Bournemouth, Christchurch & Poole
Safeguarding Adults Board
Safeguarding is Everybody's Business

A Safeguarding Adults Review for Edward

Contents

Glossary

1.1	Bournemouth, Christchurch & Poole (BCP) Safeguarding Adults Board. Provides oversight and leadership in adult safeguarding arrangements across the BCP area and oversees and coordinates the effectiveness of the safeguarding work of its member and partner agencies.
1.2	The Care Act 2014. Introduced to set out a framework to improve people's independence and wellbeing. Local authorities must provide or arrange services that help prevent people developing needs for care and support or delay people deteriorating such that they would need ongoing care and support.
1.3	Social Care Institute for Excellence (SCIE). Seeks to improves the lives of people of all ages by co-producing, sharing, and supporting the use of the best available knowledge and evidence about what works in practice.
1.3	SAR Quality Markers – a set of standards covering the whole process from initial decision making about whether a case meets the statutory criteria for a SAR, to evaluating the impact of actions taken in response to the learning identified.
2.5	Individual Management Reports (IMR). A single agency review of the circumstances at the time; and to develop an open critical analysis of both individual practice and organisational policy and practice, to see whether the case indicates that changes can and should be made.
3.8	Community Mental Health Team – provision of specialist assessment and treatment to people aged 18 years and older who are experiencing difficulties with their mental health and wellbeing.
3.8	Mental Health Care Coordinator – a role with specialist mental health knowledge to provide a consistent point of contact to review, support and manage a person's care plan.
3.15	Public Protection Notice – Information sharing notification from Police Forces to other agencies such as Adult Social Care and GP's where there are concerns about a person's wellbeing and safety.
4.1.1	The National County Lines Coordination Centre. A multi-agency team comprising Police Officers, National Crime Agency and Regional Organised Crime Units to develop a national picture of the complexity and threats emanating from illegal drug supply and links to slavery/ exploitation.
4.1.4	County Lines. Where illegal drugs are transported from one area to another, often across police and local authority boundaries (although not exclusively), usually by children or vulnerable people who are coerced into it by gangs. The 'County Line' is the mobile phone line used to take the orders of drugs.
4.1.4	Organised Crime Group. Planned and co-ordinated criminal behaviour, conducted by people, groups or networks working together on a continuing basis.
4.1.7	Community Safety Partnership - A long standing statutory multi-agency partnership established to reduce crime and disorder in their local areas.
4.1.10	Local Government Association – A national body for local authorities
4.2.5	Adult Social Care. In BCP, a joint team of social workers and public health professionals working to support adults who need support in leading safe and independent lives.
4.2.6	S42 Care Act 2014. An adult safeguarding enquiry is to enable the local authority to decide whether any action is required for an adult to support them to live safely and independently.
4.2.28	The National Police Chiefs Council. A coordinating body bringing UK police leaders together to set direction and strategy in policing.
4.6.1	TUPE - Transfer of Undertakings Protection of Employment rights. A law that protects employees, and their benefits, when their employment changes hands

1.0 Introduction

1.1 Bournemouth, Christchurch, and Poole Safeguarding Adults Board (BCPSAB) commissioned a thematic safeguarding adult review (SAR) into the circumstances leading up to the death of Edward who was tragically murdered in January 2022. Edward had been a victim of cuckooing.

1.2 The BCPSAB decided that the circumstances leading up to Edward's death met the statutory requirements for a Safeguarding Adults Review under Section 44 of The Care Act 2014.

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

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

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

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

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

1.5 In January 2024 a 'Local Learning Review' was carried out by BCP Children's Services in respect of the 2 young people who were convicted of murdering Edward. Recommendations from this review were overseen by the Pan-Dorset Safeguarding Children Partnership (PDSCP) until July 2024 when the decision was made to separate PDSCP into two partnerships. From 1 August 2024 oversight of the Local Learning Review was transferred to the newly formed BCP Safeguarding Children Partnership.

1.6 An inquest into Edward's death is yet to be heard by HM Coroner. There are no other outstanding nor ongoing processes surrounding Edward's death, whether that is internal single agency or partnership.

2.0 Review Methodology

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

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

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

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

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

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

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

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

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

2.3 This review has been identified as a **mandatory** SAR. Although not statutorily being provided with care and support as defined under the Care Act 2014, it is recognised through initial analysis of agencies' responses that Edward was a person with needs for care and support; that his death had occurred from abuse or neglect and there was reasonable cause for concern about how the SAB members or other persons with relevant functions worked together to safeguard him.

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

2.5 The documentation from agencies, through Individual Management Reports (IMR's) allowed the lead reviewer and panel members to identify key areas of focus for further analysis, and where learning could be implemented. The IMR's also formed the basis for a number of single agency discussions with the lead reviewer.

2.6 To ensure the review benefitted from the views of practitioners who worked directly with Edward, a practitioners' workshop was held. A final component of the review process was a line managers' event enabling the independent reviewer to triangulate the agencies' responses, practitioners' views with policies, strategies and their expectations. The issues discussed in these workshops are commented in this report.

2.7 The review panel met twice: the first meeting to identify the key lines of enquiry, be the conduit for the lead reviewer to seek further information and to ensure agencies were represented in the various processes of this review. The second panel meeting was held for partner agencies to consider both the narrative of the report, factual accuracy, and recommendations.

2.8 To ensure Edward's voice is heard as part of this review, Edward's father submitted a detailed letter setting out a number of concerns he and Edward's family had around the care given to him. This input also provided a valuable picture of Edward, his interests, character, and difficulties he faced. Edward's family has had the opportunity to comment on this report and recommendations.

2.9 The SAR terms of reference identified 5 areas for analysis.

1. To establish whether there are lessons to be learnt from the circumstances of the case and about the way in which professionals and organisations work together to safeguard adults at risk.
2. To review the effectiveness of procedures (both multi-agency and those of individual organisations).
3. To inform and improve local multi and inter agency practice.
4. To improve practice by acting on learning (developing best practice).
5. To connect the learning from previous Safeguarding Adults Reviews (SARs).

2.10 An important part of the review process was to enable Edward's family to comment on the report. Edward's Father and Aunt provided a detailed response including the following statement:

'Apart from the lack of joined up thinking and planning, it is our belief that the focus was largely put on Edward's drug and alcohol abuse rather than his mental illness. This was a major failing because it largely dictated the treatment he received, which was inappropriate at best and damaging and negligent at worst. Edward had severe Schizophrenia and when this wasn't managed in the appropriate and timely way, it led him to drugs and the downward spiral which eventually led to his murder. If his mental illness had been put to the forefront, we believe the outcome could have been very different.'

2.11 The report presented to the BCPSAB has been amended to reflect Edward's family response.

3.0 Edward

3.1 At the time of his death in January 2022, Edward, a white British man, was 35 years old. Edward had a keen interest in cookery and music. Edward had previously completed a Foundation course in Art and had previously completed and passed a Foundation Degree in 'Popular Music' at a college of the Arts University in Bournemouth. Edward's interest in music started at an early age, he was able to play numerous instruments such as the keyboard and guitar. He produced his own music which featured on BBC radio, with his CD's available online including YouTube.

3.2 In 2016 Edward, through inheritance, bought his own house and was also financially secure. Edward lived in this property until his tragic death. Prior to his murder, Edward worked in a local supermarket. Edward's father advises that he also owned and renovated another property in the Bournemouth area, previously, and during that time had led a very stable lifestyle.

