOP19; Re G (Court of Protection: Injunction) [2022] EWCA Civ 1312

reluctant to accept support due to a feeling of obligation towards his exploiters, and a drug debt he wished to clear before he would accept protective interventions.
Research on cuckooing, local cuckooing guidance, and legal guidance from the Crown Prosecution Service suggests a combined legal and safeguarding response to cases of cuckooing including:

- Early intervention and victim support
- Effective multi-agency working
- Protective, victim-focused legal options
- Intelligence-led police operations to disrupt exploiters
- Prosecution of related criminal offences

Agencies in the case of Paul had identified the risk of cuckooing, and had worked well together, but could have considered more legal options earlier in safeguarding processes.

Finding 2: Combined safeguarding approaches

Context
The case of Paul was subject to an active safeguarding enquiry and process for over eight months. During this time there was evidence of effective communication between mental health, housing officers, community safety and police colleagues. Interventions were discussed in multi-agency meetings and evidence showed a balanced approach to decision-making, albeit reserving legal options to the last resort. The safeguarding network appeared to be responsive and effective on a day-to-day basis but may have benefited from considering legal options earlier and seeking advice on all the options available before considering timescales and measuring proportionality.

Rationale
There is often a tendency to avoid legal options until necessary – using legal powers to intervene in an individual's life (victim or perpetrator) invariably engages an individual's human rights. Legal options are often viewed as costly and heavy-handed, however in cases of cuckooing, evidence points towards early intervention and a combined approach of safeguarding powers and legal options including anti-social behaviour legislation, housing legislation, criminal law, mental health and capacity law, and the inherent jurisdiction of the High Court. Given the diverse legal frameworks that maybe needed in cases of cuckooing it is important that appropriate expertise and knowledge is made available to safeguarding networks early in the process.

Recommendation
There is a need to address two areas:

1. Mapping the expertise on legal options in Camden and update the Cuckooing Guidance to include a summary of current criminal and civil legal options available
2. Amend the Camden cuckooing guidance and training to emphasise that exploration of legal options should not be left as a last resort – even if legal action itself should be postponed until proportionate or needed.

Impact and measurement

Mapping of the availability of expertise on legal options may show where there are gaps and the barriers to access to expertise. An audit of safeguarding procedures may identify whether there are delays in accessing legal support.

SAR question 3: System Frameworks

How well does the system in Camden work in the context of policy, guidance, and legal frameworks, in particular the Camden Cuckooing Guidance (2023) and Matthew Safeguarding Adults Review (2023).

This section explores the wider systems frameworks in place to support practice in the context of adults with care and support needs who may be at risk of, or experiencing, cuckooing and exploitation. Cuckooing practice in Camden is informed by a framework of the Pan-London Safeguarding Adults Policy [2] and cuckooing-specific local guidance. Practice is also informed by relevant statutory guidance and research [1, 9] and, to a certain extent defined and limited by the duties and powers contained in the legislative framework. In 2023, the Camden Safeguarding Adults Partnership Board also published a cuckooing-related Safeguarding Adults Review: "Matthew" which contained 13 recommendations, including some amendments and additions to the local Cuckooing Guidance.

Camden Cuckooing Guidance

Camden Safeguarding Adults Partnership Board have published guidance on cuckooing. The current guidance, 'Camden Safeguarding Partnership Adults Board Multi-Agency Cuckooing Guidance[4]' is on its third version and was published on 28/06/2023 alongside a flowchart: 'Responding to Cuckooing concerns', just two months after the publication of the Matthew SAR incorporating some of the changes recommended by the Review. The guidance was due for review in June 2024. The guidance itself contains sections on what cuckooing is, signs to look out for, reasons individuals may not report cuckooing, what to do if you suspect a person is being targeted, and prevention and moving forward. The guidance also contains a list of relevant legislation, and a glossary of terms is attached as an appendix.

Read alongside the pan-London Safeguarding Adults Policy, the guidance provides a useful guide to working with an individual who is at risk of cuckooing and encourages multi-agency working and a referral to the Multi-Agency Safeguarding Hub (MASH) for a decision about whether to initiate a statutory safeguarding enquiry under section 42 (Care Act 2014). The guidance is victim-focused and contains a summary of responses aimed at reducing risk for the individual, making their property secure or seeking alternative accommodation. The guidance makes reference to legal powers and options, however again this is focused on victim-interventions. There is very little, if anything, in the guidance about actions that may be considered against the person(s) alleged to have caused harm.

