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Domestic Abuse Related Death Review

Report into the death of Rosa in August 2023

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Contents

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

[1] Not her real name. [2] Not his real name.

understanding of who she was as a person and to ensure that the review reflects her life and experiences.

Tribute

Contribution from Rosa's Aunt (adapted from her eulogy for Rosa's funeral)

Rosa was an honest person who wore her emotions on her sleeve. When asked a direct question, she gave a direct answer and, when she was vexed, you would know about it. But she was also kind, gentle, caring and sentimental. She may not have always seen things the way that we do but we know that she often felt things deeply. She couldn't always articulate what she wanted but she was able to get our attention. The easy way or the hard way!

Rosa was brought up, with her younger brother, by her gran (nannie) – my mum. In the very early days, my youngest two brothers were also still living at home. I've seen a photo of a young uncle stretched out on the sofa, with tiny Rosa sprawled across his chest, both sound asleep. After one brother left home to start his career journey, the other brother effectively became the man of the house and took on a joint caring role for both Rosa and her brother, along with her gran. Her uncle continued to spend almost every day of her life with her.

A life-threatening accident, at aged two, gave us all a huge scare and many sleepless nights in the RVI, Newcastle. Thankfully, Rosa pulled through and was home after only a few weeks, with the promise of chocolate milk before bed for a long time afterwards. I know her preference changed to strawberry milkshake in recent years. And the best ones were always made by her uncle, of course.

Rosa, like her mum and her uncle, had severe learning difficulties. This meant a tough school life and an even more challenging transition into adulthood. However, she had a keen interest in childcare and loved nothing more than to look after younger children at family gatherings, local events, church services, and latterly, helping out friends in her favourite pub. She was even babysitting for friends and neighbours in her late teens and became firm friends with a young mum. In fact, they were such good friends, I recently learned that she persuaded Rosa to get her only tattoo between her shoulder blades!

Rosa loved animals and had owned several cats throughout the years. Her latest two cats had reportedly been missing her and moping about the house. One cat's photo was beside Rosa's hospital bed throughout her stay. Sadly, the cat pined away completely and passed away curled up on Rosa's bed, at home, exactly a week after Rosa left us.

In 2013, Rosa met Brian[2], and they married in 2014. They had beautiful twins. The twins were taken into care and have since been adopted but Rosa received updates and photos from their adoptive family, and she had a photo of them by her hospital bed. They are stunning beauties with Rosa's amazing big blue eyes.

Rosa loved music, particularly from the 80s, and Cindi Lauper's Girls Just Wanna Have Fun was guaranteed to get her up dancing – or at least jigging about in her wheelchair. The wheelchair was a

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result of the MS, which was diagnosed in her mid 20s, and in true Rosa style had been pimped up with stickers and such like.

She loved Betty Boop and there are several ornaments and models in her home. They sat side by side on the cupboard tops with pottery owls and VW beetles and campervans, which she also adored. There are several football fans in the family but she was the only Rangers supporter.

I will remember the times that Rosa asked me to give her a makeover for special events – school disco, parties, weddings, christenings, etc and her own wedding. She had a childlike joy and excitement when I came to curl her hair, put on her makeup and paint her nails. Her request for her wedding was for pink VW campervan nails and I had a few anxious trials with fake nails before she thankfully changed her mind.

She had a huge smile and could barely sit still while I was trying to get curls to stay in place or not to poke her in the eye with a mascara wand. She wore bright pink accents on her wedding day and carried a bright pink, light up bouquet.

Rosa was a social person and made friends wherever she went. Even in hospital, while she was still able to, Rosa was chatting with her ward neighbours and keeping the nurses and other care staff on their toes. When she could no longer speak, she was using hand signals to communicate. She could still show her agreement or displeasure with a thumbs up - or something else (less printable) so I'm told. Forthright, as always.

Rosa was admitted to hospital on the 6th of June following a deterioration in her condition. She was suffering from a severe MS relapse. Her Multiple Sclerosis was a relapsing remitting illness and degenerative. Over the past few years, she had been gradually declining, most recently needing the wheelchair, among other complications. Sadly, Rosa developed an infection in her lung and her body was unable to cope. She slipped into a peaceful sleep in the early hours and it was my privilege to be with her, to talk quietly to her, hold her hand and smooth her hair as she slipped away.

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!

People who knew her, that I have spoken to recently, have all commented on her great love of children, how good she was with them and how much they loved her, and also her huge clear blue eyes and brilliant smile. Her gran and I recently visited the church where she used to go to Sunday School and sing in the choir, and she was fondly remembered by the older ladies, who taught her and who sang with her. Others have remembered bumping into her in town or on the bus and that she always gave a cheerful hello. Neighbours have reiterated what a happy, smiley, friendly person she was.

Like I said, Rosa made friends everywhere she went. There was often joy in her short life and Rosa loved a giggle and a joke as well as the next person.

Abbreviations used

A&E	Accident and emergency
CIC	Cumberland Infirmary in Carlisle
CLDT	Community Learning Disability Team
CPS	Crown Prosecution Service
DARDR	Domestic Abuse Related Death Review
DI	Detective Inspector
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
IDVA	Independent Domestic Violence Advisor
KLOI	Key lines of enquiry
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
NWAS	North West Ambulance Service
OT	Occupational Therapist/Therapy
PIP	Personal Independence Payment
PLT	Psychiatric Liaison Team
RPR	Relevant Person's Representative
RVI	Royal Victoria hospital
SAF	Vulnerable Adult Safeguarding
SAR	Safeguarding Adult Review
UTI	Urinary tract infection

1. Introduction

1.1. Summary of circumstances leading to this review

1.1.1 Rosa was a vulnerable adult with a learning disability as a result of a serious head injury as an infant. She also had Multiple Sclerosis.

1.1.2 Rosa was admitted to Cumberland Infirmary, Carlisle in June 2023 with swallowing difficulties, deteriorating mobility and she was diagnosed and treated for a flare up of Multiple Sclerosis.

1.1.3 Multiple professionals noted safeguarding concerns regarding neglect, controlling and coercive behaviour and financial abuse perpetrated by Rosa's husband, Brian. Rosa's Multiple Sclerosis Specialist Nurse had raised concerns that Rosa was not taken for neurology reviews and had been unmedicated for one year prior to her admission to hospital.

1.1.4 It was documented that Rosa had bruises on her knees, clumps of hair missing, long nails with dirt underneath them and reports from the community that she had been lying in her own urine.

1.1.5 During her admission, she expressed the wish to go home, and her husband tried to insist, on several occasions, that he was going to take her home. Rosa was deemed not to have capacity to make the decision to leave the hospital and Deprivation of Liberty Safeguards (DoLS)[2] were put in place to safeguard her.

1.1.6 Later in June 2023, due to some functional improvement in her symptoms, plans were being made towards Rosa's discharge or re-ablement but this did not occur due to concerns about safeguarding and how she would manage at home as she was still fully dependent on others for personal care and feeding

1.1.7 In August 2023, Rosa became acutely unwell and was found to have pneumonia which may have been caused by aspiration[3]. 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.

1.1.8 Rosa sadly died a few days later. The cause of death was recorded as Aspiration Pneumonia and Multiple Sclerosis.

1.2. Reasons for conducting this review

1.2.1 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. The Act states that there should be a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

(a) A person to whom he was related or with whom he was or had been in an intimate personal relationship, or
(b) A member of the same household as himself, held with a view to identifying the lessons to be learnt from the death.

1.2.2 In 2024/25, the name of Domestic Homicide Reviews was in the process of being changed to Domestic Abuse Related Death Reviews (DARDRs), 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.

[2] The Deprivation of Liberty Safeguards (DoLS) are a part of the Mental Capacity Act 2005. Care homes and hospitals should apply them where a person aged 18 or over does not have the mental capacity to consent to their care arrangements, and they need to be deprived of their liberty. DoLS aim to ensure that such deprivation of liberty only happens when it is necessary, proportionate and in the person's best interests.
[3] 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.

1.2.3 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.

1.3. Purpose of the review

The Home Office Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016) sets out that the purpose of such reviews is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate.
- Prevent domestic violence and homicide and improve service responses to all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest possible opportunity.
- Contribute to a better understanding of the nature of domestic violence and abuse.
- Highlight good practice.

1.4 Cross government definition of domestic abuse.

The Domestic Abuse Act 2021 (Part 1) created a statutory definition of domestic abuse as:

Behaviour of a person ("A") towards another person ("B") is "domestic abuse" if— (a) A and B are each aged 16 or over and are personally connected to each other, and (b) the behaviour is abusive. Behaviour is "abusive" if it consists of any of the following—

(a) physical or sexual abuse;
(b) violent or threatening behaviour;
(c) controlling or coercive behaviour;
(d) economic abuse;
(e) psychological, emotional or other abuse; and it does not matter whether the behaviour consists of a single incident or a course of conduct.

1.5. Local context

Following the Local Government Review of Cumbria County Council in April 2023, Cumberland Council and Westmorland and Furness Councils became two distinct Local authorities.

The Domestic Abuse Supported Accommodation Needs Assessment for Cumbria, published in September 2023, identified that:

- In Cumbria 9,990 domestic abuse related incidents and crimes were recorded in 2021-22, a rate of 20 incidents and crimes for every 1,000 people in the population. This is an increase of +9.4% (+856 incidents and crimes) compared to 2020-21 and +7.9% (+730 incidents and crimes) compared to 2019-20.
- Compared to 43 Police force areas across England and Wales, Cumbria is ranked as having the 14th lowest rate of domestic abuse related crimes and incidents in 2021-22 placing the county within the second lowest quintile overall.

- Cumbria's rate of domestic abuse related crimes and incidents in 2021-22 (20 per 1,000 population) is similar or lower than that of statistically similar Police force areas, and lower than the rate for both the North West region and England and Wales.
- Between the year ending March 2019 and the year ending March 2021, six homicides in Cumbria were recorded as domestic homicide. Four were female victims, aged 16 years and over. Two were male victims, aged 16 years and over (Office for National Statistics, 2022c). At 31 March 2023 there were 16 active Domestic Homicide Reviews/DARDRs ongoing in Cumberland.

Local domestic abuse support services cited by Cumbria County Council include:

- Gateway 4 Women (Carlisle) providing one to one support or tailored recovery and support groups, Including the Freedom Programme.
- Women Out West offering tailored group work and drop in sessions.
- Women Community Matters (Barrow) deliver the #Ibelieveyou project supporting victims and offers support and counselling for anyone affected by domestic violence or abuse.
- Freedom Project (West Cumbria) for women, men and children affected by domestic abuse through one to one and group work.
- Springfield (South Lakeland) have a women's refuge that takes referrals nationwide and offers community based support for men, women and children.

Cumbria wide services include:

- Cumbria Victim Support providing assistance to all victims of crime, including a 24 hour helpline.
- Safety Net offering advice, support, counselling and therapy to adults, children and young people, family and friends who have experienced, or been affected by, abuse and trauma.
- The Birchall Trust offering support to anyone aged four and above affected by rape, sexual abuse or sexualised violence in Cumbria and Lancashire.

Cumbria also runs two perpetrator behaviour change programmes via Victim Support.

2. Timescales

2.1. The Cumberland Community Safety Partnership received a referral for a DARDR from the Medical Examiner's office, who questioned whether Rosa's death might have been preventable, on 4 September 2023.

2.2. 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.

2.3. The Home Office were notified of the DARDR on 15 September 2023 and the Independent Chair and Report Author was appointed in October 2023.

2.4. The review was limited in its progression from August to November 2024 due to the Police investigating whether it was appropriate to consider any charges against Brian.

2.5. The panel met seven times, six times virtually and once in person, and the review concluded in March 2025.

2.6. The completed report was presented to the Community Safety Partnership on 20 June 2025 and signed off by them, before being submitted to the Home Office Quality Assurance Panel on 27 June 2025.

3. Confidentiality

3.1. All information received through the review process and discussed at panel meetings is strictly confidential and cannot be disclosed to third parties without discussion and agreement with the Cumberland Community Safety Partnership and Chair.

3.2. There is an Information Sharing Agreement in place and a confidentiality statement which all panel members agreed to at the beginning of every panel meeting.

3.3. The findings of this report were confidential to participating professionals and their line managers until it was approved for publication by the Home Office Quality Assurance Panel.

3.4. This review has been suitably anonymised in accordance with the Statutory Guidance.

3.5. 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

4. Terms of Reference

The full Terms of Reference are provided at Appendix A.

4.1. 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. The review acknowledged that there may be events prior to this timeframe that offer important learning opportunities. Agencies were requested, therefore, to refer to any other relevant information prior to this period for consideration by the review.

4.2. 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'[i]? 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.

5. Methodology

5.1. 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.

5.2. 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 IMR (NCIC)	
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

5.3. Each report was quality assured by the producing organisation and signed off by a senior manager before being shared with the DARDR Panel.

5.4. 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 involved in the case.

5.5. A briefing session held for IMR authors to prepare them for and support them with their report writing. Follow up meetings were held to discuss the agency IMRs where necessary.

5.6. 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.
- A 39A Independent Mental Capacity Advocate (IMCA) report.
- Minutes of Adult Social Care strategy meetings.

5.7. The review panel members:

Name* / 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
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

* 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 DARDR.

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

5.9. The panel members committed to conducting the review with the following principles in mind:

- A lack of defensiveness and commitment to seeking the truth.
- A commitment to learning lessons to prevent future harm, without blame.
- Objectivity and independence.
- Transparency, whilst respecting confidential information.
- Empathy and compassion for the victim, and those impacted by her loss, ensuring their voices are integral to the process.
- Consideration of equality and diversity, and intersecting disadvantage.

6. Involvement of family, friends and work colleagues

6.1 The Chair wrote to the aunt of Rosa twice before gaining an alternative email address for her. She responded to the third request and the Chair met with her several times on video calls. This was her preferred method of communication.

6.2 The aunt reviewed the terms of reference and was provided with the Home Office leaflet about DARDRs and information on advocacy support available.

6.3 Contact between the Chair and the aunt paused between August and November 2024 due to the Police investigating whether it was appropriate to consider any charges against Brian and the aunt being a potential witness in this. Once it was established that no charges would be brought against Brian, the Chair re-established contact with the aunt.

6.4 The aunt was provided with a draft of this report and provided feedback, requesting some changes, which were incorporated within the final report.

6.5 Rosa's aunt attended the final panel meeting, which was held in person.

7. Chair and author of the report

7.1. 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 DARDR Chair and has undertaken the Home Office online training on DARDRs, including the additional modules on chairing reviews and producing overview reports, and achieved the Certificate in Chairing a DARDR 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. Further details are provided in Appendix B.

8. Parallel reviews

8.1 An inquest into the death of Rosa was suspended pending the outcome of the DARDR.

8.2 Following a referral by a People First[4] Advocate in November, a Safeguarding Adult Review (SAR) commenced in March 2024. The DARDR panel shared information with the SAR panel and the Chairs of each review remained in contact to ensure the cross referencing of learning.

8.3 **A note on limitations** – In line with its purpose and the associated Statutory Guidance, this DARDR is focussed on identifying the learning arising from responses to domestic abuse. Rosa was a vulnerable adult with multiple health and care needs which are evident throughout the review. This review has not, however, analysed responses to Rosa's health and care needs, other than in the context of the opportunities to identify and respond to domestic abuse and associated learning. It was expected that the Safeguarding Adults Review in progress would address responses to Rosa's health and care needs in more depth.

9. Equality and diversity

9.1 The review sought to be mindful of the nine protected characteristics, in line with the Equality Act 2010 (age, disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation). The review identified the following protected characteristics as being relevant in this case.

9.2 Sex: Rosa was female and women are disproportionately the victims of domestic abuse. The Crime Survey for England and Wales estimated that 1.6 million women and 712,000 men aged 16 years and over experienced domestic abuse in the year ending March 2024. This equates to approximately 7 in 100 women and 3 in 100 men.[5]

9.3 Disability: Rosa was diagnosed with relapsing/remitting Multiple Sclerosis and was known to have a learning disability. Disabled women are twice as likely to experience domestic abuse, over a longer period of time[6]. Types of abuse affecting disabled women can include the withholding of care or undertaking care neglectfully or abusively. Medication may be withheld, or mobility aids removed. Leaving can be difficult or impossible due to immobility, or a reluctance to leave a home which has been adapted, and some refuge accommodation may not be accessible which can limit the options available[7].

9.4 Pregnancy and maternity: Rosa and Brian had twins that were removed from their care. Being pregnant may put women at increased risk of abuse, with some studies suggesting

[4] People First are a charity providing advocacy support.
[5] Office for National Statistics (ONS), released 27 November 2024, ONS website, article, Domestic abuse victim characteristics, England and Wales: year ending March 2024
[6] Disabled Survivors Too. Spotlight report on disabled people and domestic abuse; SafeLives. 2017

[7] Disabled Women and Domestic Violence: (womensaid.org.uk) Accessed November 2024.

prevalence as high as 40% to 60% of pregnant women experiencing abuse during pregnancy.[8]

9.5 Marriage and civil partnership: Rosa and Brian were married. Cultural norms and beliefs can influence an individual's response to abuse in a marriage and women might be forced to stay in abusive marriage due to lack of financial independence and support systems. After divorce, systemic discrimination and marginalisation can prevent women from rebuilding their lives[9].

9.6 Religion: Rosa's aunt said that the family were all brought up attending church. Rosa and Brian met in the Pentecostal Church, but they did not continue attending church once in a relationship.

9.7 Where relevant, these protected characteristics and how they might have shaped the experiences of Rosa and the agency responses to her, are explored further in the Analysis section.

10. Dissemination

The following individuals/organisations will receive copies of this report:

- Family members
- Member agencies of the Cumberland Community Safety Partnership
- Agencies contributing to the review
- The Domestic Abuse Commissioner's Office
- Cumbria Police, Fire and Crime Commissioner's Office
- The Department of Health and Social Care.