3.3 In 2018 Edward met a woman, who later became his girlfriend and subsequently moved in with him. The relationship did not last long, and she returned to Poland. Edward was generous and an example of this was that he was about to buy his former girlfriend a car, even though she was in Poland and was not intending to return. Fortunately, Edward's father stopped the transaction. Although there is no evidence that Edward's girlfriend was attempting to take advantage of Edward nor was she aware of Edward's intent, this is an example of Edward's generosity, which at times had a detrimental impact on him.

3.4 At the time of Edward moving into his own home, he was financially secure. It is clear that over a short period of time, this fluidity deteriorated. Despite support from his family, Edward did not have the ability to manage such wealth, so much so that the aforementioned gift to an ex-girlfriend was to be paid through finance. An indication of the significant deterioration in Edward's financial circumstances is that at an early stage after receiving his inheritance, Edward bought a new vehicle, valued at around £20,000. In September 2021, Edward's mother informed his GP surgery that he was using foodbanks.

3.5 Prior to Edward being fatally stabbed by two sixteen-year-olds, a number of young people visited his house over a prolonged period of time. There may have been multiple reasons for this. Edward had an enviable music system, he was a young man who lived on his own, he had money, and he was generous. Whatever the reason that attracted young people to Edward's home, it led to a significant decline in his life, contributed to increased drug use, his deteriorating mental health, a chaotic lifestyle, and significant behaviour change.

3.6 Edward's engagement with mental health services goes back to 2007 when he was referred to mental health services in Buckinghamshire. When at university, he became mentally unwell with a diagnosis of a 'psychotic episode.' Unfortunately, this meant Edward was too unwell to complete his course. He was referred to mental health services, specifically the 'Early Intervention in Psychosis Service (EIPS)'. During this period Edward was also diagnosed with schizophrenia. Between 2009 and 2013, when Edward moved back to the Dorset area, he received input from their EIPS.

3.7 As part of Edward's support from Community Mental Health Teams he was allocated a care coordinator (CCO). During this period Edward was prescribed various medications including Amisulpride (an oral antipsychotic used to treat acute psychotic episodes) and Aripiprazole (Intramuscular [IM] or oral antipsychotic used as a maintenance drug, once stabilized from acute episodes). Later Edward was prescribed Risperidone. (IM or oral antipsychotic)

3.8 Edward's CCO was the primary conduit for other agencies in engaging with Edward. However, it was believed the benefit of CMHT services was limited, leading to consideration that Edward might need to be discharged from the CMHT caseload. In 2015, the CMHT believed that Edward's mental state was stable enough to be discharged back to his GP. In 2019, Edward was referred back to CMHT due to non-concordance with medication and a relapse of his mental health.

3.9 Latterly in Edward's life, his increased use of cocaine became a significant worry for his family, and for agencies working with him. The first reference to Edward's use of substances is in November 2019 when it was reported that Edward was smoking cannabis but was planning to stop. This coincided with further support for Edward in helping him to retain his job at a local supermarket. It is unknown whether Edward's use of cannabis and his difficulties at work was connected.

3.10 By December 2020, Edward reported to his CCO that he had been using cocaine for 'the last year'. Between December 2020 and June 2021, Edward self-referred to the substance misuse provider three times. Edward was assessed twice, the first indicating that his use of cocaine was leading to financial difficulties and 'bringing him into contact with bad people'. During this assessment, Edward also stated that he was also smoking cannabis, 2 to 3 days per week. Over the next few months, despite attempts to engage Edward, recovery workers were unable to progress any activity that may have helped him to reduce his cocaine dependency. In March 2021, Edward stated that at that time he felt he could manage his cocaine use himself but would recontact Drug and Alcohol Service 1 if needed.

3.11 In April 2021 Edward made a second self-referral. Edward stated that he was now unemployed, receiving benefits and had stopped using cocaine for about a week. Despite attempts to follow up Edward's contact, including telephone calls and letter, Edward did not respond, and his case was closed a month later.

3.12 Edward made a further self-referral in June 2021, and a second assessment was undertaken. During this assessment, Edward stated that he had stopped using cannabis, and had done so for some time, but was using about a gram per day of cocaine. His aim was complete abstinence from all substances including alcohol. At this time Edward stated that he was also drinking 4 large bottles of alcopops per day. During this referral period, Edward visited Drug and Alcohol Service 1 office and had an initial discussion with staff. However, Edward did not respond to follow up requests. Although Edward was part of the transfer process from Drug and Alcohol Service 1 to Drug and Alcohol Service 2, his case was closed by the latter provider as Edward did not respond to appointment offers.

3.13 Concerns around Edward being exploited through cuckooing first surfaced in December 2020, when during a visit from his CCO, Edward mentioned that 'young men were entering his property and using it as a base for weighing illicit drugs'. This information was passed to the police. The police did not visit Edward to follow up on this information but spoke to him on the phone. This information was shared with the Local Safer Neighbourhood Team. A Public Protection Notice (PPN) was completed which included the following information:

'These young lads have been going to Edward's address and cutting/bag drugs. Edward at first believed them to be his friends but things have since become too much for Edward to handle. One of the boys will knock at Edward's house and then approx. 3-6. others will enter the property. They have trashed his home leaving bottles of alcohol, drugs, cig butts all over the floor. When asked to leave they refuse and will stay there, playing loud music whilst Edward is trying to sleep. Edward has gone to the informant as he is now also in debt to these people because of the drugs. It is believed the suspects attend the property a few times a week.'

3.14 Although Police Officers attempted to physically see Edward, this was unsuccessful. Neighbours are spoken to, and inform police that there had been some incident, but this had now stopped. The police eventually spoke to Edward on the phone who told them that 'he is OK'.

3.15 In March 2021, Police received a call from Adult Social Care (ASC). ASC had followed up on concerns raised with them, and during their visit Edward told them that he is *'still being visited by a group of youths, that yesterday they turned up and he gave them £4,000. Edward stated that this was for a debt he still owed, and he informed us they were his friends. He stated that he is scared to contact Police as he thinks he will be prosecuted...'*

3.16 The Police did visit Edward following this information. Edward told the officer that the *'youths were simply his friends and have not been supplying him with drugs. He denied being in debt for any drugs. He admitted he was still taking cocaine and that he went out to obtain this. I offered him help*

for his drug issues, but he didn't really appear interested. I have told him that I believe he was being cuckooed by the youths and that I intend to make regular visits to check on his welfare.'

3.17 There is sufficient information that Edward was being cuckooed together with some of the thought processes that are common amongst victims of this type of exploitation, including believing those involved to be his friends, and that he was fearful that he would be prosecuted. However, in relation to the both 16-year-olds who killed Edward; although there is information clearly demonstrating that a number of young people were visiting Edward and using his house for drug related activity; it is not believed that there was prior association between Edward and the 2 people responsible for his death. Both received sentences of life imprisonment with minimum terms of 18 years.

4.0 Key learning points.

4.1 A systems understanding of cuckooing.

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

4.1.2 In essence, criminals will primarily use a person's home for drug dealing, but other criminality such as violence, including sexual violence and theft are often associated with this form of adult exploitation. Victims are often subject to threats by perpetrators as a means of control. Vulnerable adults with premises are often exploited repeatedly by different gangs, sometimes within a short period of time. In relation to Edward, and his being a victim of cuckooing, the predominant issue is that it is believed that others were using his house for the purposes of drug dealing.

4.1.3 A common misnomer relating to cuckooing, particularly amongst non-law enforcement partners is that cuckooing is a criminal offence. This became apparent during both practitioner and line managers workshops where partners were not only unaware, but in the words of one participant, 'surprised' that it wasn't. It is important that across the system there is legal literacy around cuckooing as it was the view of these partners that once a referral was made to the police, there was an assumption an investigation would take place with the police taking primacy. When this does not take place, additional support that may well be provided and required by victims from agencies such as substance misuse providers, community mental health teams or GP's may well not be considered, and valuable information missed or not shared. Non law enforcement partners may not ask the questions of victims such as Edward to gain that current understanding of the risks of harm they are facing.

