Cumbria Safeguarding Adults Board

Safeguarding Adults Review: Samantha

Learning Briefing

This learning briefing summarises the key learning and recommendations following a joint Safeguarding Adults Review (SAR) and Domestic Abuse Related Death Review (DARDR) undertaken by Cumbria Safeguarding Adults Board (CSAB) and Cumberland Community Safety Partnership (CCSP). The SAR commissioned by CSAB considered the case of Samantha, a 33-year-old white British woman who died in July 2024. Samantha had a history of substance use and mental health issues (including depression, anxiety and post-traumatic stress disorder) which affected her ability to carry out day to day activities. Samantha also experienced domestic abuse from her long-term partner.

A SAR takes place where there is reasonable concern about how the Safeguarding Adults Board or members of it worked together to safeguard the adult, the adult has died, and the SAB knows or suspects the death resulted from abuse or neglect.

The SAR combined agency reports and chronologies with a learning event for practitioners who had been directly involved with Samantha. This aimed to explore underlying factors including individual interactions and wider system factors that support or create barriers to good practice.

Samantha

Samantha was living in Cumbria with her partner and partner's father at the time of her death. Both she and James reported that James was her carer. Samantha had care and support needs, and there was concern about how agencies worked together to protect her from domestic abuse and neglect by her partner.

Samantha and her partner James had been in a relationship since Samantha was 16 years of age. Samantha reported that James had introduced her to serious drug use and there were concerns noted about their relationship dating back to 2010.

Samantha had a history of childhood trauma and struggled with her mental health. She had been placed on the Child Protection register due to emotional abuse and witnessing domestic abuse, and it is thought she became a Looked After Child. It was also reported that she had been a victim of physical and sexual abuse in her teens.

Prior to her death Samantha had numerous health needs including deep vein thrombosis, anaemia, and renal issues. Samantha found it difficult to engage with health care providers and her health needs were often left untreated, leading to deterioration and significant pain.

The report made a number of recommendations which have been accepted by Cumbria Safeguarding Adults Board. You will find a summary of the recommendations and learning below. You can also read the full SAR Samantha report.

Findings

Finding 1: Risk Assessment

Good practice was demonstrated by agencies when assessing risk including the use of professional judgement in recognising a high risk situation which led to a referral to MARAC. There was also good practice shown through the sharing of risk assessments with other professionals involved, although there was a missed opportunity to share a risk assessment with housing.

Finding 2: Safeguarding Adults at Risk

Safeguarding concerns were raised on three separate occasions, however only the third concern was taken forward as a safeguarding enquiry. The first two concerns were not progressed on the basis that no care and support needs were identified.

The review identified the need to recognise and interpret care and support needs and the ability of a person to protect themselves as a result of any vulnerabilities. As a result of other SARs undertaken locally[1], the Cumbria Safeguarding Adults Board are seeking assurance through their P&QA sub-group using case file audit process of ‘other enquiries’, this is reported quarterly through data. A session was also delivered in November 2024 regarding wider interpretation of safeguarding and how care and support needs can be interpreted for legal literacy. A recommendation has also been made as a result of a thematic self-neglect SAR to explore the use of electronic safeguarding referrals for partners which may assist in greater detail being shared in respect of potential care and support needs.

Another recurring theme relates to Registered Providers Of Social Housing, with no evidence of the use of civil measures in this case, such as anti-social behaviour injunctions to separate parties and potentially putting some distance between Samantha and James. Civil orders are easier to secure than criminal convictions, yet behaviour is often logged as nuisance and left for police to deal with.

The review has also highlighted the role that banks and the DWP can play in relation to financial abuse, and action that can be taken to protect the person experiencing such abuse.

1 Safeguarding Adult Reviews (SARs) | Cumbria Safeguarding Adults Board

Finding 3: Coercive controlling behaviour

James had full control of Samatha's finances; her benefits were paid into his bank account, and he used her money to purchase and supply her with illegal substances.

The review has highlighted the need to recognise coercive and controlling behaviours including use of drugs and access to money as a means of control and coercion. This is a recurring theme in reviews undertaken locally, and a recommendation has previously been made as a result of the DARDR/SAR 'Jessica'[2] to increase practitioner understanding and awareness of coercive controlling behaviour.

Finding 4: Making decisions

Samatha's mental capacity to make specific decisions was only formally assessed on one occasion when she was refusing treatment.

The ability to make decisions can be compromised by a range of factors, including a mental health, substance issue, coercive control, trauma and lived experience. The review highlighted that in respect of assessing mental capacity in accordance with the Mental Capacity Act 2005, there may be an over-reliance on the principle of a presumption of capacity and a potential lack of understanding or confidence in respect of the effect substance misuse has on the ability to make decisions. Cumbria held a Mental Capacity Act week of action in response to SAR Jessica, which included lunch and learn sessions and daily briefings.