The family were consulted about key dates to avoid for the publication of the review.

11. Background information and significant events prior to the review timeframe

11.1 Rosa was raised by her maternal grandmother. An incident was recorded when Rosa was a baby where she had an extradural haematoma[10] following an accident and agency records record this as the cause of her learning disability. The family note, however, that this may be an assumption and the causal link between the two is not confirmed. Rosa's mother and uncle both also have learning difficulties. The level of learning disability Rosa had is unclear. At different times, professionals state that Rosa's learning disability was mild, moderate, and severe. Her aunt said that Rosa's mental age was of around an eight year old.

11.2 The Department for Work and Pensions (DWP) recorded a health assessment for Rosa in 2012 within which a healthcare professional stated in the report that 'a return to work is unlikely in the long term' and 'due to severe learning difficulties the client has reduced awareness of hazards leading to significant risk of injury to self or others such that they require supervision for the majority of time to maintain safety. This suggests the client has limited capability for work and work-related activity.'

[8] SafeLives, A cry for health: Why we must invest on domestic abuse services in hospitals. 2016.
[9] Explorations of Post-Divorce Experiences: Women's Reconstructions of Self 1. Australian and New Zealand Journal of Family Therapy (ANZJFT). 2005.
[10] An extradural haematoma is a collection of blood in the 'potential' space between the skull and the outer protective lining that covers the brain (the dura mater). It usually occurs because of a head injury.

11.3 Brian had three children from two previous relationships, all of whom were removed from their parent's care in the past, 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.

11.4 Partner A was known to be in a relationship with Brian from approximately 2000 to 2006 and reported several domestic abuse matters, including stalking and harassment behaviours and breaches of a non-molestation order which she obtained via a solicitor. The couple had two children who were both removed from the couple and later adopted. On occasion, Partner A referred to herself as having a learning disability.

11.5 Partner B was known to be in a relationship with Brian from approximately 2006 to 2009 and reported assaults, theft of money and a sexual assault from Brian. The latter of which was investigated but no further action taken. The couple had a child who was removed and later adopted. Partner B was reported to have a learning disability.

11.6 Partner C was known to be in a relationship with Brian from approximately 2009 to 2012 and came into contact with Police, social care, and the MARAC[11] as a vulnerable adult with mental health concerns and learning difficulties, and due to allegations of sexual assaults, financial abuse, and physical abuse by Brian. Whilst with Partner C, Brian was sentenced to a 12-month Community Order and banned from keeping animals for five years for causing, permitting, or failing to prevent unnecessary suffering to two dogs and a cat.

11.7 In 2013 a girlfriend of Brian's reported that he had raped her. 18 days later she attended the Police station and stated she had made the allegation up and told Officers she was moving to the city to live with Brian. She received a caution for wasting Police time. No further information about this relationship is available.

11.8 In 2006 a boy reported that Brian had sexually abused him. Charges were put to the Crown Prosecution Service (CPS) but a 'no further action' decision was made by the CPS due to insufficient credible evidence. Rosa's family report preventing Brian being in contact with any of their children following an incident of sexualised inappropriate behaviour towards their primary school aged boys, due to their belief that he posed a risk, very early in his relationship with Rosa.

11.9 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. During a child and family assessment it was identified that the home conditions were inappropriate for new-born babies, Brian's previous allegations of sexual abuse and the three children he had previously had taken into care were a major concern, and there was concern that Rosa and her Grandmother did not see Brian as a risk.

11.10 The twins were removed from their care, due to safeguarding concerns about Brian and concerns about Rosa's ability to protect them, and placed in foster care. The Court ordered contact between the twins and their parents four times a week and this took place between July 2014 and January 2015, except where Brian cancelled this for various reasons. Brian was noted to be controlling towards Rosa during these sessions, and aggressive towards staff at times. The twins were then placed for adoption.

11.11 People First provided advocacy for Rosa during the proceedings in relation to the removal of her twins. Rosa had advised People First that Brian had told her that the reason Children's

[11] 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.

Services were involved with the twins was because of her past and the fact that she had been brought up by her maternal grandmother. However, Rosa then declined their support as she believed the advocate was on the side of the Social Worker.

11.12 In July 2014, as part of the assessment regarding Rosa's parenting ability, a capacity assessment was undertaken for Rosa. A Psychologist identified that Rosa had never lived independently and would remain dependent on those around her for significant assistance with some aspects of daily life, such as multiple household management and budgetary skills. Rosa was identified as having a mild learning disability.

11.13 In May 2016, approximately one year after presenting symptoms, 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). Rosa also reported having seizures, although these had not been witnessed by a professional. The same month, a health care professional recorded that Rosa had woken up with bruising all over her legs and unable to walk. No explanation was noted, however, of how the bruises occurred.

11.14 In February 2017 a health care professional recorded that Rosa was having seizures in bed and was covered in bruises. Again, no explanation was noted of how the bruises occurred.

11.15 In 2017 Rosa was referred to the Community Learning Disability Team (CLDT) by her Consultant Neurologist for support. An initial assessment with Rosa was completed in May 2017. Three follow up appointments with the CLDT were cancelled. Two were known to be cancelled by Brian. In July 2017, a Clinician contacted Rosa regarding input from the CLDT. Rosa advised that she was managing and did not require any input from the CLDT at the time. Rosa was advised that she would be discharged from the service but could refer herself back to the CLDT when she needed input from team.

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

11.17 In June 2020 Riverside Housing made a referral to Adult Social Care, prompted by a complaint from a neighbour regarding the language being used by Brian in the garden of the property towards his wife and a visiting female. It was reported that he was using sexually explicit language in the garden to a female visitor, and he was then overheard verbally abusing Rosa. Brian was challenged by the neighbour, and he threatened the neighbour. The Housing Officer expressed her concerns about Brian to the tenant (Rosa's grandmother) who advised that he could be angry and controlling but that it was private family business.

11.18 The safeguarding concerns were logged for further enquires under Section 42 of the Care Act[12]. A strategy meeting took place on the 26 June 2020 attended by Police, Riverside Housing and Adult Social Care. Actions of this meeting where for Police to investigate the potential of any criminal acts, Adult Social Care to co-ordinate a response to Rosa's care needs and need for advocacy, and a joint Police and Social Work visit to take place to Rosa on 3 July 2020.

11.19 Rosa was visited and spoken to separately and it was noted that there was no evidence during the visit of coercion or financial exploitation. A further planning meeting was held the same day. Whilst Police did not attend the meeting, they provided an update that there was no further role for the Police and there would be no further investigation. Actions from the meeting were for Adult Social Care to request a Clare's Law Domestic Violence Disclosure Scheme (DVDS) to be undertaken, alongside an Occupational Therapy referral for a ramp at

[12] A Section 42 enquiry relates to the duty of the Local Authority to make enquiries, or have others do so, if an adult may be at risk of abuse or neglect. Care Act 2014 (legislation.gov.uk) [14] Clare's Law (clares-law.com) Accessed November 2024.

the front door. The Domestic Violence Disclosure Scheme, also known as Clare's Law, gives people the right to ask Police if their current or ex-partner has any previous history of violence or abuse. The Police may also decide to proactively share information about someone's previous abusive behaviour with a new or an ex-partner.[14] The safeguarding enquiry was closed at this meeting due to no evidence of harm or abuse and as these actions could be achieved outside the safeguarding adults framework and any further concerns could be reported in their own right.

11.20 Around this time, People First received an advocacy referral from Adult Social Care, prompted by the allegations of sexual and physical abuse by Brian in relation to Rosa. Rosa declined advocacy support at this time.

11.21 The Social Worker contacted the Police and a DVDS disclosure was authorised at the multiagency DVDS panel on 23 July 2020 and a plan was made to give Rosa the disclosure when

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Brian would not be present. On the planned date, the Police attended the address, but a male could be seen in the window. They returned on 10 September 2020 and spoke to Rosa alone, explaining why they were there. Brian was out at a shop. He did call Rosa whilst Officers were there, and seemed unhappy, however the conversation couldn't be heard. The Officer noted that Rosa seemed keen for them to leave the property and declined hearing the disclosure, stating she was happy in the relationship and had no concerns. The Officer left her contact details with Rosa should she change her mind or wish to discuss anything further. The Social Worker was updated.

11.22 In August 2020 Rosa reported to the Police a window being smashed by an unknown male. Following investigation, it was decided that there was insufficient evidence to proceed, and no further action was taken. Vulnerable Adult Safeguarding (SAF) reports were submitted for Rosa, her uncle and the grandmother. Rosa's SAF documented that she had learning difficulties and MS and had blackouts, which were becoming more frequent as a result of the anti-social behaviour being directed towards the household. Rosa's SAF report was shared with Adult Social Care and with the local policing team for their awareness about the antisocial behaviour.

11.23 In September 2020 Rosa rang 999 to report having eggs and stones thrown at her house. Two Hate Crimes were recorded by Cumbria Police (Public Order – causing harassment, alarm and distress). Both investigations were classified 'no further action' as there was no evidence to support that the person named by Rosa was the offender. No SAF report was submitted. Information was shared with the local policing team for their awareness.

11.24 In November 2020, A healthcare professional recorded that Rosa had fallen at home, resulting in a bump to her forehead and back of head. No explanation as to how the fall had 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 her arm was swollen and difficult to move. No explanation as to how the fall had occurred was provided.

11.25 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.

12. Chronology – relevant events within the review timeframe September 2021 – August 2023

This section sets out the relevant contact that the subjects of the review were known to have had with agencies in chronological order.

2021

12.1 12 September 2021 – The Police received a report from a member of public of a fight in the street, stating three men were fighting. This involved Brian, Rosa's uncle and Brian's nephew, Todd. It would appear that Rosa's uncle and Brian were intoxicated after being in the pub most of the day. Rosa's uncle had a cut lip and Brian was the suspect. The case was closed for no further action due to insufficient evidence. Rosa was not mentioned further during this investigation. A SAF was submitted, graded medium risk, which included all persons within the household (the house that Rosa lived in with her grandmother and uncle). It documented Officers had concerns about the house, the smell of cat urine and faeces, the property being generally unhygienic and untidy. Officers were concerned about the lack of care and alcohol misuse. The SAF was shared with the GP and Adult Social Care. It was also shared with the Police neighbourhood team for follow up to the property to advise housing of the conditions. It is unclear if the neighbourhood team attended.

12.2 14 October 2021 - A healthcare professional recorded that Rosa had fallen at home, hurting her wrist and ankle, but that she was unable to say how the fall occurred.

12.3 29 October 2021 - A healthcare professional recorded that Rosa had fallen again, resulting in bruising to her head, ribcage, hips and knuckles. Rosa stated that she had lost her balance. It was noted that it was difficult to ascertain the history and nature of Rosa's injuries.

12.4 December 2021 – Rosa was offered various appointments for an EEG[13]. She cancelled one, did not attend another, and was unable to accept the date of another. Bespoke Health Care, who were commissioned to undertake the EEG by North Cumbria Integrated Care (NCIC), emailed the Neurology administration stating that 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.

12.5 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 (Cladribine[14]).

12.6 15 December 2021 – The MS Nurse made a phone call to Rosa, who was unwell with a chesty cough. Rosa was advised to delay her medication until the viral symptoms were resolved. The MS Nurse contacted Brian at Rosa's request. Non-attendance for the EEG was discussed, and Rosa said she was scared to go to hospital due to Covid. Brian stated he wanted to put the EEG on hold as Rosa's blackouts were improving. It was requested that Brian discussed this with Rosa and the MS Nurse would also discuss this with Rosa at their next encounter.

12.7 23 December 2021 - The MS Nurse made a phone call to Rosa, who was feeling unwell with a cold. A plan was discussed to commence Rosa's medication the first week in January. Rosa was reminded of her GP appointment the following week and that the MS Nurse would

[13] 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.
[14] Cladribine is a disease modifying drug for very active relapsing remitting MS. It can reduce the number of relapses by about half (50%).

ask the GP to discuss the EEG with Rosa and Brian, if needed, when they attend this appointment.

12.8 30 December 2021 – Rosa had a telephone call with the Consultant Neurologist. Rosa said that she was happy to attend the EEG but that it may be difficult due to financial difficulties, and that she needed to attend with Brian to discuss treatment aims.

2022

12.9 5 January 2022 – The MS Nurse made a phone call to Rosa. She had started her medication the day before, but the required pregnancy test was not done beforehand. Rosa said she felt lightheaded and nauseous. Rosa asked the Nurse to talk to Brian. He said he would get Rosa to do a pregnancy test but that it was very unlikely that she was pregnant. Brian requested that her care be transferred to The Royal Victoria hospital (RVI) in Newcastle as it was difficult to travel to Penrith Community Hospital. Rosa also said she wanted this. The MS Nurse agreed to discuss this with the GP and contact Rosa again tomorrow.

12.10 5 January 2022 – The MS Nurse consulted the GP who advised her that Rosa should continue with the medication as she had already started it and to do a pregnancy test as soon as possible. The GP agreed to refer Rosa to RVI hospital in Newcastle.

12.11 6 January 2022 – Rosa told the MS Nurse that her pregnancy test was negative but that she had ceased taking the Cladribine medication because she thought she had an allergic reaction to it. It was noted that Brian was not available to discuss this with – he was not at home and his mobile phone was not working.

12.12 The same day, the MS Nurse discussed Rosa stopping her mediation with the GP and agreed with the GP that treatment would not proceed. Rosa was to be referred for an MRI scan[15] for a new baseline and to be monitored annually for activity. No other treatments were deemed suitable. Rosa had been referred for an EEG. The MS Nurse was to write to the RVI hospital in anticipation of a referral by the GP.

12.13 7 January 2022 – The MS Nurse had a telephone conversation with Rosa and Brian, informing them of plan to refer Rosa for a MRI scan. Rosa stated she had a rash on her feet, face and throat. She was advised to ring the GP if it got any worse. Rosa and Brian were planning to speak to the GP regarding the referral to RVI and noted that they felt they would be able to get there by bus.

12.14 23 January 2022 - Rosa rang the Police stating that she has had her windows egged and stones had been thrown at her property. Additionally, Rosa stated that two weeks earlier, whilst she was out in her wheelchair, unknown people had thrown stones at her. On 21 February 2022 Rosa then reported that a group of 8-10 youths had thrown eggs at the address over the past few nights amounting to harassment. 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. A group of youths was identified, one of whom was interviewed and denied the offence. The group were spoken to by Police and the anti-social behaviour had stopped. As there was no realistic chance of prosecution, the crime was closed with no further action.

12.15 25 January 2022 – Rosa had a telephone consultation with the GP regarding a migraine episode and was advised about ongoing treatment.

[15] 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.

12.16 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.

12.17 13 February 2022 – A text message was sent to Rosa in response to a letter from her and Brian, dated 10 January 2022, requesting to be referred to a MS specialist in Newcastle. The GP suggested they discuss any concerns about care from local Neurology service with them before seeking a second opinion.

12.18 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.

12.19 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 as she slept on her left side and was worried that the leads would keep her awake. Rosa was to give this some further thought.

12.20 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 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.

12.21 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.

12.22 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.

12.23 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.

12.24 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[16] for Rosa could be made and also a claim for Discretionary Housing payments[17] as they were under occupying the property. It was agreed with Brian that once Universal Credit was in place this could be completed.

12.25 31 August 2022 – North West Ambulance Service (NWAS) 111 service received a telephone call from Rosa requesting transport to RVI hospital in Newcastle for an appointment in the

[16] 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.
[17] Discretionary housing payments (DHPs) are extra money from the council to assist with housing costs.

morning. Rosa was advised that NWAS 111 do not organise this. Rosa reported to the 111 Health Advisor that they had been informed by the hospital she was required to organise her own transport to Newcastle. The Health Advisor referred Rosa to her GP service to assist with organising the transport she required.

12.26 1 October 2022 – The GP received notification that Rosa did not attend her appointment at RVI with the MS Nurse. This was because the address the appointment was sent to was incorrect. RVI were informed of this and asked for the patient to be reappointed.

12.27 10 October 2022 - The money advisor noted that there had not been any contact from Brian and Rosa regarding the PIP claim. They tried to call to chase this up but received no response.

12.28 13 October 2022 - The money advisor called Brian. Brian confirmed their Universal Credit was in place and he was looking to set up an arrangement to pay off rent arrears and cover the shortfall. Agreement was made to put in a claim for Discretionary Housing payments.

12.29 5 November 2022 – Cumbria Police received a report of an incident where Brian's nephew, Todd, was chased by a group of males with knives and meat cleavers. Rosa was named in the report as Todd 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.

12.30 17 November 2022 – Brian called to ask for Rosa's morning appointment at RVI on 29 December 2022 to be rearranged. The appointment was rearranged for the 17 March 2023, and Brian was informed of the new appointment.

12.31 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 by making a small stone sized hole in the front pane. As no suspects were identified, the case was closed with no further action. No SAF report was submitted.

12.32 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. There was no loss of consciousness, but she did feel dizzy at the time. Rosa left the department prior to being seen by a physician. It is not recorded whether Rosa attended with anyone.

12.33 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.

2023

12.34 5 January 2023 – Brian attended a DWP appointment and stated that he was helping Rosa to make a claim for PIP and looking to claim carer's allowance for himself.

12.35 9 January 2023 – Riverside Housing called Brian to discuss increasing rent arrears and missed direct debit payments. Brian advised that he had spent the rent money and could not afford to make any payments until the next Universal Credit payment. An application was made to get the housing element of the Universal Credit paid direct to Riverside Housing.

12.36 17 January 2023 – A Notice of Seeking Possession[18] order was served on Rosa and Brian for rent arrears. Brian called in following this and discussed income and expenditure with Riverside Housing. Brian amended the direct debit payment and was advised that he needed to ensure these payments were made.

12.37 23 January 2023 – It was noted by the money advisor that they had been unable to make contact with Brian and Rosa regarding the Discretionary Housing payment and that no update had been received from Carlisle City Council. The money advisor noted that they assumed that Discretionary Housing payment had not been awarded and the money advice case was closed due to non-engagement.

