

Introduction

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1. Introduction

This Safeguarding Adults Review (SAR) examines the experiences of an adult with a learning disability and care and support needs, who was subjected to hate crime, exploitation, and cuckooing. The review spans July 2023 to December 2024,

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2. What Happened

A specific life event alerted agencies to the fact that the adult was not able to fully understand risk and safeguard himself from the risks of exploitation. He was assaulted in his home and had to be moved for his safety. He disclosed that drug dealers had used his home and forced him to take drugs. Jason did not raise concerns, and his responses masked the impact of his learning disabilities and his ability to protect himself.

A Care Act Assessment 10 months prior to the life event identified the need for additional financial support, and carers, plus attendance at a charity providing supported employment and agriculture for adults with a learning disability. The assessment highlighted risks and vulnerabilities but did not include an exploration of his home circumstances. It was later identified that he was unable to maintain his property and most daily living activities. He was a repeat victim of crimes – exploitation, cuckooing, assault, theft etc.

Agencies commissioned to provide personalised support reduced the session due to “non engagement”, limited professional curiosity of the reasons and his unwillingness to allow them access to his home.

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3. Learning Points

- Safeguarding must be a collective responsibility to accurately reflect risks; the full picture was not identified until Jason had experienced significant harm.
- Relationships and curiosity are critical, protocols alone do not create safety.
- Understanding the impact of learning disabilities on daily living is essential for effective risk assessment.
- Consistency is vital across services and agencies to reinforce statutory safeguarding processes.
- The role of planning meetings and MDT is paramount.

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Key findings

4. Key Findings

- Lack of a shared understanding and definition of cuckooing across agencies.
- Inconsistent engagement of health and voluntary sector partners in multi-disciplinary teams (MDTs).
- Over-reliance on assumptions about CD’s abilities and engagement, resulting in reduced support.
- The learning disability and daily living challenges were not fully understood, leading to missed opportunities for early intervention.
- Safeguarding processes were in place but failed to prevent harm due to fragmented multi-agency working and limited information sharing.
- Initial Care Act assessment reduced support rather than reassessing risk and capacity, despite clear indicators of vulnerability.
- Cuckooing and exploitation risks were not consistently identified or escalated until serious harm occurred.
- His voice revealed feelings of fear, isolation, and mistrust of services who reduced support at a time of risk/harm

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Good Practice

- The first Care Act Assessment Identified levels of support and risks. A plan for support was put in place.

- The second Care Act Assessment followed disclosures made by the adult who was the subject of the review, and agencies worked well together to find safe accommodation.



Practice Tips

- Be curious if adults disengage, refuse access to the home especially if this is not the “norm”
- Test responses can be translated into actions
- If the adult has a lead worker – (ASC, MH etc) share information with them to support a robust risk assessment, possibly via a MDT or S42 enquiry
- Exploitation of adults with learning disabilities is increasing locally and nationally – is this an area that you can recognise and respond to?
- Be curious about injuries or a reluctance to return home



Recommendations from the review

- Cuckooing Guidance: Embed clear pathways, definitions, and intelligence gathering within the Safer Barnsley Partnership Plan.
- Strengthen LD Reviews: Improve checkpoints, information sharing, and probing for exploitation.
- Was Not Brought (WNB) Guidance: Ensure escalation when adults with LD miss health appointments.
- Audit Safeguarding Processes: Review triage and decision-making to ensure risk is fully understood and acted upon.



Resources

- <https://www.councils.coop/wp-content/uploads/2020/03/Social-Care-Creative-Solutions-Forum-Plymouth.pdf>
- [South Yorkshire Police cuckooing-toolkit](#)
- [Cuckooing research and prevention network End Cuckooing](#)
- [Preventing-and-disrupting-cuckooing-victimisation-professional-toolkit](#)
- [Was Not brought Guidance](#)