4.1.4 A further issue that has the potential to impact on assessing risk and responding to cuckooing is that the primary focus, particularly in national guidance and literature is around 'county lines' and 'organised crime groups.' There are different forms of 'cuckooing', where perpetrators can be linked to organised crime groups, through to local drug dealers/networks and also associates (often described as 'mate crime'). An understanding of the type of cuckooing taking place, the relationship between the victim and perpetrator(s) and the specific heightened risk factors relevant to the victim is fundamental in how agencies can safeguard adults being exploited or at risk of being exploited through this form of adult exploitation.

4.1.5 The Jay review of criminally exploited children, 'Shattered lives, stolen futures' *https://www.actionforchildren.org.uk/our-work-and-impact/policy-work-campaigns-and-research/policy-reports/the-jay-review-of-criminally-exploited-children/* identifies this wide spectrum of criminality associated with the exploitation of children *'from local street gangs dealing drugs on a 'postcode' model, to serious organised crime groups (OCGs) operating across national borders.'*

'We agree entirely with the conclusion of this statement and would add that the lack of involvement of serious organised crime does not make the exploitation any less serious for the child. Regardless of the structures within which exploitation occurs, our concern is responding to the harm to the child. However, any unified approach to tackling exploitation must include a shared understanding of its

perpetrators and operating models, in order to deploy resources effectively in predicting, identifying and disrupting their activity.' (pg.8)

4.1.6 Replace the word child with 'adult at risk' or 'vulnerable adult', and the principles of understanding the relationship between victims and perpetrators and the different operating models is equally important in the safeguarding adult environment in responding to harm caused through exploitation.

4.1.7 One of Safer BCP Partnership's, (the local statutory Community Safety Partnership), 4 key priorities is:

Keeping young people and adults-at-risk safe from exploitation, including online risks.

4.1.8 Key actions to deliver on this strategic priority includes.

- *driving improved identification of potential victims and provide enhanced levels of immediate and sustained support.*
- *identifying and taking enforcement action against those who exploit vulnerable residents.*
- *equipping the community to recognise and report exploitation and to know how to minimise risks. (https://www.saferbcp.co.uk/Resources/Documents/BCP-CSP-Strategy.pdf)*

4.1.9 The practitioner workshops in relation to this review identified that although there is consistency of safeguarding training across agencies, this did not extend to adult exploitation or cuckooing. There were pockets of practice identified within specific agencies which includes exploitation. Drug and Alcohol Service 1 use 'facts sheets', recognising the signs of cuckooing and what measures can be taken by partners. There are also small packages of training for GP's (dependent on their role).

4.1.10 The Local Government Association guide on Modern Slavery highlights the importance of professionals within a system in both understanding the risks of cuckooing and how the 'signs of cuckooing' are identified:

'It is important that relevant professionals (primarily in councils, housing associations and the police), the public and potential victims understand the risks of cuckooing and can recognise the indicators.' https://www.local.gov.uk/publications/council-guide-tackling-modern-slavery

4.1.11 A comment in one agency's response does indicate a need for further awareness and understanding of cuckooing work to be done across BCP:

'It became evident that though Edward was at risk of exploitation by drug dealers, the situation did not fit the criteria for cuckooing as his home was not being used as a base to sell drugs from.'

4.1.12 A number of agency responses included a narrative that when speaking to Edward, he stated that the cuckooing had stopped, or the people concerned 'were his friends'. Many victims of cuckooing, particularly those who are being exploited by associates whom they believe are friends do not recognise that they are victims. Victims can also feel embarrassed at what is happening to them and may want to downplay their experience. It appears that a number of agencies took Edward's comments about the cuckooing stopping at 'face value.'

4.1.13 If the BCP SAB is to improve its response to victims of cuckooing which includes identification of potential victims, and a multi-agency response to the differing relationships between victims and perpetrators, it is proposed that an awareness package is developed to enable a consistent understanding of cuckooing which clearly sets out the different relationships between victims and perpetrators and referral processes.

4.1.14 In line with guidance to SABs in working with other strategic bodies such as CSPs to coordinate the oversight of policies, procedures and practice for safeguarding arrangements, the learning from this review around an absence of shared understanding of cuckooing and different relationships between victims and perpetrators, and not solely the 'county lines' form of cuckooing should be shared with Safer BCP Partnership. This will enable a partnership approach to improving understanding of cuckooing, in an effort for victims of cuckooing across Bournemouth, Christchurch and Poole to be identified as victims, receive timely risk assessments and support.

Recommendation 1a – The BCPSAB works with Safer BCP to develop a briefing/awareness package to improve a shared understanding of cuckooing across agencies within Bournemouth, Christchurch and Poole. This briefing package to highlight how the different relationships between victims and perpetrators require different responses, how to identify the 'signs of cuckooing' & heightened risk factors, and referral mechanisms.

Recommendation 1b – Within its Multi Agency Risk Management policy, The BCPSAB works with the Safer BCP Partnership to develop an exploitation pathway that is tailored to support adults who are being harmed or at risk of being harmed through exploitation, including cuckooing.

4.1.15 Although this recommendation directly relates to the BCPSAB as the commissioning Board for this review, given the close links with Dorset Safeguarding Board and a number of agencies, it is suggested that the learning from this element of the review is shared with Dorset SAB.

4.2 A multi-agency approach to assessing risk of cuckooing with a timely and effective response.

4.2.1 Paras 3.15 to 3.19 outline a chronology of information that was known about the exploitation of Edward.

4.2.2 In relation to the multi-agency system in identifying victims of cuckooing and responding to those risks, this review identified 3 key issues.

(i) The sharing of safeguarding information between the police and GPs
(ii) The effectiveness of the MARM.
(iii) How the criminal justice system can contribute to the safeguarding of victims.

4.2.3 Public Protection Notices (PPNs) - To enable a timely assessment of risk and response to safeguard victims, early sharing of information is fundamental. Although the early information of concerns around Edward being exploited was shared, this review identified a significant flaw in the information sharing of Public Protection Notices from the Police to Edward's GP.

(PPNs) are information sharing documents which the police will share with other agencies around safeguarding concerns about an adult or child. The PPN should form the basis of formulating a multi-agency response to that concern or providing vital information to a single service that can consider if further or different support is required.

Due to the number of agencies that may be providing a service to an adult, these notices are commonly shared with Adult Social Care and GP practices, the 2 primary services that would have an overview of a person's medical and social background, with onward communication to other specialist teams as required. Of note in relation to Edward, is that Dorset Police shared these notices to the local community mental health team which is seen as good practice.

4.2.4 The initial PPN sent on the 28 January 2021 resulted in Adult Social Care (ASC) instigating a prompt Section 42.2 Safeguarding Enquiry and further information was passed to the CMHT.

4.2.5 Significantly, the PPN's that were forwarded to Edward's GP Practice were not received by them. Given the importance of the role of the GP in coordinating care and 'front door' to other specialists, information from PPN's can inform GPs in ensuring all that can be done to support their patients can be put in place and would enable their front desk staff to adapt their response accordingly. This is particularly important if information is only being shared with GPs.

4.2.6 Early analysis by Dorset Police and Edward's GP practice identified that email addresses were not updated, and immediate action has been undertaken to resolve this issue as a direct result of the learning from this review.

Recommendation 2 – The BCPSAB seeks assurance from NHS Dorset that the information sharing process between Dorset Police and GP Practices is robust and accommodates any future changes to referral pathways.

Given this issue was identified during the first panel meeting in April 2024, it is further recommended that an update is given to the BCPSAB at the earliest opportunity.