12.38 25 January 2023 – The MS Nurse called Rosa as she did not attend her appointment. Rosa advised that she was at home unwell and stated Brian was on his way home. Rosa had previously missed appointments in August, September and December. 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 said this was because her gran was 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.

12.39 31 January 2023 – The MS Nurse called Rosa. Rosa reported a deterioration in her MS symptoms over the past couple of weeks and that she was using her wheelchair for the majority of time. Rosa was able to occupy a downstairs bedroom and ensuite shower room in the new house. Rosa agreed to provide a urine sample to rule out a urinary tract infection (UTI) and to do a Covid[19] test. Rosa shared that she had a fall a few weeks ago, falling backwards and hitting her head, and that she was seen at hospital for a cut on her head. Rosa was keen for a home visit, which was agreed. The MS Nurse was to refer to Adult Social Care Occupational Therapy as Rosa would benefit from grab rails and a step down to the second bathroom that Rosa uses. Rosa was to be seen in the outreach clinic at Penrith

Hospital, so she didn't need to travel to the RVI in Newcastle. The MS Nurse was to await the outcome of tests and plan to see Rosa at home in the next few weeks.

12.40 3 February 2023 – The MS Nurse called Rosa. Rosa had been unable to provide a urine sample yet. The MS Nurse was to take a sample container to Rosa the following Monday. Rosa reported that her mobility was still variable. Rosa was to be added to RVI clinic list on 30 March 2023 and a STRATA[20] referral made for an environmental Occupational Therapy assessment.

12.41 6 February 2023 - Brian contacted Riverside Housing as the direct debit payment had gone out of their account twice. When Brian was advised to contact the bank and ask for money to be returned via an indemnity claim, Brian became frustrated and swore at the Income Officer and hung up the phone.

12.42 7 February 2023 – It was recorded that Rosa's urine sample had still not been received by Neurology or the GP.

12.43 9 February 2023 – The MS Nurse contacted Rosa to let her know she was on her way to visit her at home, as had been arranged a few days ago. Rosa said she was going out so could

[18] Before a social landlord can start a possession claim against an assured tenant, a Notice Seeking Possession should be served. The purpose of this is to offer the tenant a final warning before possession proceedings commence and It will include the ground and or grounds for possession.
[19] Covid 19 is a strand of the coronavirus that causes severe acute respiratory syndrome. A pandemic was declared in 2020.
[20] A STRATA referral is an e-referral system used between hospital, community, social care and mental health services.

not receive the visit. The MS Nurse rearranged the home visit for two weeks' time and was to visit with a colleague.

12.44 10 February 2023 – Rosa attended Accident and Emergency (A&E) with a head injury, stating that she had fallen off the toilet the previous evening. Rosa had a laceration to her forehead, but had experienced no loss of consciousness, dizziness or vomiting. Facial pain was noted.

12.45 22 February 2023 – The GP received a urine sample for Rosa, brought in by Brian, to test for a UTI. The sample was sent to the laboratory but then returned as it had not been filled to the required line.

12.46 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 the recent fall Rosa had, resulting in an A&E 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's balance was still variable, and she was living on the ground floor of the property. It was noted that the wet room was presently occupied by two cats and litter trays. Rosa had had a couple of falls at home recently due to losing her balance and the furniture had been arranged to accommodate this. Rosa had urge incontinence and was using pull up pads to manage this but had not taken a urine sample yet. They agreed to do that the same day and to attend the RVI appointment on 30 March 2023. The records are unclear, but it appears that Rosa and Brian were to arrange transport for this. Rosa was applying for PIP and the MS Nurse agreed to do a letter of support for this.

12.47 23 February 2023 – The GP surgery called Rosa to advise that she needed a repeat urine sample. It was recorded in the notes that "Rosa says she couldn't give a F*** and hung up".

12.48 23 February 2023 - Brian called in to Riverside Housing regarding a refund of overpaid direct debit and was advised that he could not have a refund due to arrears on his account. Brian became very irate. The next day Brian advised Riverside Housing that he had changed his mind about the refund request and had cancelled the indemnity claim. A rent statement was posted to Brian and Rosa.

12.49 24 February 2023 – Rosa was referred to a Neurological Physiotherapist at the Cumberland Infirmary in Carlisle (CIC).

12.50 27 February 2023 – A Physiotherapist emailed a Learning Disability Physiotherapist to see if Rosa would be appropriate for their service. The Physiotherapist had spoken to Rosa on the phone who was unsure if she could attend an outpatient appointment. Rosa was not sure if her symptoms were a MS relapse or something else. Rosa suggested that the Physiotherapist speak to Brian.

12.51 3 March 2023 - A Neuro Physiotherapist appointment was sent to Rosa for the 09 May 2023.

12.52 21 March 2023 – The Adult Social Care Occupational Therapist (OT) visited Rosa to review her functional ability. They recorded that it was difficult to engage with Rosa as Brian answered a lot of questions for her despite them being directed at Rosa.

12.53 30 March 2023 – A letter from the Consultant Neurologist at the RVI to the GP indicated that Rosa would be seen in 12 months' time for follow up.

12.54 30 March 2023 – Brian called to say the bus had not turned up so Rosa couldn't make the Neurology appointment. She was offered another appointment at 1pm the same day, which Rosa and Brian did attend. Rosa was seen by a Consultant Neurologist from the RVI outreach clinic. The outcomes were to look at different forms of MS medication in the future, to undertake an MRI scan and to monitor for now.

12.55 11 April 2023 – The Learning Disability Physiotherapist responded to the Physiotherapist's email (see 27 February 2023) and advised that Rosa should access a Neuro Physiotherapist as her learning disability is mild, but that she would support if needed. It was noted that there was an issue some time ago regarding no lone visits to Rosa but the reason for this was unclear.

12.56 11 April 2023 – As the Physiotherapist had received no response to their letter to confirm attendance at a Physiotherapist appointment, they tried to call Rosa and Brian but there was initially no answer. They later spoke to Brian who confirmed that they would attend the appointment.

12.57 19 April 2023 – Rosa was referred to the continence service due to urge incontinence.

12.58 24 April 2023 – Brian attended a DWP appointment and said that he was still waiting for the outcome from the PIP application but there was a backlog. Carer's Allowance was discussed and the Carer's Element, if Rosa was found to have medium or high PIP.

12.59 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.

12.60 9 May 2023 – Rosa did not attend her Physiotherapy appointment. A letter was sent to Rosa giving her the opportunity to contact the Physiotherapist if she wished to have a further appointment prior to the 19 May, but if she did not contact them then she would be discharged from the service.

12.61 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 said she did not have the number. To make the call on her behalf was offered but Rosa declined.

12.62 16 May 2023 – The MS Nurse received an email regarding Rosa not attending her Physiotherapy appointment.

12.63 18 May 2023 - The MS Nurse called the GP requesting treatment for antibiotics for a UTI. and advising that she was putting in a referral to Adult Social Care for more support for Rosa.

12.64 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, Todd. Trimethoprim[21] had been prescribed by the GP. 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 Todd. Brian voiced that he would like support. He stated that he would collect Rosa's prescription that day or the next day.

12.65 19 May 2023 – As the Physiotherapy service had received no contact from Rosa, she was discharged from the service.

12.66 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[22]. 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 Todd. Brian was leaving Rosa during the day and evening, and she was cared for by Todd or her uncle. Rosa

[21] Trimethoprim (TMP) is an antibiotic used mainly in the treatment of bladder infections.

[22] Dysarthria is a motor speech disorder that occurs when the muscles used for speech are weak or difficult to control. [25] 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.

accepted a referral to Adult Social Care for a Care Act assessment[25] and Rosa was also referred to the Integrated Care Community (ICC)[23] for Physiotherapy and Occupational Therapy. When alone, the aunt expressed concern regarding controlling and coercive behaviour to Rosa, Todd and the uncle. She was concerned he was controlling the finances of them all and that the money was often spent in the pub. 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 May 2023.

12.67 20 May 2023 – Occupational Therapy attempted to contact Rosa and Brian but were unable to, so left a message requesting a call back. An unsuccessful attempt was also made to contact the MS Nurse. It was noted that OT may need to cold call visit Rosa if unable to make contact. However, after discussing this with colleagues, it was agreed that a cold call was unnecessary at present and instead, they would keep trying to make contact.

12.68 The Physiotherapist called Rosa, but Brian answered. Rosa was overheard saying she does not want any care or support. The OT and a colleague were to visit that afternoon. They did later visit and observed the transfer method Brian used to move Rosa. This was assessed as 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 was to liaise with Adult Social Care after they had visited the next day.

12.69 21 May 2023 – The OT visited 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. The OT was to liaise with Adult Social Care. If Adult Social Care were not planning an occupational therapy assessment, a referral to the community rehabilitation team OT was to be made.

12.70 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.

12.71 22 May 2023 – The Consultant from RVI emailed the MS Nurse noting that it was two years on from use of Cladribine medication so Rosa may be experiencing a MS relapse and queried whether Rosa's new urinary symptoms were an infection or neurological. Steroids were a reasonable possibility but it was necessary to rule out a UTI first. Rosa needed to have an MRI scan with contrast dyes[24] to decide on future steps.

12.72 23 May 2023 – Rosa was visited by a Neurology Nurse. There was no answer at the door and Rosa did not answer her phone. There were no signs of life or movement at the property. The MS Nurse was informed.

12.73 23 May 2023 – Rosa's MS Nurse had a telephone conversation with Brian as she could not contact Rosa. She advised him that the Neurology Nurses had visited that day but there was nobody in. Brian said they were out all day and also out all day tomorrow. 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

[23] 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.
[24] Contrast dyes are ideal for measuring and assessing brain related conditions such as multiple sclerosis, stroke, dementia.

furniture around. The MS Nurse explained that this had been done on the back of health and safety advice. Brian said he did not like the transfer device and wasn't using it and that now the furniture had been moved it was much better to lift Rosa. He blamed the MS team for a lack of intervention over the past seven months. The MS Nurse highlighted that Rosa had missed two appointments in August 2022 and January 2023 and that telephone calls were made in this time and there had been a face-to-face visit in February. 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 wasn't the only one who lives there so it wasn't just her that needed looking after. Brian did not want carers coming in unannounced. Brian also asked what would happen if Rosa didn't want any of this support. He talked about people turning up all weekend with no warning. Brian said his main concern was what was going to happen from a medical point of view. The MS Nurse explained that nurses had visited today to take bloods and to plan for the MRI scan, but Rosa wasn't in. 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 consideration of steroids to manage the MS relapse. The MS Nurse was also to liaise with RVI regarding the MRI scan.

12.74 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.

12.75 24 May 2023 – The GP surgery called Rosa to arrange a time to visit. It was recorded that Rosa had said that her husband was currently out and would like to be there for all visits.

12.76 24 May 2023 – Adult Social Care and OT discussed the planned visit today and OT feedback from the weekend. Concerns were raised over Brian's transfer method. The Adult Social Care OT agreed that Rosa had long term care needs and needs Adult Social Care involvement. The situation was to be reviewed later that day. The Community Rehabilitation team OT referral was to be closed with the option to recontact if needed.

12.77 The same day, the MS Nurse and a colleague visited Rosa at home. They were told by Todd 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. Todd also said he was an alcoholic. With consent from Rosa, a bladder scan was performed. Rosa couldn't weight bear and allowed the Nurses to check her legs for bruising. Bruising was present to her knees, right outer thigh, and left outer calf (fading). Rosa 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. A request was to be made to OT for pressure relieving cushion. 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, although his initial hesitation with this was that carers would come too early to put Rosa to bed and she wouldn't like this. He also requested a new wheelchair for Rosa. Brian apologised for being pushy the day before and said that he wanted what was best for Rosa. Rosa consented to all interventions and appeared to be happy with the visit but clearly very tired. The MS Nurse was to liaise with Neurophysiotherapy[25], refer to wheelchair services

[25] Neurophysiotherapy is a specialist branch of physiotherapy dedicated to improving the function of patients who have suffered physical impairment caused by neurological conditions.

and speak to OT for a pressure relieving cushion, and also to contact the RVI Consultant to ask if Rosa could have steroids once antibiotics were completed.

12.78 The MS Nurse spoke to the RVI Consultant who stated they would see Rosa face to face after her MRI scan to decide on future treatment. They were also happy for Rosa to have steroids from the following Friday.

12.79 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 and that all family members, excluding Brian, had a mild learning disability. It was noted that Brian has issues with alcohol and controlling behaviour. The Adult Social Care OT and Safeguarding Social Worker visited and observed that Rosa was now unable to weight-bear and queried if a neurological event last week could have caused a drastic change in her function. It was noted that Brian was "bear hugging" to transfer Rosa. Rosa was on antibiotics at the request of the MS Nurse for a possible UTI but, three days in, Rosa was showing no improvement. The situation was to be discussed by the Multidisciplinary Team (MDT)[26] the next day and to note that Rosa needs a clinical visit.

12.80 The Adult Social Care OT called the ICC OT requesting support for 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 concerns that Brian had declined carers and equipment. The Adult Social Care OT was to liaise with her manager regarding the lack of ICC support.

12.81 26 May 2023 – The MS Nurse called the GP requesting a prescription of medication for MS flare up and a pressure relieving cushion.

12.82 26 May 2023 – A MDT discussion about Rosa was recorded by the GP surgery. 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.

12.83 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[30]. Bruising to her legs was noted and discussed with the GP who believed this was due to manual handling. The plan was to visit again next week with regard to steroids. Rosa was referred to ICC District Nurses for pressure area checks.

12.84 Rosa's aunt shared that, unusually, Brian requested for her to be present at some home visits around this time. At one of these visits, the aunt made a point of saying that more manual handling training should be given to Brian and Todd, but this did not materialise.

12.85 30 May 2023 – The Neurophysiotherapy team requested clarification from the MS Nurse regarding whether Rosa needed a home visit as they would not normally do a home visit if the patient was out and about. They were to contact Rosa and check if this was needed.

12.86 The MS Nurse called the Adult Social Care OT. The 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

[26] MDT is the ICC/integrated care community MDT meeting which happens weekly in Carlisle. [30] Doxycycline is used to treat infections.

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 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.

12.87 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, where she is seated in her wheelchair for the duration.

12.88 2 June 2023 – A District Nurse visited Rosa, who was sat in a chair with Todd present. The Nurse requested that Todd leave the room whilst pressure areas were checked on Rosa 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. All pressure areas were checked and the Nurse was to arrange a pressure relieving cushion.

12.89 6 June 2023 – The MS Nurse had a telephone conversation with Brian who was not happy that the District Nurses had visited without calling first. The MS Nurse requested permission to visit that day. Brian was reminded of the need for pressure area checks due to sitting in same place for long periods of time. Brian was asked who was helping Rosa with her pad changes when he was out. He replied that her uncle and Todd did. Brian was asked if Rosa was happy with that and he passed the phone to her. Rosa did not answer and Brian took the phone back. Brian asked about any help forthcoming from Adult Social Care. The MS Nurse was to discuss safeguarding concerns with Adult Social Care.

12.90 6 June 2023 – The MS Nurse and a colleague visited Rosa. Rosa was in the chair and Todd 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[27] 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.

12.91 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.

12.92 The MS Nurse contacted the Safeguarding Social Worker to inform them of Rosa's admission to CIC. The Social Worker was to contact CIC tomorrow and find out where Rosa was and to visit the ward. She was to inform the ward of safeguarding concerns. A discussion was held regarding concerns over Rosa's care and support needs, neglect, reduced mobility and deterioration in her physical function.

[27] A contraceptive implant.

12.93 Rosa was brought to A&E by ambulance and noted to be generally unwell with intermittent speech, facial weakness and leg numbness. No safeguarding concerns were recorded. Rosa attended with a friend, (it is not recorded who this was) who stated Rosa had several falls over the past few months and feels her condition has deteriorated since a fall in February. Rosa was later noted to be conscious and orientated to time and place. She was admitted to hospital.

12.94 7 June 2023 – A Consultant at RVI emailed the MS Nurse expressing concern for Rosa and requesting the MS Nurse contact the ward to request an MRI scan. Inflammatory markers were not raised[28] but it was noted that a thorough infection screen would be required prior to steroids being given.

12.95 The MS Nurse passed on the Consultant's requests to the Acute Assessment Unit. Rosa was reported to be confused and lacking in capacity. Brian had been on the unit and had been argumentative, trying to take Rosa home. An urgent authorisation for a Deprivation of Liberty Safeguards (DoLS)[29] was requested and authorised. The urgent DoLS would remain in place for up to seven days, and then for a further seven day extension while a standard application was processed which would include a best interests assessment[30] being undertaken with Rosa.

12.96 The MS Nurse received a telephone call from Rosa's aunt. She had visited Rosa that day and noted she was distressed and anxious about being in hospital. She reiterated her concerns regarding financial abuse and control and coercion from Brian. Brian had left his nephew, Todd, on his own at the hospital last night whilst he went home. The aunt was happy that Adult Social Care had been contacted regarding safeguarding concerns, sharing that she hadn't contacted Adult Social Care herself as had other issues to deal with at the time and was also worried about the repercussions of disclosing concerns.

12.97 8 June 2023 – The MS Nurse spoke to the Safeguarding Social Worker and discussed the need for a robust mental capacity assessment. The Learning Disability Team Lead was to make contact with the ward to arrange a review. The MS Nurse also spoke to a Physiotherapist and ward staff Nurse. Brian had been in to see Rosa and instructed that they don't give any information about Rosa to any other family members. The ward were informed of the request for a MRI scan with a view to prescribing steroids if the infection screen was clear. A contact was given to the ward for the MS team.

12.98 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 June 2023.

12.99 12 June 2023 – Rosa was referred to Speech and Language Therapy and was seen the following day. It was noted that Rosa had thrush in her mouth and her teeth were in a poor state of repair. An assessment was completed and dietary requirements recommended. Rosa continued to be seen by the Speech and Language therapist every few days.