[4] Version 3 of the guidance, and a cuckooing flowchart can be downloaded from the Board website: https://www.camden.gov.uk/safeguarding-adults#lide

In April 2023 Camden Safeguarding Adults Partnership Board published the Matthew SAR, a review into a 47-year-old white British man whose body was discovered at his flat. It was suspected that "he had suffered abuse as a result of cuckooing which may have contributed to his death and there was concern that partner agencies could have worked more effectively to protect him" [11]. The report sets out a detailed account of how services worked with Matthew (a pseudonym) and contains recommendations for improvement based upon a chronological methodology. Of the thirteen recommendations made in the Matthew SAR three recommendations were about changes to policy or guidance, five focused on assurance or single-agency organisational practices, four concerned temporary accommodation and housing management processes (including the vulnerability panel), and the remaining recommendation concerned training content. All the recommendations focused on actions to protect and reduce risk for the victim, Matthew, and the Review Report does not contain any mention of the person(s) alleged to have caused harm, or any actions taken against them. While there are some similarities between the case of Matthew and that of Paul, some of the practice cited informing the recommendations was not seen in the case of Paul and many of the recommendations do not apply or have been addressed since the publication of the Report.

Combined approaches to cuckooing

Current frameworks for responding to cuckooing suggest a combined approach of safeguarding and legal options that involve supporting the victim and seeking to investigate and prosecute alleged perpetrators for offences related to the threat or harm of the victim, or the criminal activities carried out at their premises. The learning from the case of Paul suggests that the current options that are used in practice available are primarily victim-focused through offering support, protective interventions, or through a closure order forcing a move into temporary accommodation, and displacing anyone else from the premises. The balance of local guidance and legal limitations meant that actions against an alleged (known) perpetrator were not considered.

Finding 3: A perpetrator gap?

Context
Local and national guidance and legal frameworks encourage agencies to be reactive, responding to risk and following a principle of make victims safe, move perpetrators on. As is often the case in situations of exploitation, coercion, and control, victims such as Paul become reluctant to consider or support actions against perpetrators, either out of fear or obligation. For example, in the case of Paul he was reluctant to support action against the alleged perpetrator until he had cleared a drug debt that he owed them.

Rationale
Current guidance and legal options are balanced towards the protection of victims while there remain systemic challenges in tackling perpetrators or people alleged to have caused harm. While the current system is primarily victim-focused, it is important that safeguarding and community safety agencies consider how to address this apparent 'perpetrator gap' and target interventions against those cause harm.

Recommendation

The Cuckooing Guidance is due for review. It is recommended that a new section should be drafted to summarise the options that may be available to target person(s) alleged to have caused harm, including legal and non-legal interventions.

Impact and measurement
The reviewed guidance will contain a new section. Community Safety, crime prevention, and law enforcement colleagues should be consulted to evaluate new content.

Legal Frameworks

Under the current legal framework there is no specific offence of cuckooing [9]. CPS guidance points to a number of related offences, powers, and provisions, however research indicates that there are significant challenges building a case and prosecuting offenders in cuckooing cases. Victims of cuckooing do not always identify as such, having been subject to befriending, manipulation and control. Current offences under related legislation do not specifically address the coercion, control, and exploitation that lie at the heart of cuckooing.

In 2021 the Centre for Social Justice called for a specific offence, suggesting that cuckooing should be brought under the section 1 offences of the Modern Slavery Act (2015) [12]. In 2024 an amendment was made to the Criminal Justice Bill 2023 to introduce a cuckooing offence when a person exercises control over the dwelling of another person for the purpose of enabling the dwelling to be used for the commission of specified offences. Following the dissolution of parliament in May 2024 the Bill lapsed and has made not further progress. There have been no further announcements regarding the reintroduction of the Bill, and it is unclear whether there will be any further progress on a new offence of cuckooing.

In the meantime, to address cuckooing agencies must continue to use related legislative powers to support victims, to address the anti-social behaviour that can result from criminal activity in a premises, and to take action to investigate and prosecute criminal offences [10]. By way of illustration (this is not intended to be an exhaustive list), table 3 highlights the main legislative options applicable to the case of Paul.

Legislation	Description
Social Care	Safeguarding duties and powers, such as s.42 Care Act 2014, the Local Authority duty to make or cause an enquiry to enable it to decide whether any actions should be taken.
Mental Health	Powers under the Mental Health Act, such as s.135(1) MHA 1983, to remove a person to a place of safety for assessment. Enables a Constable to use reasonable force to enter a premises.
Autonomy and freedom of choice	Mental capacity legislation, powers of the High Court including Inherent Jurisdiction
Anti-Social Behaviour	Such as Closure Orders under s.80 Anti-social Behaviour, Crime and Policing Act (2014).

Drugs offences	Offences under Misuse of Drugs Act (1971) relating to the misuse of controlled drugs including those of possession, supply and production.
Violence	Offences such as common assault, threats to kill, wounding, ABH, GBH and others under Offences against the Person Act (1861).

Table 3: Examples of legal frameworks applicable to cuckooing in the case of Paul

The view that a new offence was not needed – that there are existing powers and offences that can be used to tackle the problem of cuckooing – appears to be out of step with the experiences of Paul and Matthew, as described in the Matthew SAR. In both cases the safeguarding network had knowledge of the risk and experience of cuckooing and suspicions about the criminal activity that was taking place in their dwellings. Based upon the experiences and learning in these cases, there remains a gap, and the case for strengthening the law in this area remains as compelling as it has ever been.

