Cumberland Community Safety Partnership

Domestic Abuse Related Death Review

Report into the death of Rosa in August 2023

Executive Summary

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Preface

This review is in response to the death of Rosa[1] who sadly lost her life in August 2023. Rosa is missed a great deal by those who knew and loved her. The review panel extends their sincere condolences to the family and friends of Rosa for their loss. The panel is extremely grateful for the contributions that Rosa's family have made to the review process – this has been critical to aide our understanding of who she was as a person and to ensure that the review reflects her life and experiences.

"I choose not to remember Rosa lying in her hospital bed that night, special and emotional as it was. I choose to remember her as the vivacious, happy, smiling girl who could flounce out of a room like a pro!"[2]

[1] Not her real name.
[2] Excerpt from family tribute included in the Overview Report.

Abbreviations used

A&E	Accident and emergency
CIC	Cumberland Infirmary in Carlisle
DoLS	Deprivation of Liberty Safeguards
DS	Detective Sergeant
DVDS	Domestic Violence Disclosure Scheme
DWP	Department for Work and Pensions
EEG	Electroencephalogram
ICC	Integrated Care Community
IMCA	Independent Mental Capacity Advocate
IMR	Individual Management Review
MARAC	Mult-agency risk assessment conference
MDT	Multi-disciplinary team
MRI	Magnetic resonance imaging
MS	Multiple Sclerosis
NCIC	North Cumbria Integrated Care NHS Foundation Trust
OT	Occupational Therapist/Therapy
PIP	Personal Independence Payment
PLT	Psychiatric Liaison Team
RVI	Royal Victoria Hospital
SAF	Vulnerable Adult Safeguarding
SAR	Safeguarding Adult Review

1. The review process

1.1. This summary outlines the process undertaken by the Cumberland Community Safety Partnership Domestic Abuse Related Death Review Panel in reviewing the death of Rosa.

1.2. Rosa was a vulnerable adult with a learning disability. She also had Multiple Sclerosis. Multiple professionals, as well as family members, noted safeguarding concerns regarding the possibility of neglect, controlling and coercive behaviour and financial abuse perpetrated by Rosa's husband.

1.3. Rosa died of complications arising from her Multiple Sclerosis in August 2023. The Cumberland Community Safety Partnership received a referral for a Domestic Abuse Related Death Review from the Medical Examiner's office, who questioned whether Rosa's death might have been preventable, on 4 September 2023.

1.4. The following pseudonyms have been used to protect the identities of the subjects of this review. These were either proposed by the Chair and agreed by Rosa's family or chosen by family.

Name	Sex	Age at the time of the death	Relationship with the deceased	Ethnicity
Rosa	Female	32	Deceased	White British
Brian	Male	46	Husband	White British
Todd	Male	21	Brian's Nephew	White British

1.5. Domestic Homicide Reviews were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004) and came into force in April 2011.

1.6. In 2024/25, the name of Domestic Homicide Reviews was in the process of being changed to Domestic Abuse Related Death Reviews, to better reflect all deaths which fall within their scope. The review panel chose to adopt the new name for the purpose of this review.

1.7. In this case, although there was not a homicide, it was identified that neglect and abuse may have been a concern prior to Rosa's death and so a referral for a Domestic Abuse Related Death Review was made.

1.8. The decision to undertake a review was made by the Chair of Cumberland Community Safety Partnership, in consultation with affected agencies, at a referral panel meeting on 15 September 2023.

1.9. Initial scoping requests were sent to 38 voluntary and statutory agencies to establish whether they had had any contact with the subjects of the review. Agencies were asked to secure and preserve any written records that they had pertaining to the case.

2. Contributors to the review

2.1. The following agencies were identified as having had relevant contact with the subjects of the review and so were asked to provide an Individual Management Review (IMR) report and Chronology of contact or a short report where contact was limited.

Cumbria Police	IMR
Adult Social Care	IMR
North Cumbria Integrated Care NHS Foundation Trust (NCIC)	IMR

Riverside Housing Association	IMR
Carlisle Healthcare (GP practice)	IMR
People First	IMR
Cumbria, Northumberland, Tyne and Wear NHS Foundation (Community Learning Disability Team)	Short report
Probation	Short report
Children's Social Care	Short report

2.2. The authors of the IMRs reports were independent of contact with the subjects of this review and were independent of the line management of the frontline practitioners.

2.3. The panel and/or Chair also drew upon the following information to inform the review:

- Interviews with Police Officers involved with the case.
- Interviews with Rosa's aunt.
- An interview with the church's safeguarding adults leads and review of their Safeguarding Policy.
- 39A Independent Mental Capacity Advocate (IMCA) report.
- Minutes of Children's Social Care strategy meetings.

2.4. A Safeguarding Adult Review (SAR) also commenced in March 2024. The Domestic Abuse Related Death Review panel shared information with the SAR panel and the Chairs of each review remained in contact to ensure the cross referencing of learning.

3. The review panel members

Name[3] / Job title	Agency
Nicki Norman, Chair and Independent Author	N/A
Detective Inspector, Safeguarding Team	Cumbria Constabulary
Detective Constable	Cumbria Constabulary
Specialist safeguarding practitioner and domestic Abuse lead (RGN)	North Cumbria Integrated Care NHS Foundation Trust
Safeguarding Specialist Practitioner	North Cumbria Integrated Care NHS Foundation Trust
Designated Nurse - Safeguarding All Age and Children Looked After	NHS North East and North Cumbria ICB
Team Manager Safeguarding and Public Protection	Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW)
Safeguarding Practitioner (Cumbria/Lancashire area)	North West Ambulance Service
Area Planning Manager	Cumberland Council
Domestic Abuse Strategic Lead	Cumberland Council

[3] Other than for the Chair, names are not provided for panel members. This reflects the draft revised Statutory Guidance (2024) which states that, to maintain anonymity and prevent unnecessary risks to panel members, members of the panel should not be named in the Domestic Abuse Related Death Review.

Domestic and Sexual Abuse Business Coordinator, Children Social Care	Cumberland Council
Service Manager, Adult Social Care	Cumberland Council
Public Health Locality Manager	Cumberland Council
Senior Probation Officer	Probation Service
Housing Services Manager	Riverside Housing
Advanced Customer Support Senior Leader	Department for Work and Pensions
Advocacy Manager and Volunteer Champion	People First
Service Manager	Recovery Steps Cumbria
Senior Operations Manager	Victim Support

All members of the panel were independent of direct line management or involvement with parties involved in this review.

4. Chair and author of the report

The Chair of this review and author of this report, Nicki Norman, has never worked in Cumberland, is independent of all agencies involved and has had no prior involvement with any subjects of the review. She is an Independent Domestic Homicide Review/Domestic Abuse Related Death Review Chair and has undertaken the Certificate in Chairing a Domestic Homicide Review qualification delivered by AAFDA. Nicki is nationally recognised as an expert in domestic abuse, having been active in this area of work for over 30 years.