In respect of decision making where the Mental Capacity Act 2005 would not be applicable, i.e. there is no disorder of the mind or brain, professionals should consider other factors that may compromise decision making. In such cases, use of the Inherent Jurisdiction of the High Court may be appropriate. Adult Social Care have reported that guidance is currently available to their legal team and is used for internal training. There is scope to make this guidance available to a wider audience. Previous reviews has also recommended that the CSAB, in consultation with the Safer Cumbria Partnership, should seek assurance that professionals across the partnerships are mindful of the need to consider whether mental capacity is being impaired because of coercion and control and / or the effects of substance / alcohol misuse where a person is making a decision that appears unwise and will potentially place them at risk.

2 Domestic Homicide Review: Subject of the report, "Jessica" May 2021. | Cumberland Community Safety Partnership (CSP)

Finding 5: Informal Carers

Samantha and James reported that James was her carer and that he provided support by prompting her to complete tasks, walking her to her friend's house and helping her to go out, preparing food and helping her to cook, helping her wash, and helping her to manage finances.

James also claimed carers allowance. However, there was evidence of neglect which was perceived by agencies as self-neglect.

There was a lack of curiosity about James' role as carer, with assumptions made that his caring role had been previously formally assessed by the DWP, had been agreed and deemed safe, unaware that DWP do not assess carers. A carers assessment should have been offered which may have may have indicated coercive controlling behaviour and neglect, but would unlikely to have been taken up. There were also missed opportunities to hold James accountable for his caring role and flag that he was not a carer to DWP. The CSAB will be resharing information as reminders regarding carers.

Finding 6: Multi-agency forums

There was a reliance on MARAC to address and manage risk in this case. Learning around multi-agency approaches links to a yet to be published thematic self-neglect SAR which has led to work commencing following a recommendation to explore high risk MDT/Panels for cases which do not necessarily meet thresholds for safeguarding and/or risks are escalating.

The review also highlighted the delay in MARACs which can occur during holiday periods and the need to emphasise agency's proactively safety planning during pressure points throughout the year e.g. Christmas/new year and Easter to mitigate any risks arising from the delay of MARAC.

Finding 7: Trauma-informed approaches

Samantha had Adverse Childhood Experiences and Trauma, leaving her vulnerable to the actions of others. Cumberland Council Public Health Team, along with partners, are investigating mechanisms to ensure ACES are considered and that interventions are trauma informed, to best support those with experiences like Samantha. A language guide is in development, which aims to address the use of language such as 'refuses to engage' with guidance on how this can be reframed in a trauma-informed light to better understand individual circumstances.

In relation to Samantha, whilst there are examples of good practice, there are examples of required practice improvement. Cumberland Community Safety Partnership have identified immediate, thematic learning from current DARDRs, like those arising in this case.

- Improvement in Professional Curiosity/Routine Enquiry

- Multi-Agency Involvement and Information Sharing
- Risk Assessment and Management of Risk
- Handover and Step-Down
- Typologies
- Links between DA & Substance Misuse
- Working in line with the Victim's Code 2021
- Learning and Development

In response, learning events have been rolled out Cumbria-Wide addressing these issues and resources for further learning and amending practice in each area have been provided. Partner audits are being piloted in relation to MARAC cases, with a plan to widen scope to gauge impact of identified learning improvement and embedding into practice.

Recommendations

- Adult Social Care to develop guidance on the use of Inherent Jurisdiction and share with partners of both the CSAB and Cumberland Community Safety Partnership (CCSP). (Finding 4)
- The CSAB and CCSP to develop and cascade a learning briefing on 'Informal Carers who Cause Harm' to include the role of the DWP, and the role of banks in cases of financial abuse. (Finding 5)
- All agencies to provide assurances on their proactive approach to safety planning, particularly during times of service pressure i.e. Christmas, New Year and Easter.[3] (Finding 6)
- The CSAB and CCSP to consider the learning from this review and the recurring themes, evaluating the effectiveness of recommendations from previous reviews in respect of the following areas of learning and whether further action is required
  - Identifying care and support needs
  - Coercive controlling behaviour
  - Mental capacity
  - Informal carers
  - Trauma-informed approaches
  - Multi-agency approaches

  (Findings 2,3,4,5,6,7)

3 It is acknowledged that agencies operate differently and for some services there will be no change in the delivery of core services during these periods. However, these services may need to consider how other services are accessed and the availability of additional resources, as these factors may influence the effectiveness of safety plans.

Cumbria Safeguarding Adults Board will continue to work with partners to ensure learning and recommendations from the SAR are embedded. You can read the full SAR report **here**.

Further learning & resources for frontline practitioners

A SAR lunch & learn session to share the learning from SAR Samantha has been arranged for Thursday the 4th of June from 1pm to 2.30pm. To book a place click **here**

Cumbria Safeguarding Adults Board will continue to work with partners to develop actions and improvements in response to the recommendations the report makes.