# Safeguarding Adults Review
# 'Sally' exploring multiple disadvantage and cuckooing

# Executive Summary

Reviewer: Fiona Bateman
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## Glossary

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| AWP | Avon and Wiltshire Mental Health NHS Partnership |
| GWH | Great Western Hospital NHS Trust |
| ICT | Swindon Council's Initial Contact Team for Adult Social Care |
| IDVA | Independent Domestic Violence Advocate |
| IMR | Individual Management Reviews |
| MARAC | Multi-agency Risk Management Conference (to address high risk domestic abuse) |
| LiFT | Talking therapeutic psychological services provided via GP |
| OCG | Organised Criminal Groups |
| PCLT | Primary care (mental health) liaison team |
| PPN | Public Protection Notification sent by police re safeguarding concerns |
| PTSD | Post Traumatic Stress Disorder |
| SAR | Safeguarding Adults Review |
| SBC | Swindon Borough Council |
| SDASS | Swindon Domestic Abuse Support Service |
| SIMS | Swindon Intensive Management Support (housing service) |
| SIS | Swindon Intensive Support (mental health service) |
| SSP | Swindon Safeguarding Partnership |
| SWAST | South Western Ambulance Service Trust |

# 1. Introduction

1.1. Sally[1] was a white, British woman aged 48 when her body was discovered in her home. The home environment had high levels of clutter and signs of serious self-neglect. For many years prior to her death Sally was known to be at risk by several SSP partner agencies of exploitation, including cuckooing.[2] This report explores, through a SAR in Rapid Time methodology, the social and organisational factors that make it harder or easier for agencies to come together with an adult at risk to keep them safe. The focus is on system findings, to better understand what Sally's experiences can teach us about potential changes and improvements that could strengthen safeguarding system for other people who find themselves in similar circumstances to her.

1.2. On the 24.04.24 the SSP's Practice Review Group recognised this met the mandatory criteria for a Safeguarding Adults Review ['SAR'] under s44 because abuse and neglect were factors in Sally's death and there were opportunities for agencies to improve practice to prevent future deaths.[3] The terms of reference were agreed by the three statutory safeguarding partners on the 11.06.24 and Safeguarding Circle were appointed on the 13.06.24. The review was supported by SSP team and a panel made up of senior leaders from relevant agencies who met on the 25.06.24. The period under review is from January 2022 until February 2024 and the key lines of enquiry the review will explore are:

i. Were agency assessments carried out appropriately; were these shared across agencies and was practice consistent with making safeguarding personal and mental capacity act principles?
ii. How should the Safeguarding Partnership work more effectively with people who have difficulty engaging with statutory support or sit between many services?
iii. How adept is the system at addressing intersectionality of complex trauma, addiction, domestic abuse and exploitation over a significant period of time?
iv. Are practitioners confident to use local and national tools/ best practice briefings to work with people at risk of exploitation, especially cuckooing?

1.3. Sally's family were contacted by the partnership to advise them of this review. One of her adult children spoke with the Reviewer in July 2024 and eloquently spoke of the challenges Sally had faced, her ill health and the abuse that had featured in her life. The paternal grandparents of her younger children also offered to support the review. SSP and the reviewer are extremely grateful for their input, this has enabled a more rounded view of her needs and the complexities of supporting her. There was also a multi-agency discussion in with the practitioners who worked directly with Sally during the review period. The report has also drawn on findings from recent SSP focus groups with practitioners and experts by experience exploring local responses to self-neglect and exploitation.

# 2. Short summary of Sally's experiences

2.1. Sally was socially isolated, she had been adopted as a young child. Her family reported she had been a bubbly, happy child but '*went off the rails'* at around 13. She had her older children when she was 19-22 and they were later removed from her care. Around 2007 she was imprisoned for drug offences and settled in Swindon on release from prison. Her eldest child had limited contact with Sally, but not for the last 6 years. She remains close to Sally's adoptive parents and reports that Sally had been abusive to them, so they also had very little contact. Sally's younger children (from a subsequent relationship) are in the care of their paternal grandparents. Initially, her younger children did have limited contact, but this ended as Sally reportedly found it difficult to maintain due to her ill health.

[1] This is a pseudonym was chosen in consultation with her family to protect her anonymity and out of respect for her surviving children.
[2] This is a form of criminal exploitation when organised criminal groups [OCG] take over the homes of local adults that OCG members have identified as vulnerable. They do this either by coercion or by manipulation (defined locally as fake friends or mate crime). Often this is linked to supply of drugs across county lines.
[3] There were no other outstanding parallel review or criminal proceedings directly relating to Sally. An Inquest into her death is ongoing.