5. Terms of Reference

5.1. The review considered the involvement of agencies with Rosa and her husband Brian from August 2021 until the date of Rosa's death as this captures, and goes beyond, the period it was known that Rosa was not taken for neurology reviews and had been unmedicated for around one year prior to her admission to hospital in June 2023.

5.2. The specific lines of enquiry agreed as pertinent to this review were:

i. Were there any indications of domestic abuse, including coercive control, within the relationship between Rosa and Brian? If so, what action was taken in response to this and how effective was this?

ii. Were there opportunities for Rosa or Brian to disclose concerns about domestic abuse? What barriers may have existed to prevent a disclosure?

iii. What was known about Rosa's lack of engagement regarding her care and support needs, the reasons for this and the effectiveness of agency responses to it?

iv. Were decisions concerning Rosa, her care and support needs, additional vulnerabilities, and living conditions informed by risk assessments that were updated in response to her changing needs and changes in circumstances. If so, what risk assessment tools were used and were they effective?

v. Was Rosa assessed as an 'adult at risk'? If not were the circumstances such that consideration should have been given to such an assessment and if so, what was the outcome of the assessment?

vi. What training, policies and procedures are in place to identify, respond to and escalate concerns relevant to the circumstances of this case and how effective were they? – consideration should be given to the intersections between domestic abuse (including coercive, controlling behaviour and economic abuse), learning disabilities, vulnerability, mental capacity, and safeguarding.

vii. What opportunities were there to identify and manage any risks presented by Brian?

viii. What information sharing protocols exist between agencies? Were they needed, appropriate and effective in this case?

ix. Are there any specific considerations in relation to Rosa or Brian's age, disability (including learning disabilities), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation that may have had a bearing on access to services or agency responses?

x. Were agencies sufficiently resourced and individuals effectively supervised to respond to the needs of Rosa and Brian?

xi. What did Rosa's family or community members know about Rosa and Brian, their relationship, their needs, and whether they sought or received help?

xii. What lessons can be learnt during the review process and where might practice, policy and resource allocation be improved? Have any changes already been implemented as a result?

xiii. Are there any particular examples of good practice to highlight?

Additionally, and outside of the review timeframe, the review sought information on:

xiv. The circumstances resulting in the removal of Rosa's twins after birth and any aftercare provided to Rosa.

xv. Relevant previous referrals to adult social care, their nature and responses.

xvi. An overview of Brian's previous domestic abuse related offending and responses to this.

6. Summary chronology

Significant events prior to the review timeframe

6.1 Brian had three children from three previous relationships, all of whom were removed from their parent's care, due to safeguarding concerns. Brian's previous partners all had some level of learning difficulties and concerns about domestic abuse within these relationships was noted. In 2006 a boy reported that Brian had sexually abused him, but a 'no further action' decision was made by the Crown Prosecution Service (CPS) due to insufficient credible evidence.

6.2 Rosa had been in a relationship with Brian since 2013 when they met in the local Pentecostal Church. They married in 2014 and Rosa gave birth to twins in the same year. The twins were removed from their care due to safeguarding concerns about Brian and Rosa, and placed in foster care. Regular contact between the twins and their parents took place between July 2014 and January 2015. Brian was noted to be controlling towards Rosa during these sessions, and aggressive towards staff at times. The twins were then placed for adoption.

6.3 In May 2016, Rosa was diagnosed with relapsing/remitting Multiple Sclerosis (MS). Rosa was engaged with the Neurology service and allocated a Multiple Sclerosis Specialist Nurse (MS Nurse). On two occasions, health care professionals recorded bruising on Rosa but with no explanation of how the bruises occurred.

6.4 In 2027 Rosa was referred to the Community Learning Disability Team. An initial assessment was completed but then three appointments were cancelled, two by Brian. Rosa said she was managing and declined support from the service.

6.5 Rosa became a wheelchair user following her diagnosis of MS and as her mobility deteriorated.

6.6 In June 2020 Riverside Housing made a referral to Adult Social Care, prompted by a complaint from a neighbour who reported Brian using sexually explicit language in the garden to a female visitor, and verbally abusing Rosa. A safeguarding enquiry and the Police investigation were closed after speaking to Rosa, due to no evidence of harm or abuse being identified. Rosa declined advocacy support from People First[4]. The Police attempted to deliver a DVDS disclosure to Rosa when Brian was out. However, she declined hearing the disclosure, stating she was happy in the relationship and had no concerns.

6.7 On two occasions in 2020, Rosa made Rosa reports to the Police of a window being smashed by an unknown male and of having eggs and stones thrown at her house. On the first occasion Vulnerable Adult Safeguarding (SAF) reports were shared with Adult Social Care and with the local policing team for their awareness, and on the second occasion two Hate Crimes were recorded by Cumbria Police. For both incidents, it was decided that there was insufficient evidence to proceed, and no further action was taken

6.8 In November 2020, a healthcare professional recorded that Rosa had fallen at home, resulting in bumps to her head. No explanation as to how fall occurred was provided. Again, in May 2021, a healthcare professional recorded that Rosa had a fall, resulting in bruising to her chin, face, left hand and a swollen arm. No explanation as to how fall occurred was provided.

6.9 Rosa and Brian lived with Rosa's grandmother and Rosa's uncle until July 2022 when they moved to their own tenancy. Brian's nephew, Todd also lived with Rosa and Brian. Todd and Rosa's uncle also have learning difficulties.

A summary of relevant events within the review timeframe - September 2021 to August 2023.

2021

6.10 12 September 2021 – The Police received a report from a member of public of a fight in the street. This involved Brian, Rosa's uncle and Brian's nephew, Todd. Rosa's uncle had a cut lip and Brian was the suspect. The case was closed for no further action due to insufficient evidence. A SAF medium grading was submitted which included all persons within the household (the house that Rosa lived in with her grandmother and uncle) which documents concerns about the house being generally unhygienic and untidy. Officers were concerned about the lack of care and alcohol misuse. The SAF was shared with the GP, Adult Social Care and the Police neighbourhood team.

6.11 Twice in October 2021 a healthcare professional recorded that Rosa had fallen at home. It is noted that it was difficult to ascertain the history and nature of Rosa's injuries.

[4] People First is an independent charity providing a range of support and information services to help people to engage in local authority processes who would otherwise have significant difficulty doing so.

6.12 During December 2021 Rosa was offered various appointments for an EEG[5]. She cancelled one, did not attend another, and was unable to accept the date of another. Rosa wanted her referral returned to the Consultant Neurologist as dates and times offered were unsuitable for her and that she did not want to attend the hospital due to Covid.