4.2.7 In March 2024, the BCPSAB published a SAR into the death of Billy. A key section of this review including the effectiveness of multi-agency meetings across the Bournemouth, Christchurch, and Poole
https://www.bcpsafeguardingadultsboard.com/uploads/7/4/8/9/74891967/bcpsar_billy_051023.pdf

Billy died in early July 2021, some 6 months before Edward, therefore there is some concurrency in timelines in relation to concerns around the effectiveness of multi-agency risk management meetings (MARMs)

4.2.8 The fundamental basis for a MARM is the coming together of practitioners and services to share information, assess risk and develop a management plan in an effort to support an individual or reduce risk or potential risk.

4.2.9 Comments from SAR Billy that relate to MARMs:

'…not all the services involved with meeting Billy's complex and interacting needs were present in these meetings.'

'Throughout the period under review not a single multi-agency (risk management) meeting was held.'

'There was no coordinated plan to provide wrap-around health care, accommodation and social care.'

'A whole system conversation about the types of multi-agency meetings and panels that would offer useful pathways for practitioners and operational managers would appear to be a useful way forward.'

This led to a recommendation that:

'BCP SAB should consider how to further embed in practice the use of multi-agency risk management meetings.' (Recommendation 3)

4.2.10 The issues identified in Billy's review chimed with a number of findings in Edward's review.

4.2.11 Given the early concerns around Edward being cuckooed, first in January 2021, and again in March 2021. the first indication that a MARM was considered was in May 2021 and arranged for the 29 June 2021. This meeting was cancelled either through lack of quoracy of representatives or the unavailability of IT systems. The first MARM meeting was held on the 8 October 2021, some 10 months after the first concern around cuckooing.

4.2.12 On 8 April 2021, a safeguarding enquiry planning meeting was held. This was a meeting held between representatives from Adult Social Care and the CMHT. Edward was invited but did not attend. Although this meeting discussed the cuckooing concerns, there is no evidence that this was followed up with the police nor was there any clear management plan developed. Soon after this meeting Edward's case was closed within ASC.

4.2.13 As with Billy, there was no coordinated and formulated 'wrap around' plan involving all the agencies that were directly involved with Edward to support him.

4.2.14 Although Edward's GP Practice was invited to the MARM meeting, the outcomes of the October 2021 meeting were not shared with Edward's GP, nor with any other agencies.

4.2.15 Joint MARM guidance was written in 2018 for Dorset & BCP Safeguarding Adult Boards.

4.2.16 An audit of practice was undertaken in 2020 which led to a recommendation that there was a need to strengthen the guidance to ensure it promoted consistency across organisations and improve practice.

4.2.17 MARM Guidance and MARM Summary Guidance was updated in 2021, and a series of training initiatives developed in 2024 such as MARM awareness videos, multi-agency training sessions and a MARM 7-minute learning briefing.

The decision to hold a MARM meeting should be considered by any agency working with or with knowledge of people experiencing a high or unmanageable level of risk because of circumstances which create the risk of harm to themselves or others…..Factors placing the person at a higher risk of abuse or neglect, including mate crime, network abuse or other factors which could lead to harm or exploitation. (BCP MARM guidance, pg.3/4)

4.2.18 Although this review identifies that awareness of MARM is improving and that all participants recognised any person/ agency could convene a MARM, the following comments during the review indicate further work is required to ensure a fuller understanding of the varying safeguarding meetings currently being used across the partnership.

*'Number of (safeguarding) meetings can be confusing.' (*This comment was made during a discussion around the different types of meetings that can be arranged in relation to safeguarding e.g. a section 42 enquiry, MARM, multi-disciplinary team or safeguarding enquiry meetings.)

'Needs to be more focused and proportionate to outcomes.'

'Other meetings such as multi-disciplinary team, and best interest are more well known and embedded, and more commonly used.'

4.2.19 There was a view that where all the relevant agencies are represented in a MARM with all the relevant information being shared, they do achieve the desired outcomes.

However, capacity of some agencies to fulfil the 'lead agency' requirements and whether attendance is required for all meetings was raised by some agencies.

'Lead Agency - It is expected that the agency which is working most closely with the person, or the person who has made the MARM referral, will be the one which convenes the meeting and leads the process. Unless agreed otherwise, the decision to convene a meeting will also mean responsibility for hosting and facilitating it. The agency which has chaired the meeting will be responsible for making sure there is a key point of contact appointed for communication between the organisations and the person at the centre of the MARM.' (pg.5, Dorset and BCP SAB' MARM guidance)

4.2.20 GPs in particular voiced their concerns around their capacity to undertake their 'lead agency' commitments, particularly when MARMs are arranged at short notice. Another challenge raised by some agencies related to attendance and questioned the outlay of resource to achieved outcome. A final concern surrounded sharing the outcomes of MARM meetings to agencies that are involved with the person concerned but were not invited to it or did not attend. For Edward, his GP practice and other agencies supporting Edward did not receive the outcomes of the MARM meeting in October 2021.

4.2.21 Given that the principle of the MARM is that it is a community-based process, and that all agencies have a responsibility to identify, convene, administer and lead; the focus on developing the MARM has been on raising awareness across the partnership, so that all agencies can fully contribute to this valuable mechanism to safeguard. Due to the training and awareness work from both the SAB and agencies, there is evidence from both the line manager and practitioner workshops that there is an improving level of awareness and confidence in convening MARMs. In addition, Dorset Police

has introduced a MARM coordinator within its Safeguarding Hub as a direct result of its own learning from Edward's death.

4.2.22 Although the MARM is not a statutory process, there is clear evidence that such fora are a key component in the safeguarding of adults at risk such as Edward. Therefore, it is recommended that further work is undertaken to understand the ongoing concerns raised in this review around how all agencies can be supported to contribute as best they can to the current Dorset & BCP SABs MARM guidance.

Recommendation 3 – It is recommended that the BCPSAB initiates a discussion with its partner agencies to fully understand what is working well with the MARM and the challenges they face in fulfilling their requirements within the current BCP MARM guidelines. Following this work, if required, the current MARM guidance is reviewed to identify if any changes are necessary.

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

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

4.2.25 Specifically, there are three areas where Police Forces can improve on this area:

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

https://www.npcc.police.uk/SysSiteAssets/media/downloads/publications/publications-log/2019/national-vulnerability-action-plan-2020-2022.pdf

Recommendation 4 - The BCPSAB, in the light of the NPCC Vulnerability Action Plan, seeks assurance from Dorset Police that there is an effective investigative response to crimes perpetrated against victims of cuckooing from first report through to subsequent investigation? Are they viewed as single occurrence low level crimes with limited investigation and supervision or are they seen as a course of conduct which increases the risk and harm caused to a vulnerable person? How are Dorset Police taking the responsibility of investigation away from vulnerable victims to using more 'evidence led' prosecutions?

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

the country. Dorset Police has a local intelligence/ occurrence process within their 'NICHE' system. This allows suspected cuckooing incidents to be allocated to their Safer Neighbourhood Teams. This should not only enable identification of victims but also tasking and supervision. Although this process did record Edward as a potential victim of cuckooing, both the activity and supervision could have been more robust.

4.2.27 Nottingham City Community Safety Partnership holds a database which breaks down the number of slavery and exploitation incidents including cuckooing. Cuckooing is the second most prevalent exploitation type to financial exploitation, highlighting the need for partnerships to more clearly understand the harm caused to people.