12.100 16 June 2023 – The MS Nurse visited Rosa on the ward. Rosa appeared in good spirits and engaged in conversation. Her physical health was discussed. Rosa was now able to sit, out of bed, in a chair. An outpatient appointment for RVI was organised at Penrith. Ward staff confirmed that they were to contact 999 if Brian tried to remove Rosa form the ward, although

[28] C-Reactive Protein (CRP) blood tests is an acute marker of inflammation.
[29] DoLS is the procedure prescribed in law when it is necessary to deprive a resident or patient, who lacks capacity, of their liberty to consent to their care and treatment in order to keep them safe from harm.
[30] The purpose of a best interests assessment is to decide whether a deprivation of liberty is happening or may happen, and if it is whether this is in the best interests of the person affected.

his demeanour had improved recently. Staff were informed of a planned safeguarding strategy meeting on 4 July as part of the Section 42 enquiry.

12.101 20 June 2023 – The MS Nurse had a call with a professional from the Learning Disability team. She had been to see Rosa a few times on the ward and noted that she was better this week than last and that the ward were looking at discharge planning. The DoLS was due to expire at midnight the next day and she had spoken to Brian who was verbally aggressive and said he was going to take Rosa home in a wheelchair when the DoLS expired. The Social Worker had said there were no plans yet for local authority to assess the situation from a safeguarding point of view other than strategy meeting on the 4 July. There was a discussion regarding fluctuating capacity and that it could take time to carry out full and complete capacity assessment. A professional meeting was planned for the following Friday which the Learning Disability Team representative would attend. The MS Nurse was to contact NCIC safeguarding team the next day to discuss safeguarding. It was noted that Rosa may need an Independent Mental Capacity Advocate (IMCA)[31] too but there was a six week wait unless the hospital could fund this privately. It was also noted that Rosa needed the full allocation of a Social Worker.

12.102 21 June 2023 – A meeting was held between Neurology, NCIC safeguarding, and the Learning Disability Team. Concerns were raised that the DoLS would run out at midnight and there were questions around Rosa's capacity to consent and problem solve more complex issues. There were also the safeguarding concerns. The outcomes from the meeting were that an urgent referral for an IMCA to be allocated as soon as possible was made, an urgent best interest assessment was to be requested and the legal team to be consulted regarding a Court of Protection Order[32] if there were still questions over Rosa's capacity.

12.103 The best interest assessment was authorised and took place the same day and all were aware that there may be complexities due to potential control and coercion affecting Rosa's ability to weigh up information to make a decision. The outcome was that DoLS was to remain in place until October.

12.104 People First received the referral for a 39A IMCA[33] the same day.

12.105 22 June 2023 – A People First Senior Advocate visited Rosa for the first time and consulted with the Best Interests Assessor, MS Nurse and other health professionals. They also spoke to Brian and submitted a 39A IMCA report on the same day.

12.106 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 Rosa's uncle attended a meeting later on to hear the outcome. Rosa had made progress in terms of mobility and control. The Doctor felt that a transfer to Elm A[38] for intensive rehabilitation support would be appropriate. Discharge plans were discussed and that a mental capacity assessment would take place with an allocated Social Worker. It was noted that, if Rosa was assessed as having capacity to consent to discharge and ongoing treatment and care, then she could be discharged with a full care package and support. Concerns were raised by various Health Care Practitioners in the meeting about Rosa's potential discharge home when all 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 said that there had been no evidence of

[31] An Independent Mental Capacity Advocate (IMCA) is an advocate appointed to act on a person's behalf if they lack capacity to make certain decisions.

[32] A Court of Protection Order is a legal document. It appoints someone to make decisions for someone else.

[33] The 39A IMCA's role is to represent the person in the assessments which will be carried out. [38] Elm A is the Hyper Acute Stroke Unit.

physical abuse, nor had Rosa raised any concerns herself in relation to Brian, and that there was no evidence Rosa was 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. A further meeting was to be held after the safeguarding strategy meeting. It was agreed that Social Worker allocation was required, that Rosa had further rehabilitation potential and that this should be maximised either through Elm A or a community hospital.

12.107 The hospital safeguarding team were to be invited to the safeguarding strategy meeting and the MS Nurse spoke to them the same day to inform them of this, discussing the safeguarding concerns. It was suggested a young person's DASH[34] could be completed with Rosa over time to ascertain her thoughts and feelings as to coercion and control. This does not appear to have happened as there was a blank form on Rosa's record.

12.108 27 June 2023 – Riverside Housing called Brian to discuss increasing arrears as the shortfall for underoccupancy was not being paid. Brian advised that Rosa was in hospital at the moment and, when she was discharged, she would be using the downstairs bedroom so there would no longer be an underoccupancy. Brian was advised to speak to Universal Credit and update them on the circumstances.

12.109 28 June 2023 – The MS Nurse had a telephone conversation with the ward Physiotherapist who shared that Rosa was making progress with rehabilitation. Brian had been on the ward again threatening to take Rosa home. Rosa was tearful as Brian had not yet been to visit that day. As per the safeguarding team's advice, the Physiotherapist was to pass on a message to ward staff to start asking questions around Rosa's feelings of safety at home, and to monitor her demeanour when family visit and for this to be documented.

12.110 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 to Police by a Social Worker who had visited Rosa in hospital and spoken to the nurse caring for Rosa. She was concerned that Brian was exhibiting controlling and aggressive behaviour and was dismissive of Rosa's needs, stating that, although Brian had agreed for services to engage with Rosa, it was likely he would either stop or limit this. The Detective Sergeant (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[35]. An Officer attended and spoke to staff at the hospital who informed them that Rosa had been in hospital a month and was under a DoLS order, that they believed Brian had been using inappropriate means of lifting Rosa causing her bruises under her arms, that her hair was matted and she had dirty nails and lack of change of incontinence pads where she had been sat in one set for 24 hours, and that she also had bruises on her knees. Staff did state that Rosa was being cared for by her husband Brian, an uncle and nephew and that she didn't like males touching her, hence the lack of these being changed.

12.111 The Police recorded that the staff stated that the clothes Brian brought in for Rosa were his and, at times, Rosa had been upset after phone calls with Brian but the reason was unknown. Staff shared that Rosa does not have capacity, had a brain injury as a child and MS, and that she was unable to do things for herself. Staff stated that Brian can appear to be engaging, such as when he is engaging with physios about how to lift and move Rosa. However, he could become aggressive towards staff and had accused staff of lack of care and stated that he was taking Rosa home. Brian had come into the ward drunk the previous week.

[34] Domestic Abuse Stalking and Harassment Risk Assessment.

[35] It is an offence for a person to ill-treat or neglect a person who lacks mental capacity.

12.112 The Officer spoke to Rosa in the presence of a Nurse about care at home. Rosa stated that Brian cared for her and became visibility upset, saying that she was upset because she missed her husband (he had not visited that day). 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 that if she wanted to report anything she could contact them or speak to the nurses.

12.113 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.

12.114 The SAF was screened within the Safeguarding Hub and shared with Adult Social Care. The DS within the Safeguarding Hub did not feel that a MARAC was appropriate. The Detective Constable 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 26 July 2023 and the invite was forwarded to the Police.

12.115 5 July 2023 – A 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 MDT, DoLS to remain in place until 27 October 2023, and the ward to keep the Safeguarding Social Worker updated of concerns.

12.116 13 July 2023 - Rosa was referred to the Psychiatric Liaison Team (PLT) for input by a Physiotherapist from NCIC who advised that Rosa was admitted for MS flare up, that her physical symptoms were resolving, and Rosa had engaged in rehabilitation, but there was a change in Rosa's presentation as her "mood dropped" and she had become tearful and stopped engaging. The PLT were advised about the safeguarding issues and Police involvement. Concerns remained around Brian who continued to visit Rosa in hospital despite safeguarding concerns and Police involvement at the time.

12.117 14 July 2023 – 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 discussed that PLT assessment might be counterproductive, increasing her stress, as she had no mental health diagnosis and 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 highlighted that attempts had been made to liaise with the MS Nurse for their input given their involvement in Rosa's care and treatment. 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.

12.118 17 July 2023 – There were failed attempts to contact the MS Nurse by PLT clinicians so telephone contact was made with the ward Staff Nurse looking after Rosa. A PLT clinician shared the outcomes from the MDT which included declining Rosa's referral as it was deemed inappropriate at the time. There were no identified needs or risks related to Rosa's mental health, and it had been agreed by MDT to decline referral at the time as there was no identified role for PLT. The ward staff were advised to contact NCIC safeguarding practitioner for input and support around Rosa's care and needs. It was agreed for the ward to re-refer Rosa if she posed a risk of suicide or self-harm to herself.

12.119 18 July 2018 – As there was no active involvement from the Neurophysiotherapy team at present, Rosa was discharged from their active caseload.

12.120 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. An 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.

12.121 18 July 2023 – PLT received a telephone call from the MS Nurse regarding Rosa's referral to PLT. The PLT clinician discussed possible factors that may have affected Rosa's continual engagement with her rehabilitation work while in hospital. PLT felt that the level of questioning required for a psychiatric assessment may be too much for Rosa. It was agreed that it would be discussed at the safeguarding meeting next week and, if it was felt appropriate, then PLT could undertake a psychiatric assessment. PLT was informed of plans for reassessing Rosa's capacity, and it was agreed there was no role for PLT at that time. However, Rosa was to be referred back to PLT if any need with her mental health was identified.

12.122 The MS Nurse suggested to the ward Nurse to contact the Health IDSVA. There is no record of this contact being made.

12.123 24/25 July 2023 – Rosa had contacts with a Dietician and Speech and Language Therapist who noted communication difficulties.

12.124 25 July 2023 – The MS Nurse and ward OT had an email exchange about Rosa's practical care requirements. They also discussed Rosa's disengagement with rehabilitation. The ward OT indicated that she didn't think it was the Police that triggered Rosa's disengagement, it was the day after she had a session with them with Brian present, noting that Rosa had done really well with him there and stood for longer than she had done with therapy staff. It was the following day that Rosa stopped co-operating, despite repeated attempts over the next two weeks. Rosa would not even stand for Brian. The Learning Disability Team had visited, and they suggested a timetable for her whilst she was on the ward but this was difficult due to it being an acute ward.

12.125 The same day the MS Nurse spoke with the People First IMCA who had visited Rosa that week. Rosa was asked about her home situation and stated she didn't like Todd 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 was 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. Brian's understanding of the situation and of Rosa's needs were queried, and it was noted that this would need to be discussed in detail with him along with the consequences if this was not adhered to. The IMCA was going to take further advice on this.

12.126 Later that day the IMCA emailed the Social Worker expressing concerns that the safeguarding meeting due to take place the following day had been postponed until 10 August[36] 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 for a contingency plan.

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

12.127 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, Todd.
- Whenever asked about Brian she made no disclosures and said he liked living at home with him.
- She said she didn't like Todd, because he 'bullies' her and she said she didn't trust him.

12.128 When asked what Todd does, Rosa made a movement and lifted up her elbow and made a jabbing movement. When asked where he did that to her, she pointed to her shoulder.

12.129 Rosa was questioned around how she would feel with other carers going in to support Brian, but she got upset and just kept saying she wanted Brian.

12.130 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.

12.131 On the same day the MS Nurse visited Rosa on the ward. Rosa was very tearful and upset and said she wanted her husband. Visitors were not currently allowed due to norovirus[37] on an adjacent ward. She repeated a few times that she wanted to go home. The MS Nurse explained that Rosa would need some special equipment and people to help her at home. Rosa said her husband should be looking after her. Rosa was noted to be bright and chatty at times and then very upset when talking about Brian and not being able to see him. She also talked about her uncle who she said had brought her up since she was one year old.

12.132 The Social Worker emailed the IMCA saying that he would visit Rosa the next day to carry out a capacity assessment and do a needs assessment. The IMCA responded informing him that, as per the Care Act guidance, Rosa would 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 July) 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.

12.133 27 July 2023 – Riverside Housing money advice team called Rosa to discuss a claim for Universal Credit. Rosa confirmed that they would need to speak to Brian. Rosa was advised that they would need to claim Universal Credit due to the move in property, but Brian seemed reluctant to do this. Rosa was advised that they would call back with an appointment.

12.134 28 July 2023 – Rosa was discharged from the Speech and Language Therapy service as there was no further remit for the service at this stage.

[37] Norovirus is a stomach bug that causes vomiting and diarrhoea.

12.135 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.

12.136 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 the DoLS in place until October. Brian said he had

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the right to overturn the court order and bring Rosa home again. He accused the MS Nurse of keeping information from him as she had been to see Rosa twice. The MS Nurse explained that equipment would be needed at home and Brian had cleared out the bedroom to accommodate this. Brian said that he felt Rosa was getting worse in hospital as she was refusing to eat. He said he was going to bring Rosa home in a month if there was no movement on her discharge. The ward Doctor had told Brian that Rosa would not be going to rehabilitation or a community hospital as she had stopped engaging.

12.137 2 August 2023 – The IMCA emailed a solicitor to update on recent developments. Rosa had expressed her desire to return home during her meeting with the IMCA on the 22 June 2023. The IMCA directed the solicitor to raise a 21a objection[38] on Rosa's behalf due to her objecting to her stay in hospital and wishes to return home. This email also mentioned a DVDS disclosure by Police at a previous visit to Rosa and that the situation had become more complex as Brian had prior allegations related to sexual offenses. 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.

12.138 2 August 2023 – A Cumbria Police Safeguarding DS reviewed the joint visit update and closed the SAF as no offences to investigate and the matter was more a role for Adult Social Care who could complete a capacity assessment and determine support going forward.

12.139 4 August 2023 – A Dietician was asked to see Rosa by the ward due to poor dietary and fluid intake. Brian had asked for a feeding tube and was told this was not appropriate. Rosa was at risk of malnutrition and refeeding syndrome[39] after six days of poor food intake. The plan was to continue with current advice and add in Complan with full fat milk and weigh weekly.

12.140 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.

12.141 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 (see 04 July 2023). They reported that Rosa was due to be discharged from hospital back into Brian's care and that Rosa was being assessed as to whether she had 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.

12.142 The Social Worker reported to Police that:

- Adult Social Care specific concerns were Brian's allegations in relation to sexual offences against minors, Rosa had severe MS and a moderate learning disability and had lost a lot of movement, and this would increase her vulnerability as she lacked capacity and would

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[38] 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.

[39] Refeeding is potentially a fatal condition defined by severe electrolyte and fluid shifts as a result of a rapid reintroduction of nutrition after a period of inadequate nutritional intake.

not be able to consent to sexual activity. Therefore, her returning home could potentially put her at risk of assault.

- Adult Social Care had concerns about emotional, psychological abuse and neglect and concerns about Rosa's capacity and her understanding of abuse and the concern was that Rosa may not recognise abuse due to her cognitive impairments.
- Rosa needed a significant care package and Brian kept declining any support. He provided care in the morning and then left Rosa in a chair all day, returning in the evening. This meant

Rosa had not been appropriately cared for. Brian kept making all of the decisions on Rosa's behalf and refused to let carers into the house.

12.143 The Safeguarding Hub DS was liaised with for advice on progressing the log. Adult Social Care were having a meeting on 10 August 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.

12.144 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.

12.145 Central to the discussion was a comprehensive review of the initial concern involving Rosa tracing back to 19 May 2023, when the MS Nurse brought forth observations to the safeguarding team, expressing deep reservations about Rosa's well-being, outlining instances where Rosa was left without adequate care due to the absence of Brian who had issues with alcohol. In Brian's absence, Rosa's care fell upon Todd, who was grappling with ADHD[40] 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.

12.146 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 Todd'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, facilitated through Riverside Housing.

12.147 While specific details were not immediately available as the Police did not attend the meeting, it was known that Brian had a history of allegations of sexual offenses.

12.148 Information was being sought from Children's Services to ascertain the extent of capacity assessments and DVDS disclosures conducted during the period when Rosa and Brian's twins were removed. In tandem, the IMCA and Social Worker were to work on Rosa's comprehensive care and support plan. This multifaceted plan encompassed 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.

12.149 Recognising the intricate nature of Rosa's circumstances and the demand for comprehensive capacity assessments, the IMCA was to seek legal advice. The IMCA thought it would be

[40] Attention deficit hyperactivity disorder (ADHD) is a condition that affects people's behaviour.

likely and appropriate that as part of the Section 21a proceedings, a Section 49 report[41] may be requested, especially in light of the complexities surrounding Rosa's capacity. Anyone involved in raising a Section 21a challenge (i.e. an IMCA in this case), would be reliant on guidance from the solicitor instructed in the case, to advise about the possible requirement/appropriateness of a request for a Section 49 report to be made during the Section 21a proceedings.

12.150 It was also noted that Rosa would benefit from a Neuropsychology[42] review as it was unclear if her cognition issues were due to her learning disability, MS or head injury. A further meeting was to be held the following week with Rosa and Brian invited.

12.151 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 asked to leave the building but attempted to re-enter the building around 20 minutes later, claiming he had lost money. Doors had already been secured, preventing his entry. 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.

12.152 11 August 2023 – Rosa was seen by the Dietician. There were no verbal responses from Rosa. Brian was in attendance and made reference to a number of issues throughout Rosa's hospital stay.

12.153 14 August 2023 – The MS Nurse requested advice from the Neuropsychology team to check if Rosa had been seen by them in the past and whether she may benefit from an assessment as it was unclear if her cognition issues were related to her learning disability or if her MS was having an impact on her decision making, memory and engagement with professionals.

12.154 15 August 2023 – Rosa was referred back to the Speech and Language Therapist by ward staff and assessed as possibly developing hospital acquired pneumonia. Antibiotics commenced and management advice was provided. Rosa was drowsy and unable to make her needs known. Rosa was seen again by the Speech and Language Therapist on the 16 and 17 August who noted a further deterioration in her condition.