6.13 The same month, the MS Nurse had two telephone calls with Rosa to discuss her medication and non-attendance for the EEG and Rosa had a telephone call with the Consultant Neurologist about her EEG. The MS Nurse contacted Brian at Rosa's request, who stated he wanted to put the EEG on hold as Rosa's blackouts were improving. Rosa told the Consultant Neurologist. Rosa said that she is happy to attend the EEG but it may be difficult due to financial difficulties, and that she needs to attend with Brian to discuss treatment aims.

6.14 During 2021, an Occupational Therapy assessment commenced due to Rosa's deteriorating mobility, and requests for mobility aids at home. This was never completed as Rosa and Brian ended the process, stating it was no longer needed and that Brian had fitted mobility aids. In 2021 Rosa was prescribed MS medication[6].

2022

6.15 During January 2022 Rosa had several calls with the MS Nurse related to difficulties with her medication. Rosa was to be referred for an MRI scan[7] for a new baseline and to be monitored annually for activity.

6.16 Brian requested that Rosa's care be transferred to The Royal Victoria (RVI) hospital in Newcastle as it was difficult to travel to Penrith Community Hospital. Rosa also said she wanted this. The GP agreed to refer Rosa to RVI hospital in Newcastle.

6.17 On 23 January and February 2022 Rosa reported three incidents where eggs and stones had been thrown at her property, and where stones had been thrown at her whilst she was out in her wheelchair. Rosa believed she was being targeted due to her disability. Cumbria Police recorded three associated hate crimes but concluded that there was insufficient evidence for prosecution as the victim and witness could not identify the offenders.

6.18 31 January 2022 - Rosa attended an annual learning disability annual health check. This was undertaken by a health care assistant rather than a GP or Practice Nurse, as would usually be the case.

6.19 22 March 2022 – The MS Neurology service called Rosa to change her face-to-face appointment to telephone due to sickness in the team. Rosa was not very happy as she had been informed it would be face to face.

6.20 23 March 2022 – Rosa had a telephone appointment with the MS Nurse. There was no change in Rosa's MS symptoms, but blackouts and seizures were noted to be happening more regularly. The Nurse agreed to chase up the MRI scan and the EEG was discussed again. Rosa was not keen to have this but was to give this some further thought.

6.21 20 June 2022 – Rosa's aunt contacted Riverside Housing and advised that she wanted her mum (Rosa's grandmother) to be rehoused to a more suitable property. The Housing

[5] An electroencephalogram (EEG) is a recording of brain activity and can be used to help diagnose and monitor a number of conditions affecting the brain.
[6] Cladribine is a disease modifying drug for very active relapsing remitting MS. It can reduce the number of relapses by about half (50%).
[7] Magnetic resonance imaging (MRI) is a type of scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body.

Officer confirmed that the three occupants in her property would need to be rehoused. They were Rosa, Brian and Brian's nephew, Todd. The daughter advised that she had been estranged from her mother as a result of Brian's behaviour and that had recently been able to establish a relationship with her mother again. She had spoken to her mother about her concerns and her mother now accepted that they should not be in her property.

6.22 6 July 2022 – Riverside Housing identified an adapted property that was suitable for Brian and Rosa's needs, as Rosa was a wheelchair user. On 14 July the sign-up process for the property was completed with the tenancy in the joint names of Brian and Rosa. Brian's nephew, Todd also moved into the property with them as an occupant.

6.23 3 August 2022 – Riverside Housing undertook a new tenant visit at their property and Rosa and Brian were both seen. They had moved into the property which was noted to be clean and tidy. A money advice referral was ongoing and there were no other issues noted.

6.24 17 August 2022 – Rosa missed an appointment with her MS Nurse as she had moved house and did not receive the appointment letter. The MS Nurse called Rosa who reported an increase in shakes and blackouts and was encouraged to capture this on video.

6.25 25 August 2022 – A money advisor was contacted by Riverside Housing regarding a Universal Credit claim for Brian and Rosa. It was noted that Rosa had no email address so was unable to complete a three-way call to the DWP. The money advisor assisted them to complete a claim for Universal Credit online. It was noted that a claim for PIP[8] for Rosa could be made and also a claim for Discretionary Housing payments[9] as they were under occupying the property. It was agreed with Brian that once Universal Credit was in place this could be completed.

6.26 5 November 2022 – Cumbria Police received a report of an incident where Brian's nephew was chased by a group of males with knives and meat cleavers. Rosa was named in the report as the nephew had told her what had occurred, but she hadn't seen it, and Brian then went to the area and spoke with Police. Brian spoke to Officers and said that Todd talks "bullshit" and that they shouldn't believe a word he says. Officers appeared to believe Brian and left the property. No crimes were recorded. A SAF report was submitted outlining the incident and including Todd, Brian and Rosa. This was shared with Adult Social Care.

6.27 17 November 2022 – Brian called to ask for Rosa's morning appointment at RVI on 29/12/2022 to be rearranged. The appointment was rearranged and Brian was informed of the new appointment.

6.28 9 December 2022 – Rosa made a report of Criminal Damage to Cumbria Police that an unknown offender had caused damage to the front living room window. As no suspects were identified, the case was closed with no further action. No SAF report was submitted.

6.29 30 December 2022 – Rosa attended the hospital emergency department with a head injury stating that she fell in the hallway at home and banged her head off the hallway table. Rosa left the department prior to being seen by physician.

6.30 Throughout the autumn of 2022 Rosa and Brian had several contacts with DWP regarding their benefits claim. These were largely led by Brian who stated that he was Rosa's full-time carer.

[8] Personal Independence Payment (PIP) is a benefit paid to assist with extra living costs if a person has both a long-term physical or mental health condition or disability and difficulty doing certain everyday tasks or getting around because of their condition.

[9] Discretionary housing payments (DHPs) are extra money from the council to assist with housing costs.

2023

6.31 17 January 2023 – A Notice of Seeking Possession order was served on Rosa and Brian for rent arrears. Brian called in following this and made arrangements to pay off the arrears.

6.32 In the months leading up to her death, during 2023, Rosa had many contacts with the MS Nurse who made attempts to coordinate a package of care for Rosa in response to her deteriorating condition.

6.33 On 25 January 2023 the MS Nurse called Rosa as she did not attend her appointment. Rosa advised she was now living with Brian and his nephew at a new property and no longer having contact with her grandmother or uncle. She advised this was because gran is elderly but was uncertain as to why the contact has stopped. Rosa requested that the MS Nurse call again when Brian was home and to schedule Rosa's RVI appointment in Cumbria.

6.34 22 February 2023 – The MS Nurse visited Rosa at home, accompanied by a colleague. Brian was present with his nephew, Todd. Their main concern was a fall Rosa had a few weeks ago resulting in an ED attendance with a laceration to her head. It concerned Rosa and Brian that no scan had taken place. It was shared that Rosa had lost her balance in a pub toilet and fallen into a wall, but that she hadn't been drinking alcohol. Rosa had had a couple of falls at home recently due to losing her balance and the furniture had been arranged to accommodate this.