4.2.28 In its endeavours to develop its Community Safety Partnership delivery model, Safer BCP Partnership recognises the need to improve its understanding of victims and those harming them

We know we need to improve data and intelligence sharing, including our ability to identify those who are at risk of victimisation and those who pose a risk to others, the community, and to themselves. This is key to us understanding and being able to define our problems, and our strategic groups will develop an Information Governance Network to lead this important work. The groups will work to ensure that services are addressing the root causes of the problems with effective interventions. (pg.11 BCP Community Safety Strategy 2022-2025)

Recommendation 5 - The Safer BCP Partnership may wish to consider the data collection model used in Nottingham to improve their understanding of the prevalence of the different types of exploitation, including cuckooing across Bournemouth, Christchurch and Poole.

4.3 Recognising and responding to trauma as a result of exploitation.

4.3.1 Dorset Police recognises that its response to the early information provided to them from partners about Edward being a victim of cuckooing was not of a standard they would expect. Edward should have been visited personally following the initial information and there should have been follow up visits. Although an officer stated that he believed Edward was a victim of cuckooing, there was no follow up. As such there was no assessment of Edward's risk of being a victim or other criminality that may have occurred in his home.

4.3.2 In March 2021, Edward was visited by a police officer, following information from ASC that Edward owed £4000 to some 'local youths'. Of note, part of that information passed to the police was that…

'*He is scared to contact Police as he thinks he will be prosecuted Edward was reassured that this is not the case.' (ASC)*

Edward denied that he was in debt and said that the people involved were his friends. The officer did offer support of signposting Edward to drug support services. Edward was warned that he was in breach of covid lockdown regulations. Despite the reason for the visit, knowledge about Edward being scared to engage with the police, and Edward's admission about his drug use; no PPN was submitted, meaning vital information was not shared amongst partners including his GP and CCO.

4.3.3 It is not believed that the police failure to act on the information is a systemic issue. Those involved are no longer with Dorset Police and there have been a number of initiatives introduced since Edward's death. A Multi Agency Risk Management coordinator is now employed by the Police as a direct result of their learning from Edward's death, a new Climate Team, made up of neighbourhood enforcement staff pay regular visits to vulnerable people's homes. Edward's home would have been identified as one for this team, and there is a significant piece of work ongoing around the process of how Public Protection Notices are shared with GP's.

4.3.4 However, from that point in time, the focus from the police was primarily on Edward's dangerous driving and the risk of harming himself or others through his driving, including driving under the

influence of drugs. Edward became a subject of a dedicated roads policing initiative. Edward surrendering his licence and his vehicle being seized by the police.

4.3.5 From June 2021 there is a clear picture of a person whose life is in a downward spiral and in need of support:

- 14 April, during a review by Edward's consultant psychiatrist, Edward was deemed to be at low risk of harming himself, but to be vulnerable to others.
- 20 June, Edward was arrested by the Police for driving under the influence of drugs.
- 24 June, the CCO visited Edward and noted *'a deterioration of his mental state as he presented as losing the trail of his thoughts and with some paranoid thoughts, although he did not seem to be floridly psychotic. There was evidence of self-neglect and of his living environment declining further.'*
- 29 June, Police Officers are called to Edward's address following a psychotic episode and that he 'felt he was going to hurt someone'.
- 2 July, Edward was stopped by the Police driving his vehicle. The police officer reported that Edward was *'dishevelled in appearance with unkempt hair and beard and wearing urine, food and sweat stained clothing. Edward spoke in a slow, slurred way and admitted to having drunk alcohol prior to driving.'* (Police IMR)
- 7 July, Edward was again stopped by the police and again the initial drug test was positive. Whilst in custody, Edward revealed to the custody sergeant of an *'out of control cocaine habit'*
- 22 July, Edward surrendered his driving licence.

4.3.6 Despite the initial lack of safeguarding action taken by the Police when cuckooing concerns were raised, the Roads Policing Officers did submit Police Protection Notices (PPNs) for each of the events they were involved in above.

4.3.7 This decline in Edward's life was so significant that in December 2021 due to the condition of his property including sighting of vermin by neighbours, the Local Authority cleared and cleaned the property.

4.3.8 From June 2021, despite those cuckooing concerns the primary focus of a multi-agency approach is on Edward's increasing dependency on cocaine which is affecting his behaviour.

4.3.9 On 7 October 2021, a MARM in relation to Edward took place.
*'At the meeting, the CMHT, Social Services, and the police were present. The outcome of this meeting was that Edward's issue was his drug use and associated risks. He retained capacity (*presumed mental capacity*). He needed to engage with addiction services but was not doing so. The benefit of CMHT input was felt to be very limited. He was not taking his prescribed medication. The suggested plan was that if he continued to not engage, he might need to be discharged from the CMHT case load.*'

4.3.10 From June 2021, there is no evidence in the agencies' responses that any consideration was being given to the traumatic impact on Edward as a consequence of being exploited. The primary focus appears to be on his increasing dependency on cocaine, and how this was affecting his behaviour. The harm that Edward was experiencing as a victim, and later through his driving behaviour was not explored through a multi-agency approach.

4.3.11 This is summed up by one agency in their IMR:

'There appeared to be a reliance on Edward's ability to protect himself, rather than what the risks were and how they were to be reduced.'

4.3.12 As early as March 2021, a change in Edward's demeanour was apparent when it was noted that Edward had

'…*an "edge" to him and that he had been blunt which was out of character and historically this had indicated that an episode is forthcoming.'*

4.3.13 In the practitioners' event, there was discussion about Edward's ability to make unwise decisions, and that Edward demonstrated on a number of occasions that he recognised the risks he was

facing. However, there was evidence that Edward was demonstrating signs of being exploited. He believed those exploiting him were his friends, his character was changing, he was becoming unkempt, and his house cleanliness deteriorated significantly. He had informed one person that he was afraid to speak to the police.

4.3.14 There were pockets of evidence that single people were doing what they thought was best for Edward, but in totality there was an absence of joined-up consideration on how Edward being exploited was contributing to this decline.

4.3.15 One person in the line managers' workshop stated:

'Edward was trapped in a set of circumstances that led to certain behaviour.'

4.3.16 In addition to the practitioners' event, there were a number of references in agencies' responses that Edward had the mental capacity to make his own decisions.

4.3.17 The Mental Capacity Act 2005 provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves.

4.3.18 A common challenge in assessing capacity is when people make decisions that can be seen as unwise. One of the 5 statutory principles within the Act is

'A person is not to be treated as unable to make a decision merely because he makes an unwise decision.' (Principle 3)

4.3.19 The Act highlights that it is important to acknowledge the difference between:

'… unwise decisions, which the person has the right to make and

decisions based on a lack of understanding of risks or inability to weigh up the information about a decision.'

4.3.20 There is clear evidence that Edward, in his discussions with those working with him, understood and rationalised his decisions to use drugs such as cocaine. On one occasion he informed the worker that cocaine 'helped his mental health'. Edward understood the consequences of his decision to use drugs.

4.3.21 It is also important to note that just because Edward had a particular mental health diagnosis or condition, this does not directly lead to a conclusion that he did not have capacity.

4.3.22 Although there were a number of references to Edward having capacity to make his own decisions, there was no apparent consideration about his decisions to use drugs and the exploitative situation he found himself in.

4.3.23 The MCA specifically identifies risk of exploitation as an area for further exploration:

'*There may be cause for concern if somebody repeatedly makes unwise decisions that put them at risk of harm or exploitation. This does not necessarily mean that somebody lacks capacity, but there might be need for further investigation, taking into account the person's past decisions and choices.' (MCA para 2.11)*

4.3.24 Whilst Edward understood and recognised foreseeable risks in using drugs, the issue of presuming capacity and not considering the wider duty of care was also a learning theme in a Domestic Homicide Review commissioned by the Safer BCP Partnership in 2017.