2.2. Sally had several long-term significant health conditions. She was on a wide range of medication and was referred by her GP for specialist pain management support in November 2021. In May 2022 she was referred for Mental Health support and, whilst she had lost contact with the team, reported she had found their input beneficial. Sally had historically misused alcohol and drugs, though was not believed to require ongoing support to address addiction at the time of her death.

2.3. She was known to MARAC in Swindon between 2013-21 as a high-risk domestic abuse victim and low level of perpetrator risk. MARAC discussions as early as 2017 had recognised increased risk as the perpetrator (her ex-partner) was also noted as Sally's carer. Her eldest child reported she had experienced abusive relationships for most of her adult life and that this level of abuse had '*become her normal*.' Police records indicate there were 27 incidents between 2008-21 where she was reported as a victim and, from 2012- 23 a further 23 domestic incidents where her ex-partner made allegations of abuse against her. She had been offered IDVA support through Swindon Domestic Abuse Support Service [SDASS] in 2021, but did not return any calls.

2.4. From 2017 Police records had intelligence she may be experiencing exploitation as her mobility vehicle was being used by her 'carer' to deal drugs. She also reported in 2017 that she was being financially abused by her carer. The following year she reported to police a different carer was assisting her, police noted the carer was known as a violent offender. In 2018, police referred safeguarding concerns to Swindon Borough Council [SBC] due to the level of self-neglect, possibly linked to substance misuse and risks of exploitation. There were further reports that acquaintances had taken her phone (2018 and 2021), taken house keys and refused to return these (2019), had stolen her bank card and withdrawn money without consent (2020) or taken more out than Sally had authorised (2 separate people in 2020). In 2021 police had reliable information that Sally's phone was linked to drug supply chains.

2.5. In March 2022 police arrested two men from her address and made a partial closure order[4] to safeguard her from further exploitation. In addition, they increased patrols in her area and completed several welfare checks at her address, though this support ended at her request.

2.6. In May 2022 her GP referred her to the Primary Care Liaison Service [PCLT], noting she had PTSD from previous domestic abuse and concerned her mental health was worsening. Her GP also asked for medication support from Avon and Wiltshire Mental Health NHS Partnership [AWP] but this referral was closed as Sally reportedly did not respond to an 'opt-in letter' from AWP's Swindon Intensive Service [SIS]. In June 2022 Sally contacted Swindon's Intensive Management Service [SIMS][5] for support to manage personal care, shopping and maintaining her home, she reported 'difficulty with her phone', but agreed with the SIMS worker to speak with the PCLT. In July 2022 she was conveyed to hospital by SWAST for dehydration. She told SWAST she required carers but had been 'overlooked by the council'. Conversely, adult social care practitioners from SBC's Initial Contact Team reported to this review they had made several attempts to contact her to complete assessments, but that she had refused these. They and her GP practice accepted her past experience of social care interventions meant that she was resistant to social care's offer of support. In early December 2022 Virgin media raised concerns to AWP after speaking with her. [6] She subsequently confirmed she was ok, but was admitted to hospital in late December 2022 followings another overdose. Whilst in hospital she was seen by GWH's Mental Health Liaison team who completed a full assessment. She was re-referred to SIS and confirmed she would use crisis line if felt suicidal. The referral to SIS was subsequently closed in January 2023 as she had not responded to letters or phone contacts.

2.7. In March 2023 SWAST ambulance crew attended her home due to abdominal pain and diarrhoea. SWAST crew, concerned about her home circumstances, made fire safety referral.[7] In the same month, the pain consultant reviewed her care (despite her non-attendance) and advised her GP to

[4] This is a civil police power which prohibits anyone but the tenant from using the property.
[5] Service offered by SBC's housing dept for vulnerable tenants. This involves agreeing a plan with the tenant and regular visits to check on progress, but the process also could lead on to enforcement action if tenant remains in breach of tenancy conditions.
[6] Family involved in the review wished to commend Virgin staff. They explained that, following her death, they became aware she was in debt to utility companies and that (unlike the positive approach adopted by Virgin) many had proceeded directly to debt recovery agencies without regard to the distress this may have caused Sally.
[7] This done due to public safety concerns despite her refusal to consent as she was smoking in untidy house and cooking on a portable stove, she stated smoke alarm wasn't working but had refused to allow fire service to provide new one.

reduce her high levels of opioid pain relief. They advised she may experience unpleasant withdrawal, but this wasn't dangerous and that codeine was likely causing constipation and exacerbating symptomatic abdominal pain. Her GP practice also made a re-referral for surgical review as a preventative measure given previous diagnosis of bowel cancer as she had not attended an earlier appointment in 2022.