6.35 On 24 February 2023 Rosa was referred to a Neurological Physiotherapist at the Cumberland Infirmary in Carlisle (CIC). On 30 March Rosa was seen by a Consultant Neurologist from the RVI outreach clinic. The outcomes were to look at different forms of MS medication[10] in the future, to undertake an MRI scan and to monitor for now.

6.36 27 February 2023 – A Physiotherapist emailed a Learning Disability Physiotherapist to see if Rosa would be appropriate for their service. On 11 April 2023 the Learning Disability Physiotherapist responded and advised that Rosa should access a Neuro Physiotherapist as her learning disability is mild, but that she would support if needed.

6.37 Rosa was seen by Adult Social Care Occupational Therapy in March 2023 who recorded that it was difficult to engage with Rosa as Brian answered a lot of questions for her despite them being directed at Rosa.

6.38 25 April 2023 – The MS Nurse received a call from the OT. She was concerned about Rosa's situation. She had found Rosa non communicative during a recent visit and Brian was talking over Rosa with inappropriate comments made by him. She noted she would flag this on Rosa's case notes. Adult Social Care were not planning to keep Rosa's case open at the moment. There were plans to provide grab rails. It was agreed that there were no immediate safeguarding concerns but the situation was to be monitored.

6.39 11 May 2023 – Rosa contacted Neurology reporting that she was collapsing and had no feeling down her left side. Rosa was asked to phone her GP but she said didn't have the number. To make the call on her behalf was offered but Rosa declined.

6.40 18 May 2023 – The MS Nurse had telephone contact with Rosa who was unwell and unable to move her legs. Rosa was at home with Brian's nephew. The MS Nurse phoned Brian who said Rosa was paralysed from the waist down. The MS Nurse asked who was caring for Rosa when Brian was at work. Brian said it was either Rosa's uncle or his nephew. Brian voiced that he would like support.

[10] Ocrelizumab, Kesimpta or Cladribine.

6.41 19 May 2023 – As the Physiotherapy service had been unable to make contact with Rosa, she was discharged from the service.

6.42 19 May 2023 – The MS Nurse visited Rosa at home with a colleague. Rosa was present with Brian, Brian's nephew, her aunt, uncle and grandmother. Rosa presented with significant left weakness, unable to weight bear, and with notable dysarthria[11]. Rosa's MRI scan had been abandoned last week due to her experiencing claustrophobia. Rosa was noted to be subdued when alone, tired and worried about being on her own with Brian's nephew. Brian was leaving Rosa during the day and evening, and she was cared for by the nephew or uncle. Rosa accepted a referral to Adult Social Care for a Care Act assessment[12] and Rosa was also referred to the Integrated Care Community (ICC)[13] for Physiotherapy and Occupational Therapy. When alone, the aunt expressed concern regarding Brian's economic abuse, controlling and coercive behaviour towards Rosa, the nephew and uncle. An urgent referral was made to Adult Social Care to also include safeguarding concerns and requesting a visit. Rosa was referred to community rehabilitation and the Nurse was to contact RVI regarding new symptoms and to re-arrange the MRI scan. The MS Nurse contacted ICC Community Rehabilitation Team requesting an urgent assessment of Rosa's transfers and equipment within two hours. ICC were unable, however, to provide a visit the same day but a visit was booked for the 20/05/2023.

6.43 20 May 2023 – The Physiotherapist called Rosa, but Brian answered. Rosa was overheard saying she does not want any care or support. The OT and a colleague visited later that day and observed the transfer method Brian used to move Rosa. This was noted to be unsafe with a risk of injury to both Rosa and Brian. It was noted that a hoist to assist in moving Rosa may be required but there was limited space for its use. The OT visited again the next day and demonstrated safe transfer methods to Brian. The OT noted that Rosa needed Adult Social Care Occupational Therapy and a long-term package of care. OT were to liaise with Adult Social Care and their plan.

6.44 22 May 2023 – The MS Nurse made a second referral to Adult Social Care as she had not heard anything about the referral she made on 19 May. Adult Social Care then progressed a Section 42 enquiry.

6.45 23 May 2023 – The MS Nurse had a telephone conversation with Brian as she could not contact Rosa. She advised him that the Neurology Nurses had visited today but there was nobody in. Brian said he was fed up of people attending without phoning first. The MS Nurse explained that the phone was not being answered by Rosa or Brian. Brian said people had been interfering and moving furniture around. The MS Nurse explained that this had been done on the back of health and safety advice. Brian said he didn't like the transfer device and wasn't using it and that now the furniture had been moved it was much better to lift Rosa. When informed that the OT would be visiting with a Social Worker, Brian became heated and said he didn't like the social and they'd 'better be careful', he didn't want them 'poking their noses in'. When the MS Nurse explained that the concern was for Rosa's safety and that she had support in place, Brian said that Rosa isn't the only one who lives there so it isn't just her that needs looking after. Brian said his main concern was what was going to happen from a medical point of view. The MS Nurse was to advise Adult Social Care about her concerns about the comments made by Brian and to visit face to face the next day with a colleague for re-assessment with

[11] Dysarthria is a motor speech disorder that occurs when the muscles used for speech are weak or difficult to control.
[12] A Care Act assessment is carried out by local authorities to determine whether an adult has needs for care and support, and if so, what those needs are.
[13] An Integrated Care Community (ICC) is where teams work together to improve the overall health and wellbeing of their community. North Cumbria has been divided into 8 ICCs based on groups of GP practices and their patients.

consideration of steroids to manage the MS relapse. Also, to liaise with RVI regarding the MRI scan.

6.46 Later the same day, the MS Nurse rang Brian to arrange a visit on 24 May. He indicated that Rosa had lots of small bruises to her left leg and a large one, but he was unaware of where she got them. He wondered if she had a knock at some point or if it related to a deterioration in her symptoms.

6.47 24 May 2023 - The MS Nurse and a colleague visited Rosa at home. They were told by the nephew that all they were allowed to do was take bloods from Rosa and check her bruised areas. He said this instruction had come from Brian. The nephew also said he was an alcoholic. Bruising was present on Rosa's legs but she was unsure of how the bruising had occurred. It was not possible to take bloods from Rosa, possibly due to dehydration. Rosa was not eating or drinking much. Her pressure areas were reviewed, and pressure area care discussed as Rosa was sat in a chair all day for long periods of time. Brian phoned during the visit. Pressure area care was discussed with him, and he agreed carers would be helpful to transfer Rosa back to bed whilst he was out. He also requested a new wheelchair for Rosa. Brian apologised for being pushy yesterday and noted that he wanted what was best for Rosa. The MS Nurse was to liaise with Neurophysiotherapy, refer to wheelchair services and speak to OT for a pressure relieving cushion. Also to contact RVI Consultant and ask if Rosa could have steroids once antibiotics were completed.

6.48 The same day the GP surgery called Rosa to arrange a time for visit. It was recorded that Rosa had said that her husband was currently out and would like to be there for all visits.