'No agency explored Holly's wishes, choices, and decision-making in situations of significant and growing risk. While the presumption of capacity was followed without question the wider duty of care to Holly was not considered.' (DHR into the Death of Holly, 2017)

4.3.25 In its briefing on 'Mental capacity, alcohol and other drug use: Information for social workers', the British Association of Social Workers highlighted the need for a joined-up approach across the system to enable capacity issues to be considered, not just from a medical perspective but a holistic approach.

'Working with and through the complexities of understanding the functions, nature and consequences of someone else's alcohol and drug use and its relationship with any capacity considerations takes time. It will further require liaison and co-working with a range of other professionals.

4.3.26 In 2022, Bath & North East Somerset Community Safety and Safeguarding Partnership published a Safeguarding Adult Review report into the death of Levi Swaby. https://bcssp.org.uk/assets/7a7eb990/safeguarding_adult_review_ls_vf.pdf

There are clear similarities in both Levi's and Edward's lifestyle and challenges. Levi had similar mental health issues to Edward, he misused substances, his lifestyle was described 'chaotic and messy.

4.3.27 In Levi's case, the author highlighted:

'*Critically, the linkage between mental capacity (executive capacity and compulsive behaviours), Levi's self-neglect, his use of street drugs, his cyclical pattern of compliance/ non-compliance with his medication, and the possible "cuckooing" of his flat was not made.'*

4.3.28 Given the significant decline in Edward's life including with his mental health and a perceived change in character, the cancelled MARM in June 2021 was a missed opportunity for partners to come together to discuss the emerging changes in Edward's life, (including the harm caused to him and the impact on his mental health) and to develop a multi-agency plan to support him. The MARM that took place in October 2021 did not address the impact on his life through being exploited, nor the connecting issues of mental health, substance misuse, self-neglect and noncompliance with medication.

4.3.28 Mental Capacity, including assessing capacity, forms part of the MARM guidance along with as assessment of executive functioning, where a person can manage any risks and safety implications of the choice or decision being made. This part of the guidance also recognises risks and dangers a person may face:

'The issue of an individual's capacity to understand the risks and dangers they may be faced with will, in certain cases, mean thinking about whether the Mental Capacity Act 2005 applies.' (pg.8)

4.3.29 Mental Capacity is also included as an appendix (Appendix 16) in the BCPSAP Safeguarding Adults Procedures. Although the general principles of the MCA are included as part of that information, there is no reference to the MCA guidance around further exploration of the risks a person is exposing themselves to through harm or exploitation.

Recommendation 6 - The BCPSAB, reviews in its MARM guidance and Safeguarding Adults Procedures that where a person repeatedly makes unwise decisions that puts them at risk of harm or exploitation, mental capacity act assessments or discussions around such assessments give clear direction around the need to fully explore the potential harm caused by exploitative or coercive situations and how this may impact on a person's decision-making ability.

4.4 Challenges for agencies supporting victims of cuckooing who are homeowners and financially stable from services.

4.4.1 Edward had some characteristics that were different to many victims of exploitation in that he owned his own home, and he was financially stable.

4.4.2 In particular, owning his own home posed additional challenges to agencies, in that a number of potential options were unavailable. For example, for victims living in social housing, there is always an option to move the victim to another location. Police are also limited in using Anti-Social Behaviour legislation which can be another useful operational tactic in disrupting exploitation.

4.4.3 Edward's access to money only led to a continued and increasing use of drugs rather than act as a barrier. There were a number of references to Edward spending up to £300 per day on cocaine.

4.4.4 Edward recognised the dangers to himself in living close to any area where he could access drugs but understandably did not want to move home.

4.4.5 There is no suggestion that services provided to Edward were denied through home ownership and finances. ASC on receipt of a PPN from the police prompted a S42 Care Act Safeguarding Enquiry and the allocation of a Safeguarding Practitioner.

4.4.6 Mental Health Services are a universal service and not means tested. Edward had been allocated a Care Coordinator from November 2019, notably one consistent professional over a long period of time in supporting Edward. It is also apparent that through this consistency, despite the difficulties this one person was able to provide agencies with not only a sound understanding of the challenges Edward was experiencing, but was a valuable link in engaging Edward, particularly when he became agitated.

4.4.7 When Edward self-referred, Drug and Alcohol Service 1 carried out assessments of him in terms of his drug use and risk to himself and others.

4.4.8 The National County Lines Coordination Centre has identified a number of specific heightened risk factors that make people vulnerable to cuckooing. Amongst these are:

(i) Social isolation or social difficulties.
(ii) Mental ill health.
(iii) Substance misuse.
(iv) Lack of safe home environment.

4.4.9 When the victim lives in a situation which limits the options agencies can use to safeguard them, it is extremely important that the limited opportunities available are maximised.

Recommendation 7 – The BCPSAB may wish to consider how the learning from Edward's review regarding owning his own home and access to significant cash flow coupled with deteriorating mental health, increased drug use and his isolation from his family heightened his risk factors and how this is included in future risk assessments.

4.5 A systems approach for service users who do not engage.

4.5.1 It is apparent that throughout 2021, Edward's heightened risk factors to exploitation worsened. There are a number of references to deteriorating mental health, his cocaine use increasing to £300 per day, his becoming isolated from his family, and the loss of control of his home. There was evidence of self-neglect, and his living environment declined to such an extent that the Local Authority was required to clear and clean Edward's property. An example of Edward feeling unsafe is that he secreted knives around his home for his own safety. There was also evidence that Edward's behaviour had changed where he was noted to 'have an edge about him'.

4.5.2 Undoubtedly, Edward posed a number of challenges to agencies. He self-referred to Drug and Alcohol Service 1 on a number of occasions but would then not respond to requests for assessments or follow up work. He was inconsistent in taking medication, and over time there were doubts that CMHT engagement was leading to tangible benefits for Edward. It was documented that Edward was *'chaotic, money running out for drugs and not engaging',* so much so that consideration was being given to discharging Edward if he continued to disengage or if his drug and alcohol misuse continued to be the primary problem.

4.5.3 The focus on substance misuse and disengagement from services clouded agencies' responses to Edward's vulnerabilities. The lack of a multi-agency approach through a formalised process did not enable joined up thinking as to how Edward could have been safeguarded.

4.5.4 The Drug & Alcohol Commissioning Team for Drug and Alcohol Service 2, in recognising that many of their patients will be inconsistent in their engagement, have strengthened their processes for those who 'do not attend' through their Early Discharge Outreach Pathway. This includes a more proactive approach where service users are contacted by a recovery worker or if this is not possible, after 21 days of assertive targeting, referral to use of other appropriate services.

4.5.6 Drug and Alcohol Service 1 has also introduced a new system of monitoring of frequent referrals where action is now taken to ensure clients receive a call ahead of their assessment and are offered a welcome group, both of which are aimed to break down the barriers for those accessing services at the time of crisis.

4.5.7 A further example where Edward did not attend an appointment was in relation to a referral from his GP to the 'Liver Team' at Royal Bournemouth Hospital. Despite letters being sent to Edward to rearrange appointments, Edward did not attend. The Hospital, in their response to this review stated that there was no record of Edward's risk factors and that,

'The lack of shared care records is a factor that is impacting our delivery of health services. If practitioners are unable to have sight of a person's risk factors, then professional decision making if flawed.'

4.5.8 There has been process changes to strengthen support to those people with chaotic lifestyles and who regularly miss appointments. For those people who are being harmed through exploitation it is important that agencies supporting them are aware of wider issues impacting their lives such as harm or mental health.

Recommendation 8 - The BCPSAB seeks assurance from NHS Dorset that GP referrals include wider issues that are proportionate to share, which may impact on their attendance, and how 'did not attend' processes ensure that a person who may not attend for reasons outside their control are supported.