2.8. In June 2023 she was taken to hospital by police following an assault in her home. She confirmed an associate had made threats to kill and physically assaulted her, had previously stolen her phone and pain medication so she had no way to contact for assistance. Sally reported feeling fearful to return home. The A&E consultant at GWH recorded '*significant safeguarding concerns.. I do not feel the patient is safe to be discharged to her own home'*. Sally agreed for referral to SBC's safeguarding team, the police and Domestic Abuse support services. Unfortunately, the safeguarding concern to SBC was not submitted, though this did not prevent immediate action to reduce risks as the consultant completed a DASH risk assessment, contacted police (101, who agreed to pass Sally's contact details to the officer in charge so they could provide her with any update) and a Domestic Abuse support service (who offered to support Sally with safety planning despite this not strictly falling within their remit as the associate was not in a relative or intimate partner). The consultant also arranged for Sally to be accommodated in a health step-down bed (though medically fit for discharge) and contacted Sally's housing officer and Sally was able to arrange for her locks to be changed. The housing officer also agreed to provide Sally with a new phone. All of this was in line with good multi-agency safeguarding practice.

2.9. In November 2023 SWAST crew were called to Sally's friend's home as they were concerns she was unresponsive. Whilst they found no medical abnormalities, concerned about social issues they agreed to convey Sally home and notified police of her vulnerability to abuse. The crew contacted police, but were advised they would not respond as there had been no crime reported. The police were also contacted later that month by Sally's neighbours who raised concerns they had not seen her for a few days. She was later reported to be safe.

2.10. In December 2023 she was arrested for assaulting her ex-partner. This was graded medium risk with a low DASH score, and in accordance with policy not referred to MARAC. Whilst in custody there were no concerns raised regarding her mental health, but (as she was known to AWP services) arrangements were made for her to meet with Wiltshire's Liaison and Diversion Service. That service subsequently agreed with her to make a referral to the Nelson Trust. A worker from Nelson Trust visited her whilst in custody and she agreed to outreach support at her home. She explained to them that she did not have access to a phone, so they wrote to arrange appointment in January 2024. The Trust arranged to carry out an outreach appointment, but Sally later contacted to rearrange appointment due to ill health. A follow up welfare call was made in early February and repeated voicemails were left.

2.11. In mid-February 2024 Sally called to say she was still feeling poorly and asked for support with food. Nelson Trust completed a Boxes of Hope referral for food parcels to be delivered to her address on a weekly basis for four weeks. On 20.02.24 Nelson Trust visited her property but there was no answer at her door, her phone was off, so they sent a text and made a subsequent welfare call on 26.02.24 which also went to voicemail.

2.12. On the 28.02.24 Police attended Sally's home in response to a welfare concern raised by her housing officer. The officers used s17E powers to force entry and sadly found her deceased. The attending officers and a sergeant completed a thorough search of the property, confirming the door and windows had been locked from the inside and there was no sign of any forced entry (other than the force used by police to complete their welfare check) or any indication of that an assault had taken place. It was therefore reported as a non-suspicious sudden death. The following day Boxes of Hope raised concerns to Nelson Trust as, unlike previous times when they had delivered a food parcel (including the week before), they had not seen her. Nelson Trust attended her home that day to complete a welfare check. Prior to raising a welfare concern with the police, they contacted Great Western Hospital to ask if Sally had been admitted which she hadn't. On contacting the police (via 101) the police call handler reported Sally's housing officer had also raised concerns for her welfare the previous day. Nelson Trust reported to this review that their staff had noted the doors were padlocked from the outside, likely undertaken by police to secure the property the previous day.

## 3. National and local safeguarding adults policy context

3.1. Since 2015, all 'relevant partners'[8] are expected to cooperate with the local authority in the exercise of their safeguarding function to prevent abuse and neglect, recognise, report and respond appropriately when abuse or neglect occurs. Two reviews recently completed by SSP (Kieran, 2021 and Terry, 2020) identified the adults had experienced exploitation in the years preceding their deaths. Too frequently the heightened risks of external coercion were conflated with persistent concerns that the adult wouldn't comply with treatment plans or refused support to address longstanding concerns regarding self-neglect and/or substance misuse. In 2023-4, in response to those reviews, SSP identified a need to tackle strategically all age exploitation and self-neglect. In respect of self-neglect, SSP support unit published guidance, conducted a professional survey and held showcase events. It now has a dedicated webpage collating useful information for practitioners seeking to support adults who self-neglect. In 2022 (during the earlier part of this review period), the support unit developed a practice briefing to support improvements to practice in response to adult exploitation and provided further guidance for professionals on their website.