Finding 4: The case for a cuckooing offence

Context
Under the current legal framework there is no standalone offence of cuckooing. Instead, to address cuckooing, agencies must use a safeguarding approach combined with related legislative powers to support victims, to address the anti-social behaviour that can result from criminal activity in a premises, and to take action to investigate and prosecute criminal offences [10].

Rationale
Research into cuckooing suggests that there are significant challenges in bringing the exploiters and offenders to justice. Current offences under related legislation do not specifically address the coercion, control, and exploitation that lie at the heart of cuckooing.

Recommendation or questions for the SAB
The case for a standalone offence of cuckooing should be escalated via regional and national Network of Safeguarding Adult Boards Independent Chairs as appropriate, the Safeguarding Adult Board Manager's network, and Community Safety equivalents for escalation and action, e.g. to petition the Government for legal reform.

SUMMARY OF RECOMMENDATIONS

No.	Finding	Rationale	Recommendation or questions for SAB
1.	Targeted prevention	"It is better to take action before harm occurs" [1]. Prevention may be targeted at individuals or communities and may include community awareness campaigns, training for frontline workers, routine enquiry and targeted support for at risk individuals, education, and a relationship-based approach with adults at risk. Prevention and early intervention may give potential victims the resources and confidence to seek help and potentially avoid harm.	The Safeguarding Adults Partnership Board and Community Safety Partnership should work together on the provision of preventative actions to support existing Cuckooing Guidance: • Community awareness campaign • Training for frontline workers • Targeted support and routine enquiry
2.	Combined Safeguarding Approaches	Using legal powers to intervene in an individual's life (victim or perpetrator) engages human rights. Legal options are often viewed as a last resort. However, in cases of cuckooing, evidence points towards early intervention and a combined approach of safeguarding and legislative options including anti-social behaviour legislation, housing legislation, criminal law, mental health and capacity law, and the inherent jurisdiction of the High Court. Given the diverse legal frameworks that maybe needed in cases of cuckooing it is important that appropriate expertise and knowledge is made available to safeguarding networks early in the process.	There is a need to address two areas: 1. Mapping the expertise on legal options in Camden and update the Cuckooing Guidance to include a summary of current criminal and civil legal options available 2. Amend the Camden cuckooing guidance and training to emphasise that exploration of legal options should not be left as a last resort – even if legal action itself should be postponed until proportionate or needed.
3.	A Perpetrator gap?	Current guidance and legal options are balanced towards the protection of victims while there remain systemic challenges in tackling perpetrators or people alleged to have caused harm. While the current system is primarily victim-focused, it is important that safeguarding and community safety agencies consider how to address this apparent 'perpetrator gap' and target interventions against those cause harm.	The Cuckooing Guidance is due for review. It is recommended that a new section should be drafted to summarise the options that may be available to target person(s) alleged to have caused harm, including legal and non-legal interventions.
4.	The case for a cuckooing offence	Research into cuckooing suggests that there are significant challenges in bringing the exploiters and offenders to justice. Current offences under related legislation do not specifically address the coercion, control, and exploitation that lie at the heart of cuckooing.	The case for a standalone offence of cuckooing should be escalated via regional and national Network of Safeguarding Adult Boards Independent Chairs as appropriate, the Safeguarding Adult Board Manager's network, and Community Safety equivalents for escalation and action, e.g. to petition the Government for legal reform.

REFERENCES

1. DHSC, *Care and Support Statutory Guidance (updated 12 August 2024)*. 2024, TSO: London.
2. Board, L.S.A., *London Multi-Agency Safeguarding Policy & Procedures*. 2019.
3. Spicer, J., *An Examination of the Insights and Experiences of Cuckooing Experts*. 2021, University of Huddersfield.
4. Robinson, G., R. McLean, and J.A. Densley, *Becoming Cuckooed: Conceptualising the Relationship Between Disability and County Lines Criminal Exploitation.* Disability & Society, 2022.
5. Bainbridge, L. and A. Loughery, *Understanding and Preventing 'Cuckooing' Victimisation.* 2024.
6. Fawell, L., et al., *How vulnerable are people to victimisation of County Lines drug dealing?* Crime Prevention and Community Safety, 2024. **26**(3): p. 285-300.
7. Neaverson, A., *Understanding Cuckooing: A Qualitative Study of Practitioner Perspectives.* 2024.
8. Ruck-Keene, A., et al., *Guidance Note: Using the Inherent Jurisdiction in relation to Adults*. 2020.
9. CPS, *Legal Guidance, Drug offences: County Lines Offending*. 2022.
10. Spicer, J., *Cuckoo Land: The Cuckooing Risk Environment*. 2024: Taylor & Francis.
11. Mellor, D. and SAPB, *Safeguarding Adult Review Matthew*. 2023.
12. CSJ, *Cuckooing: The case for strengthening the law against slavery in the home*. 2021: London.