6.49 25 May 2023 – The GP practice OT received a call from Adult Social Care to report concerns regarding Rosa. The history of the MS nurse reporting concerns was shared. It was shared that safeguarding enquiries had now commenced. Rosa's case was to be discussed by Multidisciplinary Team (MDT) the next day and note that Rosa needs a clinical visit.

6.50 The Adult Social Care OT called the ICC OT requesting support for a home visit. This was declined due to other pressures. The Adult Social Care OC felt that the ICC OT had left Rosa vulnerable with no contingency plan in place. The Adult Social Care OT reiterated what the OT had documented and that Brian had declined carers and equipment. The Adult Social Care OT was to liaise with her manager regarding the lack of ICC support.

6.51 26 May 2023 – As an action from the MDT, a home visit to Rosa was made by a Paramedic Practitioner. It was recorded that Rosa had bruising to her legs which appeared to be linked to poor manual handling. The Practitioner then discussed the case with the GP and whether the deterioration was due to an infection or a MS flare up. A decision was taken to treat as an infection and hold off on steroids with a plan to review the following week.

6.52 The same day, following a request from the Ms Nurse, a professional from the frailty/housebound team visited Rosa. Rosa had a chest infection and had been prescribed Doxycycline[14]. The plan was to visit again next week with regard to steroids. Rosa was referred to ICC District Nurses for pressure area checks.

6.53 30 May 2023 – The Adult Social Care OT had contacted Brian who had reported improvement in Rosa's function. OT had been planning to install a gantry hoist. Brian agreed to try a stand aid again. It was agreed to review the situation again next week with a joint visit with Neurophysiotherapist. It was noted that cats were occupying the bathroom and Rosa said she had not had a shower for two weeks. There was a strong smell of

[14] Doxycycline is used to treat infections.

ammonia in the bedroom. Rosa and Brian were not aware that safeguarding concerns had been raised. The plan was to involve the Learning Disability Team as questions were likely to arise regarding Rosa's capacity to understand the current risks to her health and safety. The OT agreed to speak to the Adult Social Care Social Worker about safeguarding.

6.54 31 May 2023 – The MS Nurse called Rosa and noted her speech was slurred. The plan was to refer to Neurophysiotherapy again. Rosa had previously been discharged from their service due to non-attendance. It was noted that Brian regularly took Rosa to the pub, often for the whole day, whereby she was seated in her wheelchair for the duration.

6.55 2 June 2023 – A District Nurse visited Rosa, with the nephew present. The Nurse requested that the nephew to leave the room whilst pressure areas were checked but he refused. Rosa was asked how she felt about this and she said she didn't trust him. The Nurse requested the nephew leave the room again which he reluctantly did.

6.56 6 June 2023 – The MS Nurse and a colleague visited Rosa. Rosa was in the chair and the nephew was present. Rosa looked unkempt, her nails were grubby, her hair matted at the back and she had dirty skin between fingers. Her lips looked dry and dehydrated. Rosa was complaining of difficulty in swallowing. She was not eating that day, only drinking milkshakes, and finding it difficult to hold a cup due to her hand shaking. Rosa complained of abdominal pain and was voiding into her pad. Her Implanon[15] had expired. There was evidence of old blood, dehydrated colour urine and small amount of fresh blood visible when Rosa's pad was changed. The MS Nurse washed Rosa but noted that this was very difficult to do without the assistance of both nurses. Rosa was asked who was changing her pads and she pointed at the nephew. Rosa was asked if she would like carers to help with this and responded that they should ask Brian. Diet was discussed but Rosa was not interested in discussing this. It was noted that Rosa had thrush on her tongue. Rosa's speech was slurred with left sided weakness to her face. The MS Nurse was to contact the GP to consider Rosa's admission to CIC for further assessment.

6.57 6 June 2023 - The GP and MS Nurse discussed concerns about Rosa's acute deterioration. An ambulance was arranged to take Rosa to A&E. Brian was informed and was very insistent that he wanted to take Rosa on the bus in her wheelchair. He was informed that an ambulance was on its way, and he agreed to come home.

6.58 Whilst in hospital, Rosa expressed the wish to go home, and her husband tried to insist, on several occasions, that he was going to take her home. Several mental capacity assessments were undertaken, and she was deemed not to have capacity to make the decision to leave the hospital. Deprivation of Liberty Safeguards (DOLS) were put in place to safeguard her.

6.59 9 June 2023 – People First received an advocacy safeguarding referral from Adult Social Care. This referral was not allocated to an advocate until the 22/06/2023. On 21 June People First received a referral for a 39A IMCA[16]. A People First Senior Advocate visited Rosa for the first time the next day and consulted with the Best Interests Assessor, nurse, physio, and MS nurse. They also spoke to Brian and submitted a 39A IMCA report on the same day.

6.60 23 June 2023 – a Best Interests meeting/discharge planning meeting was held and attended by representatives from Adult Social Care safeguarding, Learning Disability Team, the IMCA, ward Physiotherapy, ward OT and ward Doctor. Brian and the uncle attended a meeting later on to hear the outcome. Rosa had made progress in terms of mobility and control. Concerns were raised by various Health Care Practitioners in the

[15] A contraceptive implant.
[16] The 39A IMCA's role is to represent the person in the assessments which will be carried out.

meeting about Rosa's potential discharge home when all were aware that Rosa was left alone for long periods of time during the day in the care of family members whom Rosa had expressed distrust for. The extent of the coercion and control safeguarding issue was also not yet known. The Safeguarding Social Worker pointed out there has been no evidence of physical abuse and nor has Rosa raised any concerns herself in relation to Brian, and that there is no evidence Rosa is unhappy in her marriage. It was pointed out that control and coercion may affect Rosa's ability to make or communicate an informed decision about her care needs. Social Worker allocation was required. A further meeting was to be held after the safeguarding strategy meeting. It was agreed Rosa had further rehabilitation potential and that this should be maximised either through Elm A[17] or a community hospital.

6.61 4 July 2023 – Cumbria Police received a report regarding suspected concern for welfare for Rosa due to emotional and physical abuse and controlling behaviour by her husband Brian. This concern was reported by a Social Worker who had visited Rosa in hospital. She was concerned that Brian was exhibiting controlling and aggressive behaviour and was somewhat dismissive of Rosa's needs, stating that although Brian had agreed for services to engage with Rosa, it was likely he will either stop or limit this. The DS in the Safeguarding Team asked an Officer to attend and speak to Rosa to ascertain what her views were and establish capacity. If she was lacking capacity, they were to consider a Section 44 Mental Capacity Act offence[18]. An Officer attended and spoke to Rosa in the presence of a Nurse about care at home. Rosa stated that Brian cares for her and became visibility upset, saying that she was upset because she missed her husband (he had not visited today). When asked about bruising on her knees Rosa stated she had bumped these on something by the bed. Rosa did not want to talk and kept looking out of the window and it was felt that the Officer's presence in uniform was upsetting her. Rosa was advised that the Officer was there to make sure she was ok and if she wanted to report anything she can contact them or speak to the Nurses. The Officer came away and submitted a high risk SAF report for further review. The Officer also asked if a specialist Officer could speak with Rosa with an appropriate adult present and someone not in Police uniform. The DASH was not completed at this time.