12.155 17 August 2023 – The IMCA visited Rosa who was connected to a CPAP machine[43], 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).

12.156 18 August 2023 – Brian left a voicemail stating that Rosa would be unable to attend the Neurology appointment at Penrith as she was in hospital on oxygen and that this should have been known and that someone should have been to see her, and this could be classed as neglect. He then phoned five minutes later and spoke to someone in person. He didn't sound

[41] Section 21A proceedings are cases where there is a DOLS in place and the person it relates to has expressed objections to their placement. Under section 49 of the Mental Capacity Act 2005 (MCA), the Court of Protection can order reports from NHS health bodies and local authorities when it is considering any question relating to someone who may lack capacity and the report must deal with 'such matters as the court may direct.'

[42] Neuropsychology combines neurology, the study of the nervous system, with psychology, the study of the mind and how it affects behaviour.

[43] 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.

as angry and said that Rosa cannot attend as she is dependent on oxygen and that the hospital had said they won't restart her heart if it stops.

12.157 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, Todd, who had tried to approach the IMCA, but Brian immediately instructed him to sit down and stay quiet. Without hesitation, Todd had followed his uncle's instructions. Later on, Todd attempted to hand Rosa her glasses, but Brian intervened again, scolding him and telling him not to touch her belongings. Again, Todd complied. The IMCA spoke with Rosa's aunt who mentioned that Todd was still around when she arrived at the hospital later on the evening of the 17 August. Apparently, Brian had informed Todd that he was not allowed to leave until 10:30pm. Despite the aunt reassuring him that it was perfectly fine to go, Todd said that he wasn't permitted to do so. The aunt also shared that Brian had control over the nephew's bank card.

12.158 On the same day the IMCA was provided with information by a colleague about Brian's previous partner, who was also a vulnerable woman and had been supported by People First. This was not documented within the existing notes.

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

Significant events following Rosa's death

12.160 People First contacted the Police to report that they had been advocating for Rosa in a matter regarding controlling behaviour towards Rosa from Brian, and Rosa had now passed away. The caller was questioning that the lack of attendance at medical appointments may have contributed to Rosa's death. A DS and DI reviewed the information in the incident log and concluded that no Police investigation was needed, as Adult Social Care had been involved for a long time and any concerns would or should have been raised. This information was shared with Adult Social Care.

12.161 Information came to light during the course of the review which was shared with the Police and this prompted the instigation of an investigation into the offence of Causing or allowing the death of a child or vulnerable adult.[44] However, it became apparent that, following the Medical Examiner raising her concerns with the Coroner, the Coroner had posed some questions to the Police. These were picked up and reviewed at that time by a DI who deemed that there would be no Police investigation.

12.162 In summary, the Coroner's questions and DI responses were:

- Whether there was a requirement to investigate whether a general lack of care or neglect had caused Rosa's death – The DI summarised his findings and concluded that it would be far from the threshold required for criminal investigation and prosecution.
- Whether the level of care around not attending medical appointments and administering medication been a factor in Rosa's death – The DI summarised his findings and concluded that there was evidence of medical and third party involvement for some time, (including Adult Social Care, community nursing) which would be expected to have picked up any significant issues.

[44] Section 5 of the Domestic Violence, Crime and Victims Act 2004 provides for an offence of causing or allowing the death of a child or vulnerable adult.

- Whether any further investigation was needed related to the concerns about Rosa's swallowing problems and nutrition – The DI summarised that considering offences, he did not feel it justified to investigate the hospital.

12.163 These conversations were not recorded on Police recordable and searchable systems as they took place over email. Overall, while he shared concerns raised about Rosa's care needs, the DI's recommendation was that there was no requirement for further Police investigation in respect of Rosa's death. Due to this, the later investigation commenced by the Police was concluded No Further Action.

13. Overview of agency involvement

This section summarises the information about agencies providing an IMR for the review and the nature of their contact with the subjects of the review.

Cumbria Constabulary

13.1 Cumbria Constabulary is the territorial Police force in England covering the unitary authority areas of Cumberland and Westmorland and Furness in the ceremonial county of Cumbria.

13.2 Rosa was a victim in nine recorded crime reports. These appear to be hate crimes, whereby she has been the victim of harassment, and damage.

13.3 The Police responded twice to reports of coercive and controlling behaviour from Brian towards Rosa and twice to requests for a DVDS/Clare's Law disclosure.

13.4 There are no recorded domestic abuse crimes relating to Rosa and Brian.

Adult Social Care

13.5 The Adult Social Care and Housing agency is located within Cumberland Council. The role of the agency is to fulfil functions under the Care Act 2014 as well as associated legislation under Such Acts as Mental Capacity Act 2005 and the Mental Health Act 1983.

13.6 Adult Social Care responded to safeguarding referrals in relation to Rosa, twice initiating Section 42 enquiries. Several SAF reports were shared with Adult Social Care by the Police. Adult Social Care provided Rosa with OT support.

North Cumbria Integrated Care NHS Foundation Trust (NCIC)

13.7 The trust provides a range of acute hospital services based at the Cumberland Infirmary in Carlisle (CIC) and the West Cumberland Hospital in Whitehaven. It also provides a midwifery-led maternity service at Penrith Community Hospital and community services covering the Cumbria region (adult and children's community services in north Cumbria and some which are whole county based).

13.8 Rosa was known to NCIC services with regular attendances at NCIC emergency department and, in a period over 13 years (2010-2023), had attended the department on 34 occasions. This was with various injuries, seizures and falls with the last admission being in June 2023 where she was admitted to the medical ward with a suspected exacerbation of her MS.

13.9 Rosa was also known to the Multiple Sclerosis Team, the neurology service, the continence service, occupational and physiotherapy services. Her main contact was with the MS Nurse who co-ordinated her care with other agencies.

Riverside Housing Association

13.10 Riverside are a registered social landlord operating across England and Scotland with more than 75,000 homes.

13.11 The property occupied by Brian and Rosa is owned and managed by Riverside Housing Association. Brian and Rosa were joint tenants of a Riverside property, also residing at this property with them was Brian's nephew. Prior to them being allocated a property of their own they were resident at another Riverside property where they lived with Rosa's grandmother and Rosa's Uncle. Rosa had always been resident at this address and Brian moved in around July 2014.

People First

13.12 People First is an independent charitable organisation which sits within the Health and Social care sector. They provide a range of support and information services across Cumbria, Lancashire and Teeside including advocacy support to help people to engage in local authority processes who would otherwise have significant difficulty doing so. Advocacy is also provided to people in relation to other matters, including people who are deprived of their liberty under the Mental Capacity Act or who are detained under the Mental Health Act.

13.13 The advocate supported Rosa in the roles of:

- Care Act Advocacy in relation to the local authority safeguarding enquiry.
- Independent Mental Capacity Advocate (IMCA) in relation to a 39a deprivation of liberty assessment. The IMCA 39a role is to provide independent representation of the person's feelings, wishes, values and beliefs during a Deprivation of Liberty Safeguard best interests assessment. The IMCA 39a compiles a report to feed into the assessment process.
- Relevant Person's Representative (RPR) -The role of RPR is an individual who is appointed to represent and advocate for a person who lacks the mental capacity to consent to their own deprivation of liberty. The purpose of the RPR is to safeguard the rights and interests of the person who is deprived of their liberty in a hospital or care home.
- Litigation Friend - A Litigation Friend is individual who is appointed to represent and assist someone who lacks mental capacity to make decisions regarding legal proceedings.

Carlisle Healthcare

13.14 Carlisle Healthcare are a large GP practice with 38,000 patients. Due to their size, they have evolved into two teams: one looking after patients at three surgery sites across the city (North, Central and South), and one looking after housebound patients which is based at the North Carlisle Surgery site. Some members of staff, particularly the GPs, work across both teams.

13.15 Carlisle Healthcare were the GP practice that Rosa and Brian were registered with. The practice provided general medical services to them both.

14. Analysis

This section explores the thematic, multi-agency and system analysis that arises from the circumstances leading to the death of Rosa. The key lines of enquiry (KLOI) from the Terms of Reference provide a framework for this analysis.

KLOI 1: 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?

Indications of physical abuse

14.1 There are numerous incidents recorded of Rosa having injuries that were unexplained or with limited explanation.

14.2 In 2016 and again in 2017, Rosa health care professionals noted extensive bruising on Rosa but with no explanation noted of how the bruises occurred. These injuries may or may not have been caused by physical abuse. On neither occasion, however, was there an enquiry about possible abuse, a risk assessment, further investigation or escalation.

14.3 There are four occasions between 2020-2022 when Rosa had apparently fallen and sustained injuries. It is noted in relation to one incident that it was difficult to ascertain the history and nature of Rosa's injuries. The family note that Brian would likely have been telling Rosa what to say and not say and controlling the narrative.

14.4 Rosa often had bruising and injuries to her arms and legs. There were usually reasons indicated for the bruising which met the mechanism of the injury, with Brian highlighting some to health care professionals and his explanation being accepted. Inappropriate manual handling was identified as the cause on some occasions. There were however other occasions where the bruising was not explained or inconsistent with the injury and there is a perceived lack of professional curiosity from health care professionals into how these injuries occurred or the use of body maps to track information on or patterns regarding injuries.

14.5 Social Care Institute for Excellence[45] cite the following types of physical abuse that people with care and support needs might experience, some of which appear to be relevant to Rosa's experiences:

- Assault, hitting, slapping, punching, kicking, hair-pulling, biting, pushing.
- Rough handling – Rosa was bruised due to inappropriate manual handling. Brian was not using the prescribed equipment to safely move/transfer Rosa – even after education was provided.
- Scalding and burning.
- Physical punishments.
- Inappropriate or unlawful use of restraint.
- Making someone purposefully uncomfortable (e.g. opening a window and removing blankets) – Rosa had no choice at times but to sit in a wheelchair all day with no pressure relieving equipment.
- Involuntary isolation or confinement – Rosa was left at home all day, isolated from her family, Brian managed her access to health care, his nephew, Todd, was used to inappropriately provide Rosa's care needs and directed not to leave Rosa alone on the ward and to only allow bloods to be taken.

[45] Types and indicators of abuse: Safeguarding adults - SCIE [51]
Women's Aid Federation of England- Website accessed April 2024. [52]
Section 76 of the Serious Crime Act 2015.

- Misuse of medication (e.g. over-sedation) – Brian was not collecting and supporting the administering of medication to manage Rosa's physical health symptoms.
- Forcible feeding or withholding food – Brian was not providing adequate/appropriate food and fluids.
- Unauthorised restraint, restricting movement (e.g. tying someone to a chair) – the mismanagement of Rosa's MS symptoms limited her ability to leave or to move.

Indications of coercive control

14.6 Women's Aid define coercive control as 'controlling behaviour that is designed to make a person dependent by isolating them from support, exploiting them, depriving them of independence and regulating their everyday behaviour. Coercive control creates invisible chains and a sense of fear that pervades all elements of a victim's life. It works to limit their human rights by depriving them of their liberty and reducing their ability for action'[51].

14.7 Controlling or coercive behaviour in an intimate or family relationship became a crime on 29 December 2015.[52]

14.8 Some common examples of coercive behaviour are:

- Isolating you from friends and family
- Depriving you of basic needs, such as food
- Monitoring your time
- Monitoring you via online communication tools or spyware
- Taking control over aspects of your everyday life, such as where you can go, who you can see, what you can wear and when you can sleep
- Depriving you access to support services, such as medical services
- Repeatedly putting you down, such as saying you're worthless
- Humiliating, degrading or dehumanising you
- Controlling your finances
- Making threats or intimidating you.[46]

14.9 Rosa and Brian's relationship developed very quickly. It seems that within around a year they had established a relationship, married and had twins. A fast relationship progression, where the abuser seeks early and premature commitment, can be a typical feature of coercive control.[47]

14.10 A person with a learning disability who can decide for themselves about something (has the capacity to make that decision) has the same right to get married as anyone else. For consent to be legally valid the person giving it must have the capacity to make the decision, have been given enough information to make the decision and not have been under any pressure or threat of harm. Rosa's family said that she loved her wedding but that they did believe there was coercion to marry, and that marriage gave Brian more control as Rosa's next of kin. The family also shared that the Social Worker had commented that being married would help Rosa and Brian's cause to get the children back before adoption, and following this comment, they immediately went and booked the wedding.

14.11 Children Social Care hold detailed notes on the supervised contact sessions between Rosa, Brian and their twins in 2014, and they report that Brian was observed to be extremely controlling, patronising, abusive, and coercive in his behaviours towards Rosa. There is, however, no record of a risk assessment being undertaken in relation to Rosa, concerns for

[46] Coercive control - Women's Aid (womensaid.org.uk) Accessed November 2024.
[47] Love bombing: Affection today. Abuse tomorrow. - Solace Womens Aid Accessed November 2024. [55]
EMIS is the patient record system used by Health.

her safety being escalated, or domestic abuse related support needs for her being considered. When it became known to Rosa and Brian that contact was being phased out and moving to indirect contact, Brian cancelled nearly all contacts after that, which, coupled with the behaviour observed, should have raised concern that Rosa was being further isolated with no support for her in place. The family note that Rosa, her grandmother and her uncle were very unhappy when contact was reduced or didn't happen.

14.12 Later it is noted that Brian led Rosa to believe that the removal of the twins was her fault, the aim of which was likely to divert responsibility and reinforce a sense worthlessness in her.

14.13 Throughout the EMIS[55] records, until she was admitted to hospital, Rosa was documented as having capacity to understand her care and support needs but there were many concerns that and that could have been explored further to understand if these were decisions made by Rosa or whether they were indicators of coercive control as follows:

- Not being brought to appointments.
- Not complying with requests for weight to be recorded.
- Medication not being picked up in a timely manner.
- Instructions being left by Brian that Rosa is not to be seen on her own by health care professionals and the use of a third party to monitor when Brian was not present
- When brought to appointments, Brian always being in attendance.
- Rosa's refusal to undertake the second year of Cladribine despite it being in her best interest to do so. This was discussed with Rosa on numerous occasions who indicated it was because of the side effects she has experienced during the first year of Cladribine but it is not clear if this is Rosa's decision or if she was influenced by Brian to make this decision.

- Brian's behaviour when Rosa was admitted to the medical ward and his insistence on taking Rosa home despite her being on a DoLS and needing specialist care. Brian did not attempt to remove Rosa but threatened to once the DoLS had expired.
- Brian was sometimes obstructive to care staff and wouldn't always allow access to Rosa without an appointment.
- Brian would often answer Rosa's mobile phone.
- Rosa was admitted to the hospital in an unkempt condition with matted hair, dirty fingernails and dirty skin between her fingers.

14.14 Even when Rosa was hospitalised and subject to DoLS, the family highlight that Brian continued to control access to her and to isolate her from family. Brian insisted that he take all visit slots but then, unbeknown to the family, did not always visit Rosa, leaving her isolated without any visitors.

14.15 Experts like Evan Stark likens coercive control to being taken hostage whereby the victim becomes entrapped in a world of confusion, contradiction and fear.[48] Rosa's own behaviour may have been indicative of this in that she referred to him to speak for her, to make decisions regarding her care, and appeared fearful and upset when she could not consult him. Due to the lack of associated assessment, it is impossible to determine how much this

[48] Stark, E. (2007). Coercive control: How men entrap women in personal life. Oxford University Press.

was as a result of Rosa's learning disability and how much due to control exerted by Brian. The panel concluded that it was likely to have been a combination of both.

Indications of economic abuse

14.16 The charity Surviving Economic Abuse define this as "exerting control over income, spending, bank accounts, bills and borrowing. It can also include controlling access to and use of things like transport and technology, which allow us to work and stay connected, as well as property and daily essentials like food and clothing. It can include destroying items and refusing to contribute to household costs".[49]

14.17 During a safeguarding strategy meeting in August 2023, it was discussed that Rosa's aunt had disclosed concerns to a Social Worker about Brian's behaviour, which included financial coercion and a tight grip on their financial matters, extending to Rosa and Todd's finances.

14.18 In 2020, the Housing Officer raised concern that Brian was not paying the rent, despite being given the money to do so. Lack of funds was also cited as one reason for Rosa not being able to get to hospital appointments. The family note that, prior to Brian taking control, they always budgeted for Rosa's hospital visits and she never missed any. Later, on two occasions Rosa's aunt raised concerns with the MS Nurse about the financial control held by Brian, not just over Rosa but also over her grandmother, uncle and his nephew, and that Brian would take the grandmother's bank card to pay bills, but this money was often spent in the pub. A safeguarding referral was submitted in light of this.

14.19 Economic abuse is now known to be a common element of domestic abuse[50] which overlaps with and is reinforced by other forms of abuse, with estimates that up to 98% of women seeking services for domestic abuse reported instances of economic abuse in their partnership[51]. The same study found that 20% of women in the general population reported experiencing some form of economic abuse.

14.20 Additionally, Rosa's learning disability may have increased her dependence on Brian to manage finances and her vulnerability to economic abuse as people with learning disabilities are more likely than other sections of the population to need help with managing their finances.[52] Notably, Rosa's aunt stated that If she had money, Rosa would likely go and spend it all on sweets, just as a child would. Brian largely managed Rosa's communication with DWP, claiming to be her carer. Rosa did not have an email address which further limited her ability to communicate independently with DWP.

Indications of sexual abuse

14.21 Brian had a history of allegations of sexual abuse towards children perpetrated by him. In 2009, a previous partner of Brian disclosed that Brian had raped her more than once. In 2013 a partner of Brian's alleged that he had raped her. Whilst all of these allegations were concluded with 'no further action', they were enough for Children's Social Care to consider Brian a risk and to be concerned about his contact with children. The Core Group meeting (at that time) identified that Brian establishes relationships with women who have some level of learning disability or are deemed to be vulnerable.