## 4. Analysis

### KLOE 1: Were agency assessments carried out appropriately; were these shared across agencies and was practice consistent with making safeguarding personal and mental capacity act principles?

4.1. Sally mostly came to the attention of services at periods of crisis and through interventions led by emergency responders (police, SWAST crew, MHLT and GWH's A&E). There is evidence within these incidents that responses were person-centred, practitioners considered Sally's views and sought to empower her to accept help. Formal capacity assessments were not recorded. However in line with expected safeguarding practice, emergency responders usually made follow up referrals, for example, in July 2023 Police also highlighted within their Vulnerability report that she would not be safe unless received support from police and/or partner agencies. The officer did make appropriate onward referrals, but not to SBC's adult social care.

4.2. In addition, there is evidence of good preventative interventions offered by Sally's GP practice staff, AWP's Liaison and Diversion Service, her neighbourhood housing officer and SIMS (housing) team and, in the final stages of her life, by Nelson's Trust and Hope Box staff.

4.3. However, opportunities to respond to direct requests for assistance by Sally did not trigger a 'team around the person' approach. For example, when she asked for additional support for her mental health, her GP practice and the SIMS (housing) team advised her to engage with AWP's SIS or PCLT. Whilst this is within acceptable referral pathways, better use of information held across partner agencies could have enabled a shared preventative plan via the self-neglect protocol with a multi-agency meeting.

4.4. There was not a lead agency identified to coordinate her considerable needs, including when referrals were made to AWP's teams, Housing's SIMS, SBC's ICT or concerns raised through the s42 process. Given the longevity of concerns, reported within MARAC minutes between 2013-21 and repeated unsuccessful attempts to engage Sally with proactive support (including IDVA, social care, SIS and LiFT's psychological support) throughout the review period, a more systematic approach would be to explore patterns in contact to understand if she lacked executive capacity to coordinate her own care and if she could stay safe without additional support. Currently the strategic oversight of the application of the self-neglect protocol is unclear. There is a lack of clarity for frontline practice across the partnership of when concerns should trigger assertive action either through the protocol or s42 processes. There is also no system-wide mechanism for tracking high risk cases where self-neglect is a feature or for SSP to have oversight to gain assurance that multi-agency interventions (outside the s42 process) are timely, person-centred and reduced risks for adults with care and support needs. Recommendations 1 and 3 relates to these findings.

[8] defined by s6(7) Care Act 2014 and including police, NHS bodies, the DWP, prisons and probation services.

## KLOE 2: How should the Safeguarding Partnership work more effectively with people who have difficulty engaging with statutory support or sit between many services?

4.5. A review of Sally's case records provides numerous examples of agencies sharing concerns of her ability to stay safe and of good communication to respond to assaults and health crisis, but not through the s42 safeguarding process. There was some understanding of why she was resistant to social care input, but little exploration of why she failed to attend health appointments or follow up with referrals to services.

4.6. The new models (Live Well and SSP's Welfare and Safety Plans) offer a more systematic approach to understanding how best to communicate with and engage adults with additional needs who are at high-risk (either due to external barriers to accessing support due to coercive domestic abuse or criminal exploitation or lack executive capacity). But for these to have maximum impact, SSP partners will need to consider how to embed communication plans across health, housing, social care and criminal justice agencies and identify how the existence of such plans can be easily identified by practitioners e.g. through the universal care plan. SSP partners will also need to agree how to provide oversight of the effectiveness of communication plans in reducing risk and maximising engagement. Recommendation 2 relates to these findings.

## KLOE 3: How adept are systems in Swindon at addressing intersectionality of complex trauma, addiction, domestic abuse and exploitation over a significant period of time?

4.7. Presently it is difficult to extrapolate the prevalence of multiple disadvantage in Swindon from current data sources. There are no agreed measures currently collected by SSP that would enable strategic planning to decide how best to allocate resources to mitigate additional risks associated with multiple disadvantage or inform wider system reform or service design. Better understanding of the prevalence of multiple disadvantage and more sophisticated impact analysis of service delivery changes should enable reduce duplication and manage demand more efficiently whilst achieving better outcomes for adults at risk.

4.8. There are opportunities for SSP to replicate procedural changes introduced by MARAC (to track action outcomes) across all risk management processes and agree a reporting mechanism so they have strategic oversight of actions progressed, challenges or barriers for operational practice and an impact analysis of outcomes for adults at risk. Recommendations 2 and 3 relates to these findings.