6.62 The SAF was screened within the SGHUB and shared with Adult Social Care. The DS within the SGHUB, did not feel that a MARAC[19] was appropriate. The DC within the hub asked further questions of Adult Social Care via email about what their involvement was currently and about the family. The Social Worker responded via email stating there was a planning meeting arranged for 27/07/2023 and the invite was forwarded to the Police.

6.63 5 July 2023 – The Safeguarding Strategy meeting was held. This had been rescheduled due to Adult Social Care staff sickness. The outcomes were that a referral was to be made to the Safeguarding Adults team to allocate a Social Worker to be involved in case management, for capacity assessments to be undertaken in relation to understanding of care and support and residency, input to be provided by the Multidisciplinary Team (MDT), DoLS to remain in place until 27/10/2023, and the ward to keep the Safeguarding Social Worker updated of concerns.

6.64 13 July 2023 - Rosa was referred to the Psychiatric Liaison Team (PLT) due to a change in Rosa's presentation as her "mood dropped" and she had become tearful and stopped

[17] Elm A is the Hyper Acute Stroke Unit.
[18] It is an offence for a person to ill-treat or neglect a person who lacks mental capacity.
[19] A Multi-Agency Risk Assessment Conference (MARAC) is a meeting attended by agencies to discuss cases of domestic abuse that professionals consider to be 'high-risk'. The purpose of the MARAC is so that all the agencies involved in helping victims can agree how best to offer protection and support.

engaging. The PLT were advised about the safeguarding issues and Police involvement.

6.65 Rosa's referral was discussed by the PLT MDT and it was felt by the team that Rosa's disengagement was in response to the distress caused by Police involvement. It was felt that PLT assessment might be counterproductive, increasing her stress, as she had no mental health diagnosis, did not express any self-harm/ suicidality, without bringing any significant benefits. Since Rosa was deemed to be lacking capacity, it was unclear how much psychological interventions would benefit her recovery. It was agreed for PLT to proceed with the assessment, following communication with MS nurse, and if they identify that PLT input is deemed appropriate.

6.66 The PLT were unable to contact the MS Nurse so telephone contact was made with the ward Staff Nurse looking after Rosa and the outcomes shared from the MDT, which included declining Rosa's referral as it was deemed inappropriate at the time.

6.67 18 July 2023 - The Adult Social Care OT emailed the MS Nurse and shared that Rosa had stopped engaging with rehabilitation and, therefore, the ward were looking to discharge her with additional care calls, a hoist and profiling bed. A People First advocate was to visit Rosa the same day. The Safeguarding Social worker was off sick. Rosa now had a Social Worker from the short-term team who has been tasked with undertaking a robust mental capacity assessment. The next safeguarding meeting was planned for 26 July.

6.68 The People First IMCA visited Rosa that week. Rosa was asked about her home situation and stated she didn't like the nephew assisting her with personal care. When asked about carers Rosa had become upset and started to cry and said she felt that her husband should be looking after her and that he is never home. The IMCA voiced concerns about Brian accepting a care package in the long term and that a contingency plan would need to be in place to prevent a rapid deterioration in condition if care was refused. The IMCA was going to take further advice on this.

6.69 Later that day the IMCA emailed the Social Worker expressing concerns that the safeguarding meeting due to take place on 26 July had been postponed until 10 August[20] and suggesting a plan to move forward with a Best Interests meeting around accommodation options. The IMCA requested a copy of a care and transition plan, expressing concerns about how care would be delivered at home and the need of a contingency plan.

6.70 26 July 2023 – A joint visit to Rosa was made by Cumbria Police and Adult Social Care. The Officer reported that Rosa did not communicate much and when she did answer it was usually one- or two-word answers and extremely difficult to understand. Rosa was asked numerous questions by the Officer and Safeguarding Social Worker and the information they were able to ascertain was that:

- Rosa wanted to go home and she got upset when talking about going home and said she missed her husband, Brian.
- She lived at home with Brian and his nephew.
- Whenever asked about Brian she made no disclosures and said he liked living at home with him.
- She said she doesn't like the nephew, Todd, because he 'bullies' her and she said she doesn't trust him. When asked why and what Todd does, she made a movement and lifted

[20] The meeting was postponed because the police were unable to attend. They were, however, also unable to attend the rearranged meeting.

up her elbow and made a jabbing movement. When asked where he did that to her, she pointed to her shoulder.

6.71 Following this update a DS from the Carlisle safeguarding team made a further review of the SAF and stated that, although Rosa was clearly vulnerable and had disclosed that she doesn't like Todd, he believed that no offences were disclosed and that the elbow comment was more 'jovial' than assault and that Rosa was wanting to go home to Brian and Todd. The DS believed this was more of a role for Adult Social Care to determine what support was needed going forward. The SAF was closed, and no crimes recorded.

6.72 The Social Worker emailed the IMCA saying that he would visit Rosa tomorrow to carry out a capacity assessment and do a needs assessment. The IMCA responded informing him that, as per the Care Act guidance, Rosa will need an advocate present for a needs assessment. The IMCA advised they were unable to attend with the Social Worker on the date he planned to visit (27/07/23) and the IMCA suggested the Social Worker go ahead with their planned visit and undertake a capacity assessment on Rosa and asked if they could schedule a visit the following week during which the Social Worker could complete a needs assessment with the advocate present. The IMCA did not receive a response from the Social Worker with regards to this.

6.73 31 July 2023 - A duty Adult Social Care Social Worker responded to an email from the IMCA to advise that the Social Worker they were awaiting a response from no longer worked for Adult Social Care and a Service Manager would be notified of follow up needed.

6.74 1 August 2023 – The MS Nurse had a telephone call with Brian who was initially angry saying he was being 'kept in the dark'. He had received a letter from Adult Social Care regarding the safeguarding concerns and a DoLS in place until October. Brian said he had the right to overturn the court order and bring Rosa home again. He accused the MS Nurse of keeping information from him. Brian said that he feels Rosa is getting worse in hospital as she is refusing to eat. He said he is going to bring Rosa home in a month if there is no movement on her discharge. Brian was visiting Rosa every day. The ward Doctor had told Brian that Rosa would not be going to rehab or a community hospital as she had stopped engaging with rehab.