14.22 The complaint made by neighbours in June 2020 cited that Brian was using sexually explicit language to a female visitor and was then overheard verbally abusing Rosa. The Social Care

[49] https://survivingeconomicabuse.org/what-is-economic-abuse/ Accessed November 2024.
[50] Economic abuse is now a legally recognised and defined in the Domestic Abuse Act.
[51] Sharp-Jeffs N. (2015). *A review of research and policy on financial abuse within intimate partner relationships*. London Metropolitan University.
[52] Learning disability and debt | Disability Rights UK Accessed November 2024.

Institute for Excellence cite inappropriate looking, sexual teasing or innuendo or sexual harassment as a form of sexual abuse[53].

14.23 Rosa was found to have a blood-stained incontinence pad despite not having had periods for some time due to a contraceptive implant although the implant had expired and was due for renewal. This may have been an indicator of sexual abuse. Rosa was asked who was changing her pads and she pointed at the nephew, Todd. Rosa was asked if she would like carers to help with this and responded that they should ask Brian. There appears to be no further investigation or action at all in response to this concern.

14.24 Research says that woman and children with learning disabilities can be up to four times more likely to experience sexual violence than people without a disability. Some of the reasons for this, are that people with learning disabilities might lack power in relationships. They might have low self-esteem, lack knowledge about sex because they do not get high quality sex education and are worried what will happen if they speak out. Some people might. find the abuse difficult to talk about as they do not have the right words to be able to tell someone what happened [54].

14.25 In 2023, when requesting a DVDS from the Police, Adult Social Care raised specific concerns about Brian's history of allegations of sexual offences, and that, due to her vulnerabilities, Rosa would not be able to consent to sexual activity and her returning home could potentially put her at risk of assault. This appears to be the first acknowledgement of this risk.

Agency responses to domestic abuse identified

14.26 Between 2014 and 2020 indicators of domestic abuse, including coercive control, economic abuse and sexual abuse were being presented to agencies. These did not, however trigger any further exploration or risk assessment, or any escalation of response to safeguarding concerns.

14.27 In June 2020, prompted by a complaint from a neighbour of Rosa and Brian, Riverside Housing raised safeguarding concerns of abusive behaviour from Brian towards Rosa and other household members, which instigated responses from Adult Social Care and the Police.

14.28 A Vulnerable Adult Safeguarding Alert Form (SAF) Report was graded medium risk by Police following a strategy meeting held with Adult Social Care and Riverside Housing. It seems, however, that the only action from the multi-agency safeguarding response, was to undertake a joint visit to speak to Rosa and other householders. No linked crimes were recorded.

14.29 In July 2020, the Police visited Rosa when Brian was not present and attempted to deliver a DVDS disclosure to inform Rosa about Brian's known previous domestic abuse related behaviour. This was, however, unsuccessful, with Rosa declining to hear the disclosure. The Police IMR author noted that Police cannot force the information upon the person as the content is sensitive and confidential. It is up to the person to receive the disclosure if they want to hear it or not (see 14.45 for further comment on this). Following this, the Police considered the case to be more appropriate for Adult Social Care and closed the SAF.

14.30 The DASH risk assessment that was completed alongside the DVDS application was graded medium risk by the submitting Officer. However, this was not based on speaking to any parties involved. It is not clear whether the DASH included Brian's prior history of allegations of abuse towards vulnerable women and children, and cruelty to animals. The fact that there

[53] Types and indicators of abuse: Safeguarding adults - SCIE Accessed November 2024.
[54] Behind Closed Doors. Preventing Sexual Abuse Against Adults with a Learning Disability (Mencap: 2001) Accessed November 2024.

was a disclosure attempted, means that there was historical information about Brian that was disclosable in relation to risk.

14.31 Of concern is that, despite that controlling and coercive behaviour was evident in the initial referral, that it was known that Rosa had learning difficulties and there was a known history of domestic abuse perpetrated by Brian, Police and Adult Social Care concluded that there was no evidence of harm or abuse based on a single visit to Rosa. There was no reflection made on how best to approach Rosa, on how her reactions may be influenced by Brian's control and no intermediary[55] was used to communicate with her. This response is in conflict with what was known to the agencies and with their subsequent action to seek a Clare's Law disclosure and to refer to People First citing incidents of alleged sexual and physical abuse towards Rosa. Rosa, however, declined advocacy support from People First at this time. The fact that Rosa had withdrawn previously from People First, due to mistrust arising from their support during the care proceedings related to the twin's removal, does not appear to have been considered by any agency.

14.32 Had agencies more thoroughly investigated the risk and considered the information available to them as a whole, a MARAC referral would have been appropriate and provided an opportunity for a multi-agency response bespoke to the needs of Rosa. This was a missed opportunity.

14.33 Two safeguarding referrals were made to Adult Social Care due to concerns over potential neglect, control and coercion and financial abuse, both whilst Rosa remained in the community and during her time as an inpatient. The first referral was made on the 19 May 2023 because Rosa was subdued during a home visit by the MS Nurse and a colleague and worried about being on her own with Todd. Another safeguarding referral was made on the 22 May 2023 as the MS Nurse hadn't heard anything from Adult Social Care. The first referral on the 19th had not been recorded by the Single Point of Access Officer even though this was raised as a safeguarding alert. Adult Social Care note that the initial contact from the MS Nurse was logged on the system by the out of hours Social Worker as it was received at almost 5pm and triaged by the out of hours team who assessed that the referral could wait until the following Monday (22 May) and the referral was subsequently logged as a safeguarding concern.

14.34 The NCIC IMR author states that, where domestic abuse is identified or disclosed, there is an expectation that all patients are supported with the DASH and consideration for MARAC is completed by the practitioner directly involved in their care. These responses were not, however, completed by the MS Nurse or other health professionals in this case.

14.35 The referral to Adult Social Care progressed to a Section 42 enquiry[56] and when Rosa was admitted to hospital the enquiry remained open and multiple visits were undertaken to the ward to gather Rosa's views and wishes from Adult Social Care. The assessment of risk by different Social Worker's involved in the case appears to differ, with one there stating there was no evidence of physical abuse and no evidence Rosa was unhappy in her marriage, and another reporting concerns to the Police that Rosa was experiencing emotional and psychological abuse from her husband, that Brian was exhibiting controlling and aggressive behaviour and was dismissive of Rosa's care needs.

[55] An intermediary is a person used to help facilitate communication between parties. In this case, this would have been someone with an understanding of Rosa's communication needs.

[56] A Section 42 enquiry is any action that is taken (or instigated) by the local authority, under Section 42 of the Care Act 2014, in response to indications of abuse or neglect in relation to an adult with care and support needs who is at risk and is unable to protect themselves because of those needs.

14.36 The referral to the Police resulted in a visit to Rosa by a uniformed Officer. Rosa did not want to talk with them and kept avoiding eye contact looking out of the window. This unexpected situation may have been especially difficult and intimidating for Rosa, so it is not surprising that she did not engage. There had been no pre-consideration of Rosa's needs in relation to this visit. This is explored further at 14.47.

14.37 The Officer did, however, clearly reflect on this and request that a specialist Officer, not in Police uniform, speak with Rosa with an appropriate adult present. The Officer did also submit a high risk SAF report for further review, but did not complete a DASH, and despite the high risk status of the SAF, a MARAC referral was deemed to be inappropriate, whilst Adult Social Care involvement was clarified. Additionally, the fact that Rosa was in hospital for some time was considered a safeguarding factor. Again, the lack of referral to MARAC at this stage is concerning and it does not appear to have been considered again once Adult Social Care involvement was clarified. The Police IMR author notes their concern that this high-risk domestic abuse SAF report was not shared with MARAC as this would have allowed for a wider safety discussion between Police and a wide range of partner agencies. This would also have allowed for tasking/actions to be allocated to the most appropriate agency. Safety/Risk would have been discussed along with the history known to Police and other agencies, and a collaborative approach would have been taken moving forward. They do highlight, however, that the Officer submitting the High-Risk Domestic Abuse SAF did so correctly, in their opinion.

14.38 The panel noted that Victim Support should have received a copy of the high risk SAF report because the policy is that consent for referral is overridden for high risk cases. It was not shared so an opportunity to offer specialist domestic abuse support was missed. This appears to be due to human oversight.

14.39 The panel also discussed that there is an issue in terms of how Section 42 enquiries and the MARAC work collaboratively and that there can be a tension between the two and which has primacy. Whilst Rosa wasn't referred into the MARAC, this is an issue that needs attention locally.

14.40 Overall, there were clearly concerns amongst professionals about the risks Rosa would be exposed to if she were to return home from the hospital and steps were taken to prevent this from happening. The action was however, at the point of crisis and it could be argued that this was too little and too late.

14.41 Lacking from all agency responses is a comprehensive risk assessment, that drew together the multiple strands of information, including historical intelligence and information from Rosa's family, and a coordinated response to the identified concerns. This process would have benefitted from specialist domestic abuse expertise input, which was also lacking.

KLOI 2: Were there opportunities for Rosa or Brian to disclose concerns about domestic abuse? What barriers may have existed to prevent a disclosure?

14.42 Victims of domestic abuse face many barriers to reporting domestic abuse. They may, for example, fear reprisals from the abuser, fear that their children will be removed, be unable to identify the risk they face due to normalising the abusive behaviour, be fearful of homelessness, debt, and other practical factors – all of these are further exacerbated when the victim is suffering from poor mental health.[57]

[57] Rose, D et al; Barriers and Facilitators of Disclosures of Domestic Violence by Mental Health Service Users; The British Journal of Psychiatry: The Journal of Mental Science (198) 3 (2011) pp.189-94

14.43 Violence against people with learning disabilities is profoundly under-reported, and comparatively low in comparison to other protected groups.[58] Furthermore, people with learning disabilities may find it challenging to report violence due to inaccessible reporting systems and also out of fear of institutional reprisals from the Police. People with learning disabilities may be concerned that they will not be seen as credible or be fearful because the person "supporting" them may also be the perpetrator of violence.[59]

14.44 There were a number of opportunities for Rosa to disclose concerns about domestic abuse. Although perhaps, not as many as there might have been due to Brian keeping Rosa away from professionals and/or speaking on her behalf to them. Additionally, Rosa may not have been able to identify that she was experiencing domestic abuse, to understand what domestic abuse is, or to articulate her experiences in relation to this.

14.45 Rosa was pro-actively approached by the Police to enquire about domestic abuse and to attempt to deliver a Clare's Law disclosure. Since Rosa has a learning disability and this would have impacted her ability to understand complicated information, to articulate herself, and to interact with other people, the way in which Rosa was approached by professionals wishing to talk to her about domestic abuse, and the formality of the situation, may have been especially difficult for her. Also, receiving telephone calls from Brian during the visit must have caused further stress for her. Lacking in these interactions was pre-planning to take account of Rosa's needs, how best to communicate with her, or the use of an intermediary with whom Rosa had a trusted relationship. Rosa may have been so conditioned by Brian not to say anything that she would never have taken the opportunity. In the early contact with the Police, Rosa's family resided with Brian, and a fear of what would happen to them if she were to speak out may have been a factor. Furthermore, when these visits did not illicit a disclosure, this was assumed to be the end of the enquiry, when further visits to Rosa may have enabled some trust to build and communication to occur at her pace.

14.46 The Police Officer attempting to deliver the DVDS in 2020 visited Rosa alone, noting that it can be very difficult to coordinate a joint visit with a Social Worker due to working patterns and availability, particularly as this was the year that Covid was very live and impacting on service responses. The Officer had the limited information on the referral that Rosa had a learning disability but no understanding of what this looked like for Rosa, noting that the Police would normally take the lead from the Social Worker in cases like this. No consideration was given to an alternative intermediary for Rosa and the Officer was not aware of the IMCA role or that the MS Nurse played a key role in supporting Rosa.

14.47 At that time, the visiting Officer would have been required to wear a mask due to Covid and the practice would have been to remain standing at visits to minimise Covid related risks. This must have not only heightened the confusion, intimidation and anxiety related to the situation for Rosa, particularly given her expressed fear of Covid, but also made clear and supportive communication extremely difficult.

14.48 When the uniformed Police Officer visited Rosa with a colleague in hospital in July 2023 in response to reporting concerns that she was experiencing emotional and physical abuse and controlling behaviour by her husband, again, they were not equipped with much information prior to the visit about Rosa's needs, although they recall that there may have been a query flagged about her capacity. The visit took place early evening and the body worn video shows Rosa lying in a bed whilst the Officers stood and long, descriptive sentences were

[58] Macdonald S. J., Donovan C., Clayton J. (2017). The disability bias: Understanding the context of hate in comparison with other minority populations. Disability & Society, 32(4), 483–499.
[59] Wiseman, P., & Watson, N. (2022). "Because I've Got a Learning Disability, They Don't Take Me Seriously:" Violence, Wellbeing, and Devaluing People With Learning Disabilities. Journal of Interpersonal Violence, 37(13-14).

used by them to explain the reason for their attendance. Given Rosa's aunt's comment that Rosa had the comprehension of around an eight year old, this must have been especially confusing and scary for Rosa. One of the Officers shared that they were quite shocked at how Rosa presented and her inability to communicate.

14.49 When a subsequent visit was made by an Officer in plain clothes and with a Social Worker, Rosa did, however, appear to make a direct disclosure about physical abuse from Todd when she was reported as saying that Todd bullies her, and she doesn't trust him. When asked why she raised her arm and made a jabbing movement with her elbow and when asked where he did this, she pointed to her shoulder. When the DS reviewed the SAF following this visit, and in conversation with the PC, it was determined 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 panel noted that this was not a fair assessment of what Rosa may have been trying to communicate and that the Police response was dismissive of this. The panel reflected that the DS should have further reviewed the incident log and other information available to make a more informed decision.

14.50 Furthermore, in arriving at a decision that no crime was apparent, the DS had not considered Brian's past history, did not consider talking to family members, or Brian or Todd, to gather more information, nor had they considered the possibility of a Section 44 offence. (see 14.92 for further comment on the DS safeguarding role and training needs).

14.51 People First provided a helpful comment on the barriers that may have existed to prevent Rosa disclosing concerns about domestic abuse in that may have been a combination of the impairment of Rosa's ability to identify concerns in relation to domestic abuse and to articulate them due to the suspected control and coercion she was subject to, the limitations of Rosa's capacity to retain and use and weigh information due to her learning disability and the deterioration of her health impacting on her mental and emotional wellbeing. A further barrier may have been Rosa's reluctance to engage with professionals in relation to disclosing concerns about domestic abuse which also links into the suspected control and coercion it was suspected she was subject to. People First also point out that there may, at times, have been a lack of professional curiosity in relation to suspected domestic abuse and a lack of consistency of input and support in relation to the services and professionals involved in Rosa's welfare.

14.52 The removal of Rosa's twins must have had a profound impact on her. The Good practice guidance on working with parents with a learning disability (2021)[60] states that parents should have access to both emotional and practical support when the child protection process concludes with children being removed. It goes on to state that "Parents' grief should be recognised and responded to. Such bereavement is particularly hard to bear when parents have experienced other losses in their lives (including in their own childhoods) and services should be aware of parents' vulnerability and needs for considerable support in such a situation".

14.53 Rosa does not appear to have received any support following the loss of her twins. This, coupled with the mistrust of agencies involved in this process, would likely have reinforced her attachment to Brian and reluctance to engage with agencies.

14.54 The author of the IMCA report submitted in June 2023 suggested that someone spends time with Rosa on a daily basis, engaging in activities such as colouring. They noted that, while

[60] The Working Together with Parents Network (WTPN); Good practice guidance on working with parents with a learning disability (2021). FINAL 2021 WTPN UPDATE OF THE GPG.pdf (bristol.ac.uk)

Rosa may initially express resistance or claim inability, with a little time and patience, Rosa was willing to participate. The family report, however, that this did not happen.

14.55 The opportunities for Brian to share concerns about his relationship with Rosa and his behaviour within this were very limited as no carer's assessment was undertaken and he was not directly spoken to about the allegations of abuse towards Rosa.

KLOI 3: 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?

14.56 Rosa's engagement with the Community Learning Disability Team (CLDT) was poor. This was evident following her referral to the CLDT by her Consultant Neurologist in 2017. After the initial assessment, her next appointments were cancelled by Brian citing Rosa was not well enough to engage. It is evident that clinicians attempted to engage Rosa, but this was not successful. However, the clinical records do not evidence if Rosa understood the role of the service she declined and the impact or risk of this.

14.57 Adult Social Care point out that at an early stage during MS Nursing involvement, it became increasingly apparent that the involvement of Brian and the wider dynamics in the house made it difficult to engage Rosa around her possible care and support needs.

14.58 The main team caring for Rosa and co-ordinating referrals was the Neurology team (specifically the MS Nurse) and they made appropriate and timely referrals to all other agencies. It is of concern that Rosa missed appointments with a number of the services offered but it is not clear if this was Rosa's decision or Brian's and whilst attempts were made to communicate the difficulties that Rosa had attending morning appointments, this does not appear to have been taken into account when making reasonable adjustments for her disabilities. Rosa's aunt noted that hospital transport is only for the patient and not the carer, which was not appropriate in Rosa's case.

14.59 According to the MS Nurse, Rosa was very strong willed and would only do something if she wanted to. She would accept referrals to Adult Social Care for an assessment of her care and support needs but then say she didn't need them and wanted Brian to care for her. She got upset when Brian wasn't able to provide the care and whilst in hospital voiced that she didn't want carers as she expected and wanted Brian to provide the care that she needed.

14.60 Rosa could never give an answer as to why she was missing health appointments and if Brian was there when she was asked, he would speak for her and said that reason was because of financial difficulties which prevented Rosa from being able to afford to travel to and from appointments. Brian was thought to have full control over Rosa' money as well as his own and his nephew's. (see references to economic abuse at 14.16-14.20). Brian's explanation was taken at face value and no further exploration made regarding the reasons for non attendance or any possible reasonable adjustments that could be made to assist Rosa to attend. The possibility of disguised compliance, whereby a parent or carer appears to co-operate with professionals in order to allay concerns and stop professional engagement, was not considered or explored at all.