4.5.9 Edward was demonstrating many of the signs that the exploitation and abuse he was facing was having a traumatic impact on his life. There was clear evidence that his life was in decline whether that was in deteriorating mental health, increased drug misuse, or a chaotic homelife. Another significant element of Edward's life is that despite his previous sound financial status, he was using foodbanks.

4.5.10 Despite this, there does not appear to be any tangible evidence that those involved directly with Edward were receiving any line management supervision or management oversight. For example, the ASC IMR identifies that important elements of safeguarding practice such as formal risk assessments, management planning, and outcomes of planned visits were not recorded. Although the Police Neighbourhood Team received information about Edward being cuckooed and according to one officer, '*I believe he was being cuckooed by the youths and that I intend to make regular visits to check on his welfare',* there is no evidence that line managers ensured this happened. The only reference to a manager's involvement across the agencies is the attendance of one during a joint visit on the 22 December 2021, a few days before Edward's death.

4.5.11 In their report on the criminal exploitation of children, the Child Safeguarding Practice Review National Panel raises the value of agencies identifying critical moments in a person's life to act as a catalyst for an approach for support. The national panel report identifies the need for *'agencies needing to find ways of being flexible and responsive enough to be ready to engage in those moments in real time. Days after the event might be too late. Services have to be constructed to be nimble enough to respond in the right moment, in the crisis.' (pg.29)*

4.5.12 The IMR's and other information provided for this review show that at times of need, Edward did engage and self-refer, but then, eschewed any support offered. This is common amongst many victims, particularly those who are coerced into withdrawing support by perpetrators. Deteriorating

mental health and continued use of substances will also impact on a person's willingness to engage with agencies.

4.5.13 For adults, critical moments not only include time in custody, or when they report a crime as a victim, but also when they are hospitalised or during other medical episodes, or where they may require financial support. There were a number of critical moments in Edward's life including arrests, a psychotic episode in June 2021, and a call from his mother in September 2021 informing that Edward was needing food and money.

4.5.14 The key learning point from this particular aspect of the national panel was that:

'…. organisations must be flexible enough to respond immediately to the critical moment when the child (adult) is more likely to be open to change. (pg.29)

4.5.15 For Edward, in triangulating individual agencies' IMR's and reports, there was sufficient information held by individual agencies, that when aggregated should have led to a MARM much earlier than 8 October 2021. The absence of evidenced supervision/line management oversight exacerbated the lack of MARM where one was clearly required and may have instigated challenge around how Edward's behaviour was a consequence of the harm he was experiencing.

Recommendation 9 – BCPSAB seeks assurance from partner agencies that for those adults at risk who are being exploited or at risk of being exploited; that trauma informed practice, including trauma from being exploited is fully embedded into practice.

Recommendation 10 – BCPSAB seeks assurance from its partner agencies that there are clear supervision/ line management systems in place to not only support their staff in their safeguarding practice, but to support them in convening multi-agency meetings, but also to ensure victims of exploitation receive the multi-agency response they require to keep them safe.

4.5.16 In response to the draft report, Edward's family believed that Edward should have been detained in a psychiatric hospital and that those supporting him were too focused on Edward's substance misuse and not his psychiatric illness. In their response to this, Dorset Health Care University NHS Foundation Trust has stated that a patient would always be offered voluntary/informal admission to hospital if deemed to be so unwell that they cannot be supported in the community (by a CMHT or crisis team). In Edward's situation, this was never deemed necessary because he agreed to have the recommended care and treatment, and their view was that risks were not so high, and that he was not so unwell as to warrant detention under the Mental Health Act 1983/07 for care and treatment for his mental disorder.

4.6 Commissioned drug support services.

4.6.1 On 1 November 2021, as part of a recommissioning process, Drug and Alcohol Service 2 became the commissioned drug and alcohol provider for Bournemouth, Christchurch & Poole, taking over from Drug and Alcohol Service 1 for the Christchurch area. Consequently, Edward's supporting documentation including referral, comprehensive assessment, risk information and care plan would have been similarly transferred.

Implementation of recommissioning was a significant piece of work that involved three drug and alcohol service providers, HR issues around staffing including TUPE, an electronic case management system and over 1,000 people in drug and alcohol treatment at the time.

As part of the transfer priority. provision from the incoming provider should have been given to people in receipt of opiate substitute medication and/or those with significant risk indicators.

4.6.2 Information from the Referral Form and Comprehensive Assessment, completed on the 15 June 2021 portrays Edward as a man seeking support primarily for cocaine use.

4.6.3 Risks relating to Edward being exploited was documented in Drug and Alcohol Service 1 notes, which were part of the transfer process to Drug and Alcohol Service 2

- *22/12/20 Risk from others: Edward was concerned that his cocaine use had bought him into contact with dangerous people (dealers)*
- *10/03/21 A safeguarding referral regarding Edward as there were concerns that he was being cuckooed by a group of teenage boys who sold him cocaine and had been using his property to weigh up product. States that the Police visited him the previous week in regard to this.'*
- *15/06/21 Assessment Crime … states he has driving convictions from around a year ago but that he is not currently under probation.*

4.6.4 Arguably, Edward, although not an opiate user could have received a level of prioritisation due to the level of risk of harm from others, and information that was known to agencies. There are also references to Edward using crack cocaine. Risks were identified in Drug and Alcohol Service 1 records. Any risk relating to previous treatment journey would have been explored in future appointments, however Edward did not attend. Similarly, as it was felt that the cuckooing risks had been notified to the Police, and with primary support from the CMHT CCO; the risks relating to cuckooing were being led by other agencies.

4.6.5 Although all the information held by Drug and Alcohol Service 1 was transferred, there does appear to be opportunities to improve the information that is shared between outgoing and incoming providers. Such information could include the person's character, identified risks and wider social circumstances to allow incoming providers to have a holistic view of a person's life.

4.6.7 The BCP Drug & Alcohol Commissioning Team (DACT) has refreshed its record keeping policy to include new sections such as workers' observations into case notes and an open summary which has improved the quality of information that is readily accessible. Another new section has been included to identify where a vulnerable adult or child in a household who is experiencing exploitation, has left treatment.

4.6.8 A further issue identified in this review was that due to the data migration, valuable qualitative information such as multi-disciplinary team meeting notes by the outgoing substance recovery provider due to the IT specific related issues, some information was not retained and therefore lost to the incoming provider.

4.6.9 It is understandable that treatment prioritisation focuses on opiate users. Under the previous Government's strategy, 'From Harm to Hope, a 10-year plan to cut crime and save lives', the primary focus was on opiate use. Within this document, Bournemouth was named as the 9th worse area in the country for Opiate and Crack misuse and the 8th worse area in the country for multiple and complex needs. There are clear links between opiate use and drug related deaths. There is also local data that highlights that in Bournemouth particularly, there are high levels of opiate misuse. In its 'Global Cocaine Report' from 2023, The United Nations Office on Drugs & Crime identifies that the global supply of cocaine is at record levels fuelled by a continuing growth in demand. Specific comments relating to the UK market speak of dealers creating drug debts and exploitation of vulnerable people. (https://www.unodc.org/documents/data-and-analysis/cocaine/Global_cocaine_report_2023.pdf)

4.6.10 Further research has identified that the UK has become Europe's largest consumer of cocaine which is linked to the ease with which the drug can be acquired. Edward during one time in police custody spoke of his cocaine use akin to 'drinking water'.

4.6.11 Data contained within the Safer BCP Partnership current strategic assessment indicates that that there was an increase in cocaine toxicity in Dorset's drug related deaths.