6.75 2 August 2023 – The IMCA emailed a solicitor to update on recent developments. The IMCA directed the solicitor to raise a 21a objection[21] on Rosa's behalf due to her objecting to her stay in hospital and wishes to return home. This email also mentions a DVD disclosure by Police at a previous visit to Rosa and that the situation has become more complex as Brian has had prior allegations related to sexual offenses with young girls. The IMCA shared that, given these new circumstances, extensive capacity assessments would need to be conducted and that she was quite certain that Rosa lacked capacity in most areas. As a result, it was unlikely that she would be discharged into her husband's care.

6.76 7 August 2023 – The local authority safeguarding services called the Community Learning Disability Team enquiring if Rosa was open to the team. They were advised that Rosa was not currently open to them, and if input was required, to complete a referral and send this via email.

6.77 7 August 2023 – Adult Social Care requested a DVDS disclosure for Rosa from Cumbria Police. They raised the same concerns about Brian as previously raised (04/07/2023). They reported that Rosa is due to be discharged from hospital back into Brian's care and

[21] If the person you represent is objecting to their care arrangements, you have an obligation to support them to exercise their rights of review under section 21A of the Mental Capacity Act and make an application to the Court of Protection. This is referred to as a Section 21a Objection.

that Rosa is being assessed as to if she has capacity. It was noted that Rosa had previously refused a DVDS in 2020 and if she did lack capacity a DVDS would not be appropriate.

6.78 It was noted that Adult Social Care were having a meeting on 10/08/2023 and were requesting a representative from the Police attend. The meeting invite was shared to the Cumberland safeguarding email address. The log was closed with an update that Adult Social Care would need to establish if Rosa had capacity before a DVDS could be considered.

6.79 10 August 2023 – A Safeguarding Strategy meeting was held. Rosa was deemed medically fit for discharge, but it would not be safe to send her home without a full care package. Lots of concerns were raised by professionals about discharging Rosa as no mental capacity assessments had been undertaken to determine if Rosa understood her care and support needs.

6.80 Central to the discussion were concerns about Rosa's well-being, outlining instances where Rosa was left without adequate care due to the absence of Brian who has issues with alcohol. In Brian's absence, Rosa's care fell upon her nephew, who was grappling with ADHD and literacy challenges, and proved to be an unsuitable caretaker according to Rosa's wishes. This circumstance left Rosa visibly withdrawn, neglected, and in dire need of urgent medical attention. The MS Nurse also noted concerning bruises on Rosa's thighs and knees, raising further alarm. Rosa's aunt had disclosed concerning behaviour by Brian, which included financial coercion and a tight grip on their financial matters, extending to Rosa's and the nephew's finances. It came to light that Rosa had been deprived of necessary medication since August 2022, coinciding with her relocation to a shared property with Brian. While specific details were not immediately available as the Police did not attend the meeting, it was known that Brian had a significant history of allegations of sexual offenses.

6.81 The IMCA and Social Worker were to work on Rosa's comprehensive care and support plan, encompassing the implementation of assistive technology, feeding, continence care, nocturnal repositioning, and measures to mitigate choking risks. An urgent reassessment of Rosa's speech and language needs was also requested.

6.82 10 August 2023 – Brian and his nephew approached People First seeking to speak to the IMCA, who was working from home that day, so they spoke to the business manager instead. Brian's demeanour during the interaction was reported to be quite hostile, with Brian speaking through gritted teeth and a noticeable smell of alcohol. Brian was sent a formal letter, requesting that he refrain from visiting the office. This incident was reported to the Police, and Adult Social Care and the ward were notified.

6.83 17 August 2023 – The IMCA visited Rosa who was connected to a CPAP machine[22], and found her unresponsive. Present during the visit were her aunt and grandmother. The aunt shared historical information about Rosa and concerns about Brian and provided the correct maiden name for Rosa (Adult Social Care had a misspelt her maiden name on the record).

6.84 18 August 2023 – The IMCA raised a safeguarding alert with the Single Point of Access team because they had observed Brian speaking quite forcefully to his nephew, who had tried to approach the IMCA, but Brian immediately instructed him to sit down and stay quiet. Without hesitation, he had followed his uncle's instructions. Later on, the nephew attempted to hand Rosa her glasses, but Brian intervened again, scolding him and telling him not to touch her belongings. Again, the nephew complied. The IMCA spoke with

[22] A CPAP (continuous positive airway pressure), machine is a commonly used treatment for a sleep disorder called sleep apnea, which is when someone experiences periodic gaps in breathing while sleeping.

Rosa's aunt who mentioned that the nephew was still around when she arrived at the hospital later on the evening of the 17 August. Apparently, Brian had informed the nephew that he was not allowed to leave until 10:30pm. Despite the aunt reassuring him that it was perfectly fine to go, he expressed that he wasn't permitted to do so. The aunt also shared that Brian has control over the nephew's bank card.

6.85 In August 2023, Rosa became acutely unwell and was found to have pneumonia which may have been caused by aspiration[23]. She was treated with antibiotics and high flow nasal oxygen. She was reviewed by the intensive care unit who felt that she was not suitable for invasive ventilation due to underlying frailty and severe Multiple Sclerosis.

6.86 Sadly, on a later date in August 2023, Rosa died in the CIC. The cause of death was recorded as Aspiration Pneumonia and Multiple Sclerosis.

7. Conclusions and lessons learned

This section summarises the key learning identified by the review.

Identifying and responding to domestic abuse

7.1. As a woman with a learning disability, Rosa was at particular risk of abuse, and the multiple sources of intelligence suggest that Rosa was abused at home, although to what extend is unknown.

7.2. Due to her learning disability, Rosa's levels of comprehension would have influenced her capacity to understand that she was experiencing domestic abuse, or to identify the risks she faced. Specialist advocacy, over a period of time with a trusted professional and utilising information and tools appropriate to Rosa's understanding, may have assisted her to relate and articulate her experiences.

7.3. When Rosa did disclose concerns about the nephew's behaviour towards her, that he bullies her and she did not want him giving personal care to her, this was not acted upon.

7.4. There appeared to be a lack of understanding across all agencies around domestic abuse and how this can present in a person with previous trauma, learning disability and who is being cared for by the perpetrator. Indicators of possible domestic abuse were present, but overlooked, or recorded but often with no resulting action planning.

7.5. Rosa could have been identified as an adult at risk as far back as 2014. Whilst the Care Act 2014 and its definition of an adult at risk was not enacted until 2015, prior to this the 'No Secrets'[24] guidance set out a code of practice for the protection of vulnerable adults and provided a clear framework for identifying and responding to concerns.

7.6. When safeguarding concerns were identified, multiagency collaboration was limited and lacking at times in clear oversight, effective communication, shared risk assessments and management plans. No one agency could be expected to be knowledgeable about all of the issues that were present during this case. The multi-agency information sharing and strategic planning meetings were, therefore, a critical tool in facilitating appropriate assessment and responses, but did not do so effectively for Rosa.

