CORNWALL COUNCIL
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Mr Andrew Cox
Senior Coroner for Cornwall and the Isles of Scilly
Cornwall Coroners' Service
Pydar House
Pydar Street
Truro
TR1 1XU

My ref: [redacted]
Date: 18th July 2025

Dear Mr Cox

RESPONSE TO REGULATION 28 REPORT TO PREVENT FUTURE DEATHS –
MR WARNER, HEAD OF HOUSING OPTIONS CORNWALL COUNCIL

We write in response to the Regulation 28 report (hereinafter referred to as the "Report" or "Reports") provided to the Council 's Housing Options Service (hereinafter referred to as "Us", "We", "Our") by the Senior Coroner on 28 May 2025 in relation to concerns raised following the inquest into the death of Callum Hargreaves.

On behalf of Cornwall Council, and all those who personally attended the inquest, we would firstly wish to extend our sincere condolences to Callum's family. Whilst it will in no way compensate for their loss, Callum's family should rest assured that Cornwall Council remain determined to continually improve and develop the delivery of its services.

We are grateful for the observations made by the learned Coroner in the Reports, which have assisted us in our policy of continuing development and improvement.

For the purposes of clarity, and insofar as they relate to the local authority, we have extracted the points raised by the learned Coroner in the Reports. These are as follows:

The Report

"On the facts of this case, Callum had a social tenancy with Sanctuary Housing but it is recognised the Council will have professional relationships with a number of housing providers. Safeguarding alerts were raised that Callum was being cuckooed. There was then a 'stand-off' between Sanctuary and the Council as to who had responsibility for housing Callum. This was not resolved even though there were seven Safeguarding conferences held over half a year. It was felt by the Chair of the Safeguarding conferences that Callum had been failed and that the question of who was responsible for his accommodation should have been resolved much more quickly. Going forward, the Council may wish to reflect upon:

How it would like social housing providers with whom it has professional relationships to resolve concerns about the cuckooing of tenants…;

How disagreements about who has responsibility for housing a cuckooed tenant who becomes effectively homeless may be resolved more rapidly;

Council witnesses held conflicting views as to whether a social tenancy disqualified a tenant from making a homelessness application. It is for the Council to decide how to ensure a consistent approach is taken by its staff."

The Concerns

From the points raised above, and consideration of the Reports in totality, We understand that the learned Coroner seeks Our response to the following discrete concerns:

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1. How would the local authority like social housing providers with whom it has professional relationships to resolve concerns about the cuckooing of tenants?

2. How disagreements about who has responsibility for housing a cuckooed tenant who becomes effectively homeless may be resolved more rapidly.

3. How consistency in the determination of whether a social tenancy disqualified a tenant from making a homeless application may be achieved amongst staff.

Action Taken and Our Response

1. While we cannot dictate what individual providers do operationally in terms of their own policy, we are in a position to promote and encourage the adoption of a unified understanding of cuckooing and, if possible, reach consensus in the following key areas;

   Where a social housing provider has concerns of suspected cuckooing, they engage as early as possible with partners (police, ASB, social care, Housing Options) by way of a multi-disciplinary meeting to reach agreement on cuckooing being a potential cause of harm or homelessness.

   Following this and with the engagement of the alleged victim, we would expect the following options to be considered (and documented) to resolve the concerns:

a. Working closely with the police and the Council's ASB and Housing Options Teams, explore the potential for the obtainment of partial or complete closure of the demise and/or injunctions to exclude offenders from property.

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b. The provision of an appropriate level of support to the resident in order to sustain the tenancy and live safely.

c. Managed moves and relocation within their own housing stock when a resident is not able to continue to live safely in a property.

d. Whether any contiguous legal duty to provide emergency accommodation, on an interim basis or otherwise, exists.

In addition to the above, We have tabled this PFDO for the next Home Choice Partnership (Social Housing providers operating in Cornwall) meeting on the 16th of July 2025 to discuss these recommendations and track ongoing actions through this forum.

2. An escalation of Callum's situation following the safeguarding/MDT meetings did not occur. Had the difficulties encountered triggered an escalation, then there may have been further opportunities to explore and potentially resolve the housing issue.

In order to ensure this, managers and supervisors will be directed to the Council's 'Escalation of Professional Differences Procedure and Guidance' (- cios_sab-escalation-procedure-october-2020.pdf). This document provides clear guidance on steps to resolve professional differences and strategic steps for the escalation of concerns.

By August of 2025, all managers and supervisors will be able to demonstrate a thorough understanding of this document, its intended effect and its application.

Furthermore, it is accepted that Callum's individual case was not sufficiently highlighted through caseworker supervision. In light of this, we are currently reviewing the framework under which

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caseworker supervisions take place to ensure that the highest levels of consistency and uniformity are maintained. We expect this review to be completed by the 31st of October 2025.
We believe that the above steps will address the concerns raised by the learned Coroner.

3. We accept that an opportunity to open a case based on existing homelessness triggers under Part 7 of the Housing Act 1996 existed and that this could have been explored further. Of relevance to this matter was the fact that Callum had a tenancy. The question (and test) then of whether '*…it [is] reasonable to occupy..*' should have been considered and applied following any concerns of alleged disrepair and suspected cuckooing. If the threshold for priority need was also met, then an offer of interim accommodation under s188 duty would be triggered.

   Accordingly, a Housing Options '*all staff briefing*' has been held (June 2025) to reflect upon Callum's specific case and highlight the importance of applying the correct homelessness test and whether the s.188 duty had been triggered. This will be supplemented by robust case worker supervision to ensure that the correct legal tests and thresholds are applied in each and every case.

   All staff to have access to, and be required to read and understand, the 'Homelessness Code of Guidance'. This will be referred to in case worker supervision to ensure compliance and understanding.

   We will also implement a Quality Assurance Framework to ensure expertise and legal compliance. This will be achieved through a combination of rigorous induction training, continual professional development and continual case sampling. Once approved through internal governance, we expect this to be in place by 1st December 2025.

Further considerations

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In addition to the above, we considered the situation (as set out between paragraphs 150-160 of the judgement) generally so as to ascertain where improvements might be made.

In order for employees to better understand the nature of cuckooing and thereby be better placed to identify and respond appropriately, Housing Options staff have completed e-learning training provided by Shelter on 'cuckooing'. This will now form part of the training framework. This training will be completed on a bi-annual basis to ensure the knowledge is retained and current and will be mandatory for all new starters with Housing Options. It will be a requirement that this training be completed within the six-month probationary period for new starters.

A subject matter expert (e.g. an ASB Officer) will be invited to speak at the next Housing Options staff away day.

Closing Comments

We trust the above has sufficiently addressed the concerns of the learned Coroner as articulated in the Report and sets out sufficiently the steps the local authority intends to take and the timetable for doing so.

Finally, we would like to take the opportunity to thank you for highlighting these matters of concern and for the opportunity to respond. We would like to provide an assurance to Callum's family that the findings of the learned Coroner will be positively acted upon and that the local authority will continue to work to improve practices to support the residents of Cornwall.

Yours sincerely,

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[redacted]

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Head of Housing Options

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