## KLOE 4: Are practitioners confident to use local and national tools/ best practice briefings to work with people at risk of exploitation, especially cuckooing?

4.9. Responses to cuckooing are fragmented, reactive and too heavily focused on criminal or civil sanctions. For Sally this meant that too little regard was given to supporting her longer-term recovery and wellbeing in a trauma-informed way. This increased the risk of re-victimisation and resulted in a deterioration in her health and escalation of her social care needs.

4.10. Whilst SSP's website already provides guidance to support practitioners respond to adult exploitation, this could be further enhanced with a 'making every contact count' briefing specific to cuckooing and developing a risk profile tool which should include opportunities to work across risk management forums, so, for example, if issues are identified within MARAC meetings these can inform the s42 enquiry process. SSP are currently developing an all-age exploitation strategy so are in a strong position to build a strong community of practice in response to cuckooing. This should seek to agree new pathways and monitoring arrangements to support the development of a culture within the partnership of shared ownership of responses that disrupt perpetrators and support victim's recovery. Recommendations 2 and 3 relates to these findings.

## Recommendations

Prior to completing the report, the reviewer met with SSP support unit to better understand how partners were taking forward recommendations and actions to address learning from recently published local

reviews. In light of their current workplan, the reviewer recommended SSP focus on the following recommendations to compliment previous recommendations and further improve responses to cuckooing.

**Recommendation 1**: SSP should review the e-guidance reporting to ensure that concerns can be lodged, even if all the information is not known by the referring agency.

**Recommendation 2**: SSP should formalise reporting by multi-agency panels to capture data regarding the prevalence of multiple disadvantage (including trauma, addiction, domestic abuse and exploitation) and report of outcomes using the MSP measures[9]. This should also include reporting on the use of engagement plans to evidence reasonable adjustments are made by services in line with the public sector equality duty for adults with complex needs. SSP partners could audit closed referrals, particularly where there is professional disagreement or escalation to ensure decision making is consistent with NICE guidance and safeguarding best practice briefings. This will enable partners to provide SSP with assurance of safe systems.

**Recommendation 3**: Partner agencies should work with SSP to develop communities of practice in response to cuckooing. To enable a whole system approach, this should focus on:

- Direct practice: Providing MECC briefings which highlight indicators for frontline practitioners and give details of s42 reporting pathways and local support available (including from voluntary sector agencies). Neighbourhood policing, housing officers, social prescribers and community pharmacists, district nursing and social care triage staff should be targeted for training opportunities including induction training, so the burden does not continue to fall on emergency responders.
- Team around the person: Linked to recommendation 2 and building on the Living Well pilots and Safety and Wellbeing plans, primary and secondary health leads should explore how health inclusion initiatives to address health inequalities could support identification of those at higher risk due to multiple disadvantage and ascertain adults at risk who require communication plans to alert statutory services if they are at imminent risk. All SSP partners should identify increased opportunities for assertive outreach to adults at high-risk of exploitation, but specific focus should be given to capacity within LiFT, SIS and ICT to provide this. SSP partners should also identify champions within their organisation who have support wider dissemination of good practice in response to cuckooing.
- Organisational support: Further clarification within self-neglect and safeguarding adults' policies (both SSP and partners internal policies to ensure consistency) about when concerns should trigger multi-agency consultation and when formal s42 enquiries should be undertaken in respect of cuckooing and/or self-neglect would enable consistent decision making. In addition, the adult MASH should consider hosting a case action tracker and monitor through a monthly panel to review cuckooing s42 enquiries and escalate cases that have not received support to assess capacity, their needs or received support to address psychological or practical support needed to stay safe.[10] Regular membership of that panel should include primary care leads, neighbourhood housing, police and community safety and operational social care representative who are able to commit their agencies to complete necessary actions and provide relevant data/ case information.
- Governance: SSP partners should agree any information sharing protocols that might be necessary to enable the cuckooing panel to operate effectively. SSP should also agree oversight and assurance reporting mechanisms from multi-agency panel processes report regularly to the SSP executive so that strategic leaders can build an understanding of the severity and prevalence of exploitation (especially cuckooing) over time.

[9] This could be easily achieved by recording cuckooing concerns via s42 processes as this already records KPIs required by NHS Digital for the safeguarding adults collection

[10] SSP partners are currently developing a panel process to explore high risk exploitation cases so arrangements to track cuckooing cases and report on short and longer-term outcomes should form part of those discussions.