7.7. The MARAC could have provided a forum for a multi-agency response, but it is essential that this is equipped with knowledge and understanding around learning disability and

[23] Aspiration occurs when contents such as food, drink, saliva or vomit enters the lungs. The lungs are guarded by protective reflexes such as coughing and swallowing. This condition occurs if these reflexes are diminished.
[24] No_secrets__guidance_on_developing_and_implementing_multi-agency_policies_and_procedures_to_protect_vulnerable_adults_from_abuse.pdf (publishing.service.gov.uk)

domestic abuse and that the interface with safeguarding enquiries is clear. A multi-agency response might also have benefitted from expert domestic abuse input in any forum.

7.8. The attempts to communicate with Rosa about possible domestic abuse and deliver a DVDS were wholly inadequate and likely to have been very stressful for her. The Police need to be better equipped to prepare for and facilitate communication with people with a learning disability, to respond to the related safeguarding concerns, and to progress crimes against them.

Appropriate assessment, care and support for Rosa

7.9. There was a gap in assessing and responding to Rosa's particular needs and vulnerabilities related to her learning disability. The understanding of the level of learning disability that Rosa had varied a great deal and Rosa's capacity was never assessed until she went into the hospital admission preceding her death. The care by the MS team was important, but the learning disability support that Rosa clearly needed wasn't there.

7.10. Rosa not attending medical appointments should have been a red flag for agencies and prompted earlier exploration. The Prevention of Adult Not Brought Strategy and Reasonable Adjustment Campaign launched by the North East and Cumbria Learning Disability Network is a positive response to the challenges faced by this group.

7.11. Within the GP practice, the MDT process could be improved to ensure that the right people are being informed where there are concerns so that timely and appropriate action can be taken.

7.12. Rosa's particular needs related to her safety and well being were overlooked when her twins were removed and during the assessment prior to this.

7.13. No Care Act Assessment was undertaken to understand Rosa's needs in full. Therefore, information about her needs was absent, bitty and/or disconnected. Despite the efforts of the MS Nurse to coordinate responses for Rosa, she never had a wholistic, needs led package of appropriate care in place prior to her death.

7.14. Overall, the safeguarding responses did not align with the expectations of the Care Act or associated statutory guidance and the execution of the local authority's statutory duties was delayed at times.

7.15. The hospital policies and practice did not seem conducive to people with a learning disability and the family felt that Rosa was disempowered and further isolated whilst in hospital.

7.16. Police Officers placed in safeguarding roles were given little preparation and not provided with any specific training in a timely manner to support this role. This suggests a gap in the training of Officers expected to respond to safeguarding concerns and related crimes within their roles.

7.17. Rosa's family were knowledgeable about the situation was in, the risks she faced, her needs and could have assisted in facilitating communication with her. Supportive family members need to be seen as key stakeholders in the planning of responses.

Responding to the risks posed by Brian

7.18. There were multiple sources of intelligence about Rosa's experiences and Brian's behaviour, that would assist in establishing risk and hold him to account, yet these were largely not drawn upon, meaning incidents tended to be responded to in isolation.

7.19. Brian was still exerting control over Rosa throughout their interactions with agencies and whilst in hospital, but this was not challenged. Brian was never spoken to about the allegations against him or held accountable at any stage.

7.20. Despite claiming to be and speaking to professionals as Rosa's carer, Brian was not given a carer's assessment. This meant that his own needs related to being a carer were not addressed, but also that a structured opportunity to assess that the care he was providing for Rosa was appropriate and safe was missed.

8. Recommendations

8.1 National recommendations

The Department of Health and Social Care (DHSC) are requested to consider and engage with the priorities set out by the National Network for Safeguarding Adults Board Chairs, *'Safeguarding Adults: An Agenda for Transformative Change'* to facilitate transformative change in adult safeguarding policy and practice, taking account of the Domestic Abuse Related Death Review and Safeguarding Adults Review undertaken for 'Rosa' (2025).

8.2 Multi-agency recommendations

- The MARAC Steering Group to undertake a review of how the MARAC and Section 42 enquiries related to vulnerable adults interface with a view to identifying improvements to how the two processes maximise collaboration for better outcomes.
- Promote the availability of the young person's DASH risk assessment. Explore with partners the possibility of adapting this to be suited for adults with learning disabilities.
- Identify the critical training required by key partners and create an attendance agreement to ensure key partners are present at critical training events.

8.3 Single agency recommendations

People First

- To ensure historic records on the database are easily accessible and cross-referenced or merged with any duplicate records-There is already a section on our referral form that asks if the person has ever been known by any other name and this is also a question that would be asked to anyone making a referral by phone. This will be achieved by staff training to ensure they know how to cross-reference/merge duplicate records effectively.
- To ensure there is clear guidance to staff who triage and allocate referrals in respect of timescales of allocation of urgent referrals and that these guidelines are implemented and met on every occasion. This will be achieved by clear guidance being defined on allocation procedures in relation to timescales and this will be implemented and will be monitored by management checks.
- Staff within the advocacy department should receive more detailed training on domestic abuse including how to spot the signs and actions to take when domestic abuse is suspected, identified or disclosed. This will be achieved by liaising with the training coordinator within the organisation to source and implement appropriate Domestic Abuse, Stalking, Harassment and Honour based violence risk identification training to appropriate staff within the advocacy department.
- Risk Assessments should be completed and attached to the clients record on the database and these should be updated as appropriate.
- To develop a Domestic Abuse Policy to support and guide staff in their responses to service users.

Adult Social Care

- Cumberland Council to liaise with NCIC with regards development of in-patient strategy when individuals are admitted to hospital, who are subject to Safeguarding procedures.

North Cumbria Integrated Care NHS Foundation Trust (NCIC)

- Issue a briefing to all ward staff to ensure they understand the DoLS urgent and standard authorisation process, including the need to request prioritisation of a best interests assessment.
- Review the communication mechanism required to ensure ward staff are alerted to the need to escalate the standard DoLs authorisation process.
- To share the learning from this review with the hospital specialist learning disability lead and ask that this is incorporated into their improvement plan. Share associated plans incorporated with the Community Safety Partnership.

Cumbria Constabulary

- Address the training needs of safeguarding leads and ensure that this covers vulnerable adults, learning disabilities, communication and the use of intermediaries.
- The Public Protection Unit (PPU) to create an induction pack for Officers moving into safeguarding roles.
- Short briefing to be circulated to all personnel via the intranet highlighting the key learning from this Domestic Abuse Related Death Review and implications for frontline responses.

Carlisle Healthcare

- Establish an improvement plan for the effectiveness of the MDT to support the early identification of concerns and to ensure that the right people are being informed where there are concerns so that timely and appropriate action can be taken.

Elim Pentecostal Church

- For Elim Church Carlisle to access an Introduction to Domestic Abuse Session for all Ministers/ Volunteers, delivered by Cumberland Council and for all Safeguarding Leads to attend a one day in person Responding well to Domestic Abuse session, also held on licence by Cumberland Council.