4.6.12 Prolonged cocaine use leads to a number of effects on a person including paranoia, hallucinations, mood swings, social isolation, including withdrawal from family, increased risk taking, including driving under the influence of drugs, exacerbation of mental health issues and financial difficulties from increasing drug debts. Edward demonstrated all of the above signs and the references to use of crack cocaine increases vulnerability significantly.

Recommendation 11 - The BCPSAB, together with the Safer BCP Partnership develop a greater understanding of cocaine use across Bournemouth, Christchurch and Poole, and the harmful impact it is having on its citizens, including medical, social, emotional, and criminal harms.

5.0 National issues.

5.1 In their report, entitled '*Cuckooing. The case for strengthening the law against slavery in the home.*', The Centre for Social Justice highlight the local challenges in prosecuting offences of this form of exploitation. The report highlights the evidential difficulties that police forces face in applying existing legislation to cuckooing. Section 1 of the Modern Slavery Act is the legislation that investigators are frequently signposted to, but unless there is tangible evidence of 'servitude, then 'mere occupancy' is inadequate to pursue a charge under s.1 of the Act.

5.2 Section 45 of The Serious Crime Act 2015 is a second piece of legislation commonly identified as pertinent to cuckooing. However, this offence requires a minimum of 3 people acting in concert as part of an organised gang. This leads onto the second misnomer, in that the narrative around cuckooing in national documentation too often focuses on 'county lines' and 'gangs'.

5.3 A thematic review into 3 people (*Luke, Katie & James, Hampshire SAB, July 2024*) who were victims of cuckooing clearly demonstrates the contrast of response to victims where the operating model was within an organised crime group, to victims such as Edward where the operating model of perpetrators was more loosely defined. (https://www.hampshiresab.org.uk/safeguarding-adult-reviews/cuckooing-thematic-sar-katie-james-and-luke-july-2024/)

Luke was a victim of cuckooing of an organised crime group, who hid drugs and weapons in his house. Violence and threats of violence including weapons was a feature of this exploitation. The prompt action taken by the police and other agencies reflected this level of risk and ultimately led to *Luke* being moved to another area. Perpetrators were arrested and subject to the criminal justice system. In *Luke's* case, the legislation and level of risk allowed a more direct approach in keeping him safe. This robust and timely approach was enabled through legislation such as The Modern Slavery Act and The Serious Crime Act 2015. For victims such as Edward, *Katie* and *James*, this approach was not possible.

5.4 The Jay review of criminally exploited children, 'Shattered lives, stolen futures' identifies the challenges faced in safeguarding children who are being exploited.

'We heard that the absence of a clear definition in statute plays a role in failures to protect and support children, with responses to safeguard and protect being limited by the lack of a solid legal basis for services to intervene and a lack of understanding of the range of forms that exploitation can take.' (pg.40)

5.5 These challenges are identical in the safeguarding of adults at risk of exploitation, particularly cuckooing.

Recommendation 12 – The learning from Edward's review is to be escalated to the National Independent Chairs Safeguarding Adults Board Network Criminal Justice subgroup as part of ongoing work to identify legislative and data collection opportunities to improve the safeguarding of adults at risk. This subgroup may then determine how the national Network may consider recommendations to the Ministries of Justice, Home Office and Department of health & Social Care

6.0 Single agency IMRs & identified learning.

6.1 The primary criterion for safeguarding adult reviews is to identify how agencies work together as a partnership. Although there are recommendations for specific agencies included in this report, the primary focus is on the partnership safeguarding system.

6.2 A number of agencies identified their own learning when reflecting on their respective service to Edward within their IMRs.

Recommendation 13 - The BCPSAB may wish to seek assurance from those agencies that submitted IMR's for this review that this learning has been embedded into their safeguarding practice.

6.3 I would like to thank the agencies who have contributed to this review. I have found them to be open to how the improvements could be made in the light of their own offer to Edward. Without this openness and proactive approach, this review would not be able to give the report the context of the challenges faced by agencies in difficult circumstances.

Appendix 1 **Table of Recommendations.**

	Recommendation
1a	The BCPSAB works with Safer BCP to develop a briefing/awareness package to improve a shared understanding of cuckooing across agencies within Bournemouth, Christchurch and Poole. This briefing package to highlight how the different relationships between victims and perpetrators require different responses, how to identify the 'signs of cuckooing' & heightened risk factors, and referral mechanisms.
1b	Within its Multi Agency Risk Management policy, The BCPSAB works with the Safer BCP to develop an exploitation pathway that is tailored to support adults who are being harmed or at risk of being harmed through exploitation, including cuckooing.
2	The BCPSAB seeks assurance from NHS Dorset that the information sharing process between Dorset Police and GP Practices is robust and accommodates any future changes to referral pathways. Given this issue was identified during the first panel meeting in April 2024, it is further recommended that an update is given to the BCPSAB at the earliest opportunity**.**
3	It is recommended that the BCPSAB initiates a discussion with its partner agencies to fully understand what is working well with the MARM and the challenges they face in fulfilling their requirements within the current BCP MARM guidelines. Following this work, if required, the current MARM guidance is reviewed to identify if any changes are necessary.
4	The BCPSAB, in the light of the NPCC Vulnerability Action Plan, seeks assurance from Dorset Police that there is an effective investigative response to crimes perpetrated against victims of cuckooing from first report through to subsequent investigation? Are they viewed as single occurrence low level crimes with limited investigation and supervision or are they seen as a course of conduct which increases the risk and harm caused to a vulnerable person? How are Dorset Police taking the responsibility of investigation away from vulnerable victims to using more 'evidence led' prosecutions?
5	The Safer BCP Partnership may wish to consider the data collection model used in Nottingham to improve their understanding of the prevalence of the different types of exploitation, including cuckooing across Bournemouth, Christchurch and Poole.
6	The BCPSAB, reviews in its MARM guidance and Safeguarding Adults Procedures that where a person repeatedly makes unwise decisions that puts them at risk of harm or exploitation, mental capacity act assessments or discussions around such assessments give clear direction around the need to fully explore the potential harm caused by exploitative or coercive situations and how this may impact on a person's decision-making ability.
7	The BCPSAB may wish to consider how the learning from Edward's review regarding owning his own home and access to significant cash flow coupled with deteriorating mental health, increased drug use and his isolation from his family heightened his risk factors and how this is included in future risk assessments.
8	The BCPSAB seeks assurance from NHS Dorset that GP referrals include wider issues that are proportionate to share, which may impact on their attendance, and how 'did not attend' processes ensure that a person who may not attend for reasons outside their control are supported.
9	BCPSAB seeks assurance from partner agencies that for those adults at risk who are being exploited or at risk of being exploited; that trauma informed practice, including trauma from being exploited is fully embedded into practice.

10	BCPSAB seeks assurance from its partner agencies that there are clear supervision/ line management systems in place to not only support their staff in their safeguarding practice, but to support them in convening multi-agency meetings, but also to ensure victims of exploitation receive the multi-agency response they require to keep them safe.
11	The BCPSAB, together with the Safer BCP Partnership develop a greater understanding of cocaine use across Bournemouth, Christchurch and Poole, and the harmful impact it is having on its citizens, including medical, social, emotional, and criminal harms.
12	The learning from Edward's review is to be escalated to the National Independent Chairs Safeguarding Adults Board Network Criminal Justice subgroup as part of ongoing work to identify legislative and data collection opportunities to improve the safeguarding of adults at risk. This subgroup may then determine how the national Network may consider recommendations to the Ministries of Justice, Home Office and Department of health & Social Care
13	The BCPSAB may wish to seek assurance from those agencies that submitted IMR's for this review that this learning has been embedded into their safeguarding practice.