14.61 People First believe that when Rosa and Brian moved into their own home Rosa's health began to decline along with her mental ability to understand her care and support needs, and she was not receiving the necessary support from those around her to prompt or support her to attend medical appointments or to obtain and take her prescribed medication.

14.62 It later came to light that Rosa had been deprived of necessary medication since August 2022, coinciding with her relocation to a shared property with Brian. The MS Nurse did make a safeguarding alert in May 2023 in response to this information.

14.63 Rosa's aunt felt that there appeared to be a lack of interest or understanding of patients in hospital with learning difficulties, and how to deal with them. An example she gave was that

the nurses had moved the call button out of Rosa's reach because she was using it too much, so she was unable to get attention and would call Brian for help instead. This, and the visiting restrictions which the aunt notes Brian used to his advantage, further reinforced the lack of access Rosa had to others.

KLOI 4: 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?

14.64 There are many Police SAF reports that document concerns and vulnerabilities, and concerns relating to Brian. A SAF report facilitates the sharing of information from the Police regarding risk with partner agencies who may already be involved with the subject(s) or who should be involved and or need to know. The SAF reports appear to have been either closed by the Police and not shared, or only shared with Adult Social Care who were already involved.

14.65 Adult Social Care completed an initial risk assessment as part of the open safeguarding adult's enquiry when Rosa was admitted to hospital in July 2023. This was logged as a medium concern against prioritisation criteria, as Rosa was an adult with care and support needs at risk of abuse and harm and appeared to be unable to protect herself. This followed the Care Act 2014 Section 42 criteria. As per process, Adult Social Care notified NCIC's safeguarding team of the open safeguarding concern and remained in contact with the ward with respect to potential risks Brian may pose to Rosa during admission.

14.66 Adult Social Care have acknowledged that, whilst a hospital admission can be viewed as an environment which can maintain a degreed of safety, is it important that safeguarding procedures continue to progress at the appropriate pace whilst someone is an in-patient on a ward.

14.67 There were numerous incidents of unexplained injuries on Rosa reported that could have prompted a risk assessment to be completed by healthcare professionals, but did not.

14.68 Rosa was eligible for annual health checks with her GP practice. The last one that she had done was March 2022 which was outside of the expected timeframe. This is normally done by a GP or advanced nurse practitioner but on this occasion the check was completed by a health care assistant. This means that she would not have had a full check. A full check would have given an opportunity to do a holistic review of her health and care needs and an opportunity to identify any concerns.

14.69 A comprehensive multiagency safeguarding risk assessment should have been completed as part of the Section 42 safeguarding enquiry process. There were occasions when a DASH risk assessment could have been completed, by Children's Social Care, NCIC and the Police, and would have been aligned with procedural guidance. It is unclear why this was the case.

14.70 When Rosa was in hospital, it was suggested a young person's DASH risk assessment[61] could be completed with Rosa over time to ascertain her thoughts and feelings as to coercion and control. This does not appear to have happened as there is a blank form on Rosa's record. The panel noted that the young person's DASH form is available on the

council's website but appears to be little used as all of Victim Support referrals are received with adult DASH forms.

14.71 People First point out that when Rosa was diagnosed with Multiple Sclerosis this was viewed as her primary need and her Learning Disability was the secondary need. Previously Rosa

[61] Dash risk checklist: young people - SafeLives Accessed January 2025.

had been supported by the Adult Social Care Learning Disability team, but after being diagnosed with Multiple Sclerosis her care and support was reviewed by a different Social Work team. The advocate did not complete a risk assessment in relation to decisions concerning Rosa and her care and support needs.

14.72 The lack of a shared risk assessment and understanding of the full history may have contributed to the ineffectiveness of the safeguarding system for Rosa with all agencies working in silos and holding a single agency view of the concerns.

14.73 Collectively, there were many red flags indicating a potential high risk situation, but the lack of a coordinated response to these hampered an effective multi-agency, risk management plan. This may have been facilitated by a MARAC referral, had this occurred.

14.74 Brian had taken on the role of carer and agencies interacted with Brian regarding the care and support needs of Rosa, but he did not have a carer's assessment. NICE Guidance[62] reinforces requirements concerning carers in line with the Care Act 2014 that local authorities must offer carers an individual assessment of their needs which:

- Recognises the complex nature of multiple long-term conditions and their impact on people's wellbeing
- Takes into account carers' views about services that could help them maintain their caring role and live the life they choose
- Involves cross-checking any assumptions the person has made about the support their carer will provide.
- Check what impact the carer's assessment is likely to have on the person's care plan
- Support carers to explore the possible benefits of personal budgets and direct payments, and how they might be used for themselves and for the person they care for.
- Offer the carer help to administer their budget so that their ability to support the person's care or their own health problems are not undermined by anxiety about managing the process
- Consider helping carers access support services and interventions, such as carer breaks.

14.75 In addition to ensuring that his needs were addressed as a carer, a carer's assessment may have provided a structured opportunity to assess and ensure that the care he was providing for Rosa was appropriate and safe.

KLOI 5: 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?

14.76 Under the Care Act 2014 Section 42(1), enacted in April 2015, the term 'an adult at risk' was adopted. An 'adult at risk' is considered in need of safeguarding services if she/he:

a) has needs for care and support (whether or not the authority is meeting any of those needs),

b) is experiencing, or is at risk of, abuse or neglect, and

c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

[62] Older people with social care needs and multiple long-term conditions: NICE guideline [NG22] Published date: 04 November 2015. https://www.nice.org.uk/guidance/ng22/chapter/recommendations#supporting-carers

14.77 Under the Care Act 2014 definition, Rosa was an adult at risk due to the following:

- Rosa was over the age of 18.
- She did have care and support needs by virtue of her learning disability and MS diagnosis.
- She was experiencing, or at risk of, abuse or neglect.
- As a result of those care and support needs, she was unable to protect herself from either the risk of, or the experience of abuse or neglect.

14.78 Adult Social Care note in their IMR that, at the point where a decision was made to proceed an enquiry under Section 42 of the Care Act, Rosa was defined as an adult at risk.

14.79 Rosa was referred for a Care Act assessment on a number of occasions. This would have provided the opportunity to gain a fuller picture of Rosa's needs from the points of view of all those involved in the assessment process and the individual personal outcomes in relation to the nine areas of wellbeing:

- personal dignity (including treatment of the individual with respect)
- physical and mental health and emotional wellbeing
- protection from abuse and neglect
- control by the individual over day-to-day life (including over care and support provided and the way it is provided)
- participation in work, education, training or recreation
- social and economic wellbeing
- domestic, family and personal
- suitability of living accommodation
- the individual's contribution to society.[63]

14.80 The NCIC IMR author recalls that, although a safeguarding Social Worker was present during MDT meetings on the ward there was mention of a delay in allocation for a short term Social Worker to complete a Care Act assessment. That a Care Act assessment was never undertaken with Rosa is a significant gap in the response.

14.81 There was also a delay in a referral for an IMCA given that Rosa was assessed as lacking capacity to understand her care and support needs and under a DoLS.

14.82 It is indicated in the clinical record that Rosa was allocated a short term Social Worker who was to undertake a robust mental capacity assessment into her capacity to understand her care and support needs. This assessment did not take place with the Social Worker indicating they wanted the safeguarding aspect of her care to be resolved first. It is not understood what this meant.

14.83 The Police IMR author believes that Rosa should have been assessed as an adult at risk and that, because Police had knowledge of Adult Social Care involvement, they thought that they were best served to deal with the case.

14.84 The Police IMR author states that, although strategy meetings were held and attended by Officers where concerns were discussed, they feel that there have been offences missed and as a result investigations did not commence. They query whether Section 44 of the Mental Capacity Act should have been identified and pursued – the Act states that a person commits that offence if he/she ill-treats or wilfully neglects a person, who lacks mental capacity or whom he/she believes lack mental capacity and, that person has care of the other person.[72]

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[63] Care and support statutory guidance - GOV.UK (www.gov.uk) Accessed December 2024. [72] Mental Capacity Act 2005 (legislation.gov.uk) Accessed November 2024.

14.85 When Rosa was admitted to hospital she was deemed to be lacking capacity as urgent DoLS were put in place. DoLS is the procedure prescribed in law when it is necessary to deprive a resident or patient, who lacks capacity, of their liberty to consent to their care and treatment in order to keep them safe from harm. The DoLS was extended to October 2024 following a best interests assessment that was requested and authorised on 21 June 2023. A best interests assessment is a process of evaluating whether a decision is in the best interests of a person who lacks capacity to make it themselves against a checklist of factors.[64] The panel discussed that, while the authorisation of a best interest assessment is part of the standard DoLS application process, the local authority responsible for processing this are under great pressure and the process is not quick. The local authority would rely on the DoLS applicant to press for the prioritisation of a decision, where this was required. The hospital did not do this until the day that the urgent DoLS was expiring, and Brian was threatening to take Rosa home.

14.86 Two days later a best interests meeting/discharge planning meeting was held and one outcome was that a mental capacity assessment would take place with an allocated Social Worker. The need for this had already been raised by the MS Nurse two weeks prior to this and a Social Worker from the short-term team had been tasked with undertaking this a week prior. On 5 July, and again on 10 August 2023, when safeguarding strategy meetings were held, the need for a mental capacity assessment was pressed.

14.87 The Social Worker did make plans to undertake a capacity and needs assessment on 27 July but this did not happen once the IMCA informed him that, as per the Care Act guidance, Rosa would need an advocate present for an assessment and that the IMCA was unable to attend with the Social Worker on the date he planned to visit. Follow up contact by the IMCA with Adult Social Care noted that the Social Worker they were awaiting a response from had now left and the information had been passed onto a Service Manager for follow up.

14.88 Prior to Rosa's admission to hospital, it was assumed that she had capacity to make her own decisions. This is in reflective of the starting point of the Mental Capacity Act 2005, in that it should be assumed that an adult (aged 16 or over) has full legal capacity to make decisions for themselves (the right to autonomy) unless it can be shown that they lack capacity to make a decision for themselves at the time the decision needs to be made. This is known as the presumption of capacity. The Act also states that people should be given all appropriate help and support to help them make their own decisions.[65]

14.89 As previously noted, however, it was unclear in many cases whether Brian was actually decision making for Rosa. Acknowledging that Rosa's aunt said that her mental capacity was similar to an eight year old, and the presentation of Rosa in some situations, may have suggested her capacity warranted further investigation. At the very least, Rosa would have benefitted from more targeted assessment and support to understand and respond to her particular needs around decision making.

14.90 Actions that were taken by agencies do indicate that Rosa was being considered as an adult at risk and, in the main, safeguarding referrals were made that reflect this. These did not, however, result in enough action to make a notable difference. It should be noted that the MS Nurse showed determination in her attempts to draw in the assessments, care and support Rosa required, but this was hampered by delays and a lack of, or slow action. The MS Nurse could, however, have escalated their concerns through the Cumbria Safeguarding Adults Board Escalation Policy, which allows for situations when staff within one agency feel that the

[64] ibid.

[65] Mental Capacity Act 2005 Code of Practice; Department for Constitutional Affairs (2007). Mental-capacity-act-code-ofpractice.pdf (publishing.service.gov.uk)

actions, inaction or decisions of another agency do not adequately safeguard an adult at risk of abuse or neglect.

KLOI 6: 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.

14.91 The Chair has seen evidence that almost all agencies contributing to this review had in place appropriate policies and procedures for responding to domestic abuse and safeguarding. The Chair noted that People First do not have a Domestic Abuse Policy. Given what is known about the particular vulnerabilities of their service user group to abuse, this is a gap.

14.92 Details about training available/attended in relation to domestic abuse and safeguarding was also shared by all participating agencies. If policy, procedure or training was identified as a potential issue in the review, this has been highlighted and discussed in the relevant section/within context or is highlighted below.

14.93 The DS who concluded that no crime had been committed when a report was made about possible abuse towards Rosa and when Rosa was interviewed, acknowledged that he had been placed in an acting DS in safeguarding role but wasn't given any specific training to support this. The Police Officer who visited Rosa in hospital with the Social Worker was also a Safeguarding Officer but noted that there was little preparation for this role or CPD (continuing professional development) opportunities to support this role. All Officers spoken to about their response were unaware of the potential advocacy roles that may have been able to support their engagement with Rosa. This suggests a gap in the training of Officers expected to respond to safeguarding concerns and related crimes within their roles.

14.94 Safe Lives had recently undertaken a review of the MARAC locally and identified gaps in reaching some victims with protected characteristics. In response to this, the Community Safety Partnership recognise that there is a need for training locally on victims of domestic abuse with a disability but are concerned that there are no funds available for this and so, as an alternative, were undertaking mapping across the partnership to identify what was available that could be shared to facilitate learning.

14.95 A further concern identified during panel discussions was that, when multi-agency training was made available locally, partners struggled to free up staff to attend this so it was poorly attended. The panel agreed that it may be appropriate to make some multi-agency training mandatory for relevant partners.

KLOI 7: What opportunities were there to identify and manage any risks presented by Brian?

14.96 Brian has a significant history of allegations of abuse towards vulnerable adults and children. As far back as 2009, a Children's Social Care Core Group meeting identified that Brian establishes relationships with women who have some level of learning disability or deemed to be vulnerable and there is an extensive history of allegations of domestic abuse from Brian towards previous partners documented. Again in 2014, Children's Social Care documented concerns about Brian's controlling behaviour towards Rosa.

14.97 Forensic history is ordinarily shared in the safeguarding strategy meeting to inform risk assessment and planning. – clearly something was shared which resulted in a DVDS request for disclosure – yet doesn't appear to have formed any part in the decision making and risk assessment.

14.98 There have been a number of missed opportunities to identify and manage any risk posed by Brian. Reports were made to the Police in 2020 and again in 2023 by professionals reporting concerns of controlling and coercive behaviour by Brian towards Rosa and other vulnerable members of the household, including emotional and financial abuse, potential neglect, thefts and fraud. These reports have not been pursued or investigated due to a lack of disclosure from Rosa to support the allegations.

14.99 The Police IMR author points out that if a professional reports concerns, then the Police should identify offences and crime record at the first opportunity as per the current crime recording policy. Victim confirmation of offences is not required when a professional reports. An investigation would then be recorded and commence and would have Police supervisory oversight. The victim would then be approached, which may or may not lead to disclosures, however there would still be an investigation created and other options would be considered in relation to non-criminality.

14.100 Additionally, although the Police have taken the opportunity to speak with Rosa who didn't disclose, they could have tried to speak to other family members - perhaps her grandmother, her aunt, or her nephew - within the household to see if they could have provided evidence to support allegations of abuse or may have made disclosures themselves. They could also have sought evidence from the professionals making the referral, via third party material and evidential statements.

14.101 Brian's prior history was not considered. Police just accepted that Rosa did not make disclosures. Opportunities to record and investigate crimes were missed and, therefore, Brian was not ever a domestic abuse suspect in a criminal investigation by Cumbria Police relating to Rosa, which may have allowed for Police bail conditions to further safety. He was never interviewed either whilst under arrest or as a voluntary interview. Overall, the Police appear to have been assuming that Adult Social Care involvement dissolved them of needing to investigate a potential crime further.

14.102 In relation to the incident involving Rosa's uncle and a cut lip (see chronology 12 September 2021), Brian took control of the incident telling Officers that he had caused the injury to Rosa's uncle accidentally and, as a result, was never interviewed, albeit he was a suspect in a crime recorded by Cumbria Police. The Officers reattended to speak to Rosa's uncle after the event, who informed Officers that he had been intoxicated and couldn't remember what happened, and that he wanted no further Police action. Rosa's grandmother was present at this time.

14.103 The caller of this incident was anonymous, however, there would have been opportunity to pursue house to house enquiries and CCTV in this area which the IMR author believes should have been carried out in order to thoroughly investigate. From the description given by caller, the women present at the time of the fight was Rosa's grandmother and it does not appear that her account was gained.

14.104 Health care professionals had concerns about lone visits being made due to a risk posed by Brian but the reason for this was never substantiated by anyone or detailed in Rosa's medical record.

14.105 People First do cite an incident when Brian attended their office and was quite hostile with the smell of alcohol on his breath. The advocate subsequently contacted the ward staff to alert them of Brian's planned visit Rosa on the ward later that day. Overall, when the advocate identified any risks presented by Brian they spoke to the safeguarding team at the local authority, the Police and the Social Workers to share this information as quickly as possible. The advocate also communicated with a solicitor and the manager of the supervisory body for support and advice in relation to risks she identified.

14.106 The summary report received from the Probation Service only relates to their involvement in 2012 (following cruelty to animals). They do note, however, that while Brian was complying with the Community Order, they became aware that Brian had been harassing his former partner and had been aggressive to staff. There is no record, however, of this being followed up. The IMR author notes that it would be expected that information of this nature would be included in a review of his risk assessment and shared with the staff. There is no evidence that this review took place. That said, information is no longer available due to the various organisational change programmes and the time that has lapsed since this order was made.

The author believes that, in hindsight, Brian had offending related needs which would have benefitted from rehabilitative intervention where his approach to relationships could have been explored with him in more detail and interventions undertaken to support him to address relationship behaviours. There are issues which almost immediately came clear post sentence but may not have been known to the pre-sentence report author. They do point out though that organisational change which has impacted the Probation Service since this time has seen the creation of dedicated court teams. The domestic call out information is also routinely obtained prior to court now and would offer useful information for the report author which may have informed the sentencing proposal.

14.107 The panel also reflected that animal abuse is widely recognised as both a risk factor for and a potential consequence of domestic abuse[66] and that, where animal abuse is known, further exploration of the individual's behaviours across their relationships might surface other indicators of domestic abuse.

14.108 The review has not analysed the responses to Brian's domestic and sexual abuse related allegations related to his several ex-partners as these are outside of the review time frame and are historical enough that it would be expected that policy and practice has since developed in any case. It is important to note, however, that collectively, this information suggests a repeat offender targeting vulnerable women and provides a history that should have been acknowledged and influenced later responses to Rosa and Brian.

14.109 The panel were informed by Rosa's family that Rosa and Brian had met at the local Pentecostal Church but that they stopped attending once established in a relationship. They were also informed that Brian had met a previous partner there. The panel discussed the potential for the church environment being used to access and develop relationships with vulnerable adults.

14.110 As a result, the Chair contacted and met with the church's safeguarding adults leads, one of whom had known of Rosa and Brian when they met. Whilst they were aware that Rosa had a learning disability, they understood that she had full capacity to enter into a relationship and were not aware of any concerns about their relationship at all. Where the church is aware of a potential risk from a church goer, they described strategies to manage this and to protect other church goers. Rosa's aunt provided a more revealing account of the church's involvement and knowledge of the situation, stating the Brian had lived with a couple who were very involved in the church when he moved to the area and that they, and other church members, would have been aware of his background.

14.111 Elim Church has a fairly comprehensive Safeguarding Policy. This does not, however, address a response to the possibility of grooming in the church environment. The safeguarding leads were open to learning opportunities, with a view to continually improving safeguarding practice, and were linked in with the local authority lead taking forward work with churches in the area.

[66] See for example, Animal Abuse as an Indicator of Domestic Violence: One Health, One Welfare Approach - PMC (nih.gov) Accessed November 2024.

14.112 After Rosa's death, it is concerning that the opportunity to progress an investigation into the offence of Causing or allowing the death of a child or vulnerable adult, which would have drawn upon statements from the family at that time, appears to have been hampered by the fact that a DI had reviewed the case and questions posed by the Coroner and concluded that there would be no Police investigation. Due to this, the later investigation commenced by the Police was undermined and concluded No Further Action. This was an understandable disappointment to the family and meant a missed opportunity to properly investigate a potential crime and hold Brian to account. Also of concern is the lack of recording related to the actions of the DI and their decision making on Police recording systems.

KLOI 8: What information sharing protocols exist between agencies? Were they needed, appropriate and effective in this case?

14.113 Cumbria Safeguarding Adults Board have published information sharing guidance and NCIC have a data protection policy both of which are readily accessible on the Trust intranet. Safeguarding information sharing is shared in line with Caldicott principle no 7[67] where the duty to share information for individual care is as important to protect patient confidentiality and where information sharing is required it is reasonable, proportionate and timely.

14.114 The NHS and Adult Social Care have agreed protocols in place around Section 42 concerns. Concerns around risk would also the form the legal basis for information sharing between agencies. The Chronology demonstrates there was pertinent information sharing while Rosa was in hospital.

14.115 The GP practice held a MDT meeting to discuss concerns raised about Rosa, but note that this happened quite late in the in Rosa's journey and highlight the importance of ensuring that staff delivering specialised services know about these and how to refer into them.

14.116 The Police were aware that Adult Social Care were already involved and, therefore, shared Police information via SAF reports when the occasion has arisen. Only one SAF was domestic abuse related, the rest were vulnerable adult related. In addition to the lost opportunity to share information through a MARAC, the Police IMR author also points out that when professionals report concerns and there is a SAF created, then the Safeguarding Hub sharing that SAF back to the reporting professional without the addition of any further information is pointless and consideration should be given to probing further and raising the concern with the area safeguarding teams.

14.117 When meetings were held in relation to Rosa's safety and care, the lack of Police representation when invited did not assist in fostering effective multi-agency communication and responses (see 14.129 for further comment). The People First Advocate also gave apologies for the strategy meeting in August 2023 and has noted that it is unclear from the notes whether the advocate provided the Social Worker with an update for the meeting as would be normal practice.

14.118 Overall, while critical information has been shared between agencies, the IMRs indicate a lack of clarity of partners involvement and primacy, and that communication has not been good and consistent in this case.

KLOI 9: 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?

[67] Eight_Caldicott_Principles_08.12.20.pdf Accessed December 2024. [77]
Violence against women (who.int) Accessed November 2024.

14.119 As a woman with a learning disability, Rosa was at particular risk of domestic abuse. Domestic abuse is a crime which is deeply rooted in the societal inequality between men and women. It is a form of gender-based violence, violence "directed against a woman because she is a woman or that affects women disproportionately." (CEDAW, 1992).

14.120 The World Health Organisation recognises that intimate partner abuse is a gendered crime that it is generally perpetrated by men against women and describes violence against women as a major public health problem that affects over a quarter of women aged between 15 and 49 who have been in a relationship[77].

14.121 People with learning disabilities, autism or both are thought to experience domestic abuse at about three times the rate of the general population.[68] Furthermore, the Joint Committee on Human Rights, Seventh Report, noted that adults with learning disabilities experiencing abuse, face greater hurdles to achieving justice than the general population and are less likely to report the crime and abuse they have suffered and are less likely to seek help, noting that 'For many, the violation of their human rights is seen as a normal part of their everyday lives'.[69]

14.122 Stay Safe East assert that, for disabled women, the experience of domestic abuse can be different from that of non-disabled women in that the abuser may use their disability against them, or that they may use how people see the disabled person, or the barriers they face, to further control them.[70]

14.123 People First reflected that Rosa's learning disability may have impacted on her ability to clearly identify that she was experiencing domestic abuse and therefore, may have made it more difficult for her to reach out to services that could have provided her with help and support. Indeed, Rich (2014) lists factors that increase vulnerability for girls with developmental disabilities as:

- inability to understand that acts are abusive
- exposure to multiple carers
- difficulty in reporting crime • habitual submission to authority.

14.124 Clearly agencies were aware of Rosa's disabilities, and utilised associated safeguarding frameworks to steer their responses. The responses did not, however, effectively assess and respond to Rosa's particular and individual needs. There were instances when the barriers to communication and understanding for Rosa were not given sufficient consideration. The use of an expert and trusted intermediary may have assisted in reducing these barriers for Rosa.

14.125 Furthermore, due to a focus on responding within a safeguarding vulnerable adults framework, opportunities to draw upon and utilise best practice in responding to female victims of domestic abuse may have been overlooked. This might for example have including ensuring Rosa was questioned and assessed by a female professional, or drawing in the expertise and support and/or guidance of a specialist domestic abuse agency. Sadly, specialist domestic abuse services that may have been appropriate for Rosa's particular

[68] The 'Us Too' Project: domestic abuse and women with learning disabilities, autism or both - ARC England (website accessed May 2024) Accessed November 2024.
[69] Joint Committee On Human Rights - Seventh Report (parliament.uk) Accessed November 2024.
[70] Domestic & Sexual violence - Stay Safe East | Stay Safe East (staysafe-east.org.uk) Accessed November 2024. [81] The UK's only refuge for women with learning disabilities and the people who live and work there (lggroup.org.uk) Accessed November 2024.

needs are rare. Beverley Lewis House is a refuge base in London specifically for women with learning disabilities fleeing abuse.[81] It is, however, the only scheme of its kind in the UK.

KLOI 10: Were agencies sufficiently resourced and individuals effectively supervised to respond to the needs of Rosa and Brian?

14.126 There are some instances when resources impacted on the speed and effectiveness of responses to Rosa.

14.127 In May 2023 the ICC were contacted by the MS Nurse to request a visit within two hours to assist with pressure area care and review the need for urgent equipment assessment. This support could not be provided due to staffing constraints.

14.128 When the advocacy referral was submitted to the Advocacy Hub at People First on the 09 June 2023, the advocate was not allocated the referral in relation to safeguarding support until the 22 June 2023.

14.129 People First were unable to attend a safeguarding strategy meeting in July 2023, as they were on annual leave and there was no capacity within the department for another advocate to attend on their behalf. The Advocacy department at the time had a capacity challenge due to staffing issues and has since developed a contingency plan to ensure that if there are capacity issues in the future these do not cause any delays in providing advocacy support.

14.130 The Police were unable to attend two multi-agency planning meetings due to lack of capacity. It is unclear if the Police were informed of the outcome of these meetings. When Police are asked to attend a planning or strategy meeting, then there should be Police representation, if Police cannot attend, then the meeting should be rearranged to the first available opportunity, or the outcome of the meeting should be provided to the Police immediately after its conclusion.

14.131 An email was sent to the to the Police safeguarding inbox on the 25 July 2023 asking If the Police needed to attend a planning meeting two days later. The department had no capacity to attend as they only had one DS on that day and other meetings were already planned, therefore there was no Police safeguarding representation at this meeting. The response to the email was that if the Police didn't attend the initial strategy meeting and there were no crimes recorded then there was no need for Police to attend as there was no information to share or role for them.

14.132 Adult Social Care point out that there is reference to the strategy discussion being rescheduled. This appears to have been due to an unforeseen sickness episode.

14.133 There were several requests for a Care Act assessment but the progression of this seems to have been hampered by delays in the allocation of a named Social Worker.

14.134 The panel discussed the increasing pressures on agencies with year on year increases of reported safeguarding concerns and a widening pool of issues they are required to respond to including homelessness, substance use and destitution related to no recourse to public funds. A recent report by the National Network for Safeguarding Adult Board Chairs (NSCN) highlighted that Safeguarding Adult Boards 'report significant strain on partner agencies, including challenges across adult social care, primary care, and secondary acute and/or mental health services to manage demand' and sets out priorities for transformative change in adult safeguarding policy and practice for the incoming government.[71]

[71] National Network for Safeguarding Adults Board Chairs (2014). Safeguarding Adults: An Agenda for Transformative Change.

14.135 No agencies raised concern regarding their supervision arrangements.

15. Good practice

15.1 During the course of the review, some examples of good practice were identified. Some of these were not available prior to Rosa's death but do offer some reassurance that responses have improved since Rosa's death.

15.2 Riverside Housing made a referral to Adult Social Care in 2020 following the concerns raised by the neighbour.

15.3 Whilst they did not always achieve the desired outcome, the MS Nurse showed determination in making multiple referrals in her attempts to make Rosa safer.

15.4 The GP practice has developed a pop up on EMIS[72] for all patients on the learning disability register. This is a prompt to consider if reasonable adjustments are needed and if the patient has capacity to make decisions about their treatment plan. This was active on Rosa's record since August 2021. This is something that should be considered for roll out across all GP practices in North Cumbria.

15.5 In 2023 the North East and Cumbria Learning Disability Network launched the Prevention of Adult Not Brought Strategy and Reasonable Adjustment Campaign as outlined below:

15.6 **Prevention of Adult Not Brought[73]** - Two toolkits have been made available for primary and secondary care. Alongside the toolkits, Primary Care and Social Care Workforce education packages, a risk concern tool, prevention of adult not brought flow chart and top tips resources have been developed as supporting resources. The purpose of the toolkits is to:

i. Raise awareness of adults not brought to appointments
ii. Increase usage and awareness of the adult not brought code to ensure people are appropriately coded
iii. Identify people at risk of not being brought to appointments
iv. Attempt to mitigate those risks by proactively using reasonable adjustments
v. Raise awareness of reasonable adjustments
vi. Improve workforce education at all staff levels across primary care in reasonable adjustments and supporting people with a learning disability to access appointments
vii. Link with the national digital reasonable adjustments flag work and Learning Disability and Autism awareness training

15.7. **Reasonable Adjustment Campaign[74]** - A series of posters have been developed for Healthcare professionals, social care professionals and people with a learning disability and their families. Their aim is to raise awareness of people's rights and legal obligation to reasonable adjustments and to understand what they are.

16. Conclusions and lessons learned

This section summarises the key learning identified by the review.

[72] The GP electronic medical records.
[73] The strategies, workforce education packages and supporting resources can be found at www.necldnetwork.co.uk/workprogrammes/reasonableadjustments/panb Accessed November 2024.
[74] All resources and more information can be found at www.necldnetwork.co.uk/work-programmes/reasonableadjustments

Identifying and responding to domestic abuse

16.1 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.

16.2 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.

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

16.4 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.

16.5 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'[75] guidance set out a code of practice for the protection of vulnerable adults and provided a clear framework for identifying and responding to concerns.

16.6 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.

16.7 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 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.

16.8 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

16.9 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.

16.10 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

75 No_secrets__guidance_on_developing_and_implementing_multiagency_policies_and_procedures_to_protect_vulnerable_adults_from_abuse.pdf (publishing.service.gov.uk) Accessed November 2024.

Adjustment Campaign launched by the North East and Cumbria Learning Disability Network is a positive response to the challenges faced by this group.

16.11 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.

16.12 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.

16.13 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.

16.14 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.

16.15 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.

16.16 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.

16.17 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

16.18 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.

16.19 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.

16.20 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.

17. Recommendations

17.1 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).

17.2 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.

17.3 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 DARDR 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.

Appendix A: Terms of Reference

Cumberland Community Safety Partnership

Terms of Reference for the Domestic Abuse Related Death Review into the death of 'Rosa' (pseudonym)

1. Introduction

These Terms of Reference will guide the review being undertaken following the death of Rosa in August 2023.

The Terms of Reference for this review have been written in accordance with the Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews, now renamed Domestic Abuse Related Death Reviews.

The relevant Community Safety Partnership (CSP) must always conduct a Domestic Abuse Related Death Reviews (DARDR) when a death meets the following criterion under the Domestic Violence, Crime and Victims Act (2004) section 9, which states that a DARDR is:

A review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

- a person to whom he was related or with whom he was or had been in an intimate personal relationship, or
- a member of the same household as himself,

held with a view to identifying the lessons to be learnt from the death.

Consequently, in September 2023 a Cumberland Community Safety Partnership Core Group met and agreed that the criteria for a DARDR had been met.

2. Purpose of a DARDR

The Statutory Guidance for the Conduct of Domestic Homicide Reviews outlines the purpose of a DARDR as a process to:

a) establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

b) identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

c) apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;

d) prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

e) contribute to a better understanding of the nature of domestic violence and abuse; and f) highlight good practice.

3. Principles of the Review

The Panel members commit that this review will be conducted with:

i. A lack of defensiveness and commitment to seeking the truth.

ii. A commitment to learning lessons to prevent future harm, without blame. iii. Objectivity and independence. iv. Transparency, whilst respecting confidential information.

v. Empathy and compassion for the victim, and those impacted by her loss, ensuring their voices are integral to the process.

vi. Consideration of equality and diversity, and intersecting disadvantage.

4. Timeframe for the Review

The review will consider 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. The review acknowledges that there may be events prior to this timeframe that offer important learning opportunities. Agencies are requested, therefore, to refer to any other relevant information prior to this period for consideration by the review.

5. Key Lines of Enquiry

In particular the DARDR Panel (and by extension, IMR authors) will be seeking answers to the following, case specific key lines of enquiry:

5.1 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?

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

5.3 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?

5.4 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?

5.5 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?

5.6 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.

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

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

5.9 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?

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

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

5.12 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?

5.13 Are there any particular examples of good practice to highlight?

Additionally, and outside of the review timeframe, the review is seeking information on:

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

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

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

6. Panel Membership

Panel members will consist of representatives from the following agencies:

- Cumberland Council
- Cumbria Constabulary
- North Cumbria Integrated Care NHS Foundation Trust
- NHS North East and North Cumbria ICB
- Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW)

- North West Ambulance Service
- Probation Service
- Riverside Housing
- Department for Work and Pensions
- People First
- Recovery Steps Cumbria
- Victim Support

The Panel membership should remain static with consistent representation of named individuals. Any proposed changes of Panel representation should be discussed with the Chair. Panel members must be independent of any line management of staff involved in the case and must be sufficiently senior to have the authority to commit on behalf of their agency to decisions made during a panel meeting.

7. Disclosure & Confidentiality

Confidentiality should be maintained by all individuals and organisations involved in the Review. However, the achievement of confidentiality and transparency must be balanced against the legal requirements surrounding disclosure.

Where a criminal investigation is running in parallel to the Review, any material received by the Panel must be disclosed to the SIO.

The subjects of the Review will be granted anonymity within the Overview Report and Executive Summary and will be referred to by a pseudonym.

Where consent to share information is not available, agencies should refer to and consider Section 10 of the Multi-Agency Statutory Guidelines for the Conduct of Domestic Homicide Reviews and consider whether the information can be disclosed in the public interest. In this case, any information shared should be proportionate and relevant to the aim of the review to prevent future harm.

8. Family involvement

The review will seek to involve the family of the victim in the review process in ways that they are comfortable with, taking account of their needs and wishes.

Other individuals known to the subjects of the review may be invited to participate where their contribution might add intelligence and depth to the review. This could include neighbours, employers, the alleged perpetrator and their family/friends.

With their agreement, we will seek to establish communication methods that keep the family informed throughout the process.

Contact with the family and any other contributors to the review will be led by the Chair.

These Terms of Reference will be kept under review and are subject to change with agreement of the review panel.

Appendix B: Further information about the Chair and report author

In 2020 Nicki was awarded an OBE for services to the prevention of violence against women and girls, in recognition of working for over 30 years to end domestic abuse in all its forms – through the provision and management of direct services, training and support to improve the practice of other agencies, and nationally to influence legislation, policy, practice and public attitudes. This includes 14 years' experience as Director and Acting CEO of a national domestic abuse charity, working at a senior level across government and with partner agencies to improve responses to domestic abuse.

Much of Nicki's experience has involved challenging and supporting the improvement of responses to domestic abuse. For example, in her role as expert panel member leading the Ministry of Justice review of family court responses to domestic abuse[76], or Commissioner on Barking and Dagenham Domestic Abuse Commission reviewing the borough's response to domestic abuse.

Nicki has worked as an independent consultant since 2021 and, as part of this, has led the development of the Domestic Homicide Review (DHR) Network on behalf of AAFDA and aimed at improving the standard of DHR/DARDRs by supporting professionals involved in them – providing her with extensive knowledge of the DHR/DARDR framework and process, and all its challenges and opportunities.

[76] Assessing Risk of Harm to Children and Parents in Private Law Children Cases (publishing.service.gov.uk)