Cumbria Safeguarding Adults Board

Safeguarding Adults Review

'Samantha'

Overview Report

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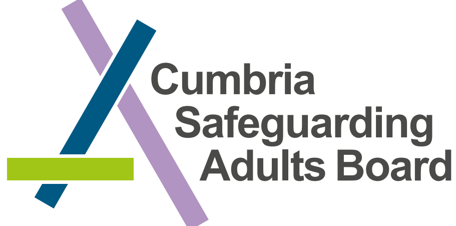

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Introduction

1. The decision to undertake a Safeguarding Adults Review (SAR) was agreed following a Cumbria Safeguarding Adult Board (CSAB) SAR Sub-Group meeting and this decision was endorsed by the CSAB Independent Chair in accordance with The Care Act 2014. The SAR sub-group meeting considered information provided by all the agencies involved with the person, who is the subject of this review, and following discussions concluded that there was reasonable cause for concern about how the CSAB members worked together to safeguard the adult who sadly died. The review has been completed as a joint SAR and Domestic Abuse Related Death Review (DARDR) but has produced separate SAR and DARDR review reports.

2. The person who is the subject of this review has been referred to as Samantha to protect her identity. Ordinarily, family members would be invited to participate in choosing pseudonyms, unfortunately there were no family members to consult and therefore the SAR panel members have chosen and agreed the pseudonym used.

3. Samantha was a 33 year old white British woman. She had a history of substance misuse. On a day in July 2024 paramedics attended Samantha's address to reports that she was unresponsive. She was transported to the West Cumberland Hospital, Whitehaven. It was not possible to resuscitate Samantha and her death was confirmed later that day.

Terms of Reference

1. A multi-agency panel was established by Cumbria SAB and Cumberland CSP to conduct the reviews and report progress to the Cumbria SAB and the Cumberland CSP Board. Membership included a Lead Reviewer/Chair and representatives from key agencies with involvement.

1.1. The panel agreed that the review would cover the timeframe from March 2023 to the date when Samantha died in July 2024. These dates provide for a period during which there was non-attendance at GP appointments, safeguarding concerns being identified and Vulnerable Adult reports from Cumbria Police. It was agreed that any significant incidents outside of this scoping period would be included in the analysis completed by each agency.

2. The specific areas for consideration are as follows:

- What was the response to Samantha being a victim of Domestic Abuse including concerns about coercion and control;
- How did agencies respond to concerns about informal carers and risks to Samantha;
- Were multi-agency frameworks and working effective at keep Samantha safe from abuse or neglect;
- How did agencies respond to Samantha's substance misuse and the impact on her ability to protect herself including her capacity to understand the risks;
- What was the response to, and outcomes of, consideration of Samantha's housing options to keep her safe including the impact on her physical health;
- What strategies were applied to secure engagement with Samantha in a safe and person-centred way, including for missed appointments;
- What risk assessment was undertaken, what consideration was there of the risks and the impact on Samantha's well-being;

- What good practice was identified;
- Are there any relevant changes/improvements that have been implemented subsequent to the review scope period?

Legal Context

1. Under the Care Act 2014 Safeguarding Adults Boards (SABs) are responsible for Safeguarding Adults Reviews (SARs) in the following circumstances.

(1) A Safeguarding Adults Board must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if;

(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

(b) condition 1 or 2 is met.

(2) Condition 1 is met if;

(a) the adult has died, and

(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

(3) Condition 2 is met if;

(a) the adult is still alive, and

(b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

(4) A SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

Methodology

1. Agencies involved with the adult were asked to provide information of significant contacts by preparing an agency chronology and outline report with a focus on the purpose and scope of the review. Other agencies/services were asked to contribute following review of the information provided.
2. Agency information included a brief analysis of relevant context, issues or events, and an indication of any conclusions reached. Information about action already undertaken or recommendations for future improvements in systems or practice was included if appropriate.
3. Following receipt of the agency reports and initial analysis by the panel, a Practitioner Learning Event was held in order to further explore hypotheses, draw out themes, good practice and key learning from the case including any recommendations for the development or improvement to systems or practice, with practitioners and managers who were directly involved with Samantha.
4. Previous SARs commissioned by Cumbria SAB which had been identified as containing similar themes were reviewed and have been incorporated into the analysis and learning.

Family Involvement

1. Engagement with family members and listening to their perspectives and experiences is essential to develop learning when undertaking a Safeguarding Adult Review. A focus on their understanding about their family member’s lived experience, how their family member was supported and experienced services and whether they found these to be helpful, provides a more personal insight into how agencies managed events.
2. The review wrote to Samantha’s brothers and a friend, informing them of the review and enquire how/if they would like the opportunity to engage in the review. Unfortunately, no response was received.

Background Information

1. Samantha had a history of childhood trauma and struggled with her mental health. As a child she was placed on the Child Protection register under the category of emotional abuse due to witnessing domestic abuse and her father being an alcoholic. It is understood she may have become a Looked After Child. It is reported that she had experienced physical abuse and had been a victim of sexual offences as a child.
2. Samantha and James Jnr had been in a relationship since Samantha was 16 years of age. Samantha reported that James had introduced her to serious drug misuse. Substance use was a key feature in Samantha’s life. She used multiple substances and used high risk administration methods (intravenously in her groin). Samantha would regularly present under the influence of drugs, sometimes requiring immediate medical attention. These incidents often involved her using plant food[1] and/or illicit pharmaceuticals (namely benzodiazepines[2]). Samantha would struggle to attend appointments due to her use of substances and led to concerns relating to her self-care and physical health deterioration.
3. 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. Samantha found it challenging to take her required medication regularly (other than Methadone[3]), such as Apixaban[4].
4. Samantha had a criminal history with a heavy focus on acquisitive crime which revolved around her long-standing substance misuse issues and regular association with other prolific offenders and drug users.
5. In September 2015 Samantha requested help with her drug use, and during this contact disclosed historic rape. Advice was provided and the referral was closed. In May the following year Samantha overdosed on heroin. Her GP was notified and a referral was made to adult social care, with no further action taken.

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[1] “Plant food” is often a euphemism for synthetic drugs like mephedrone, which are sold under this guise to evade legal restrictions and are associated with significant health risks.

[2] Benzodiazepines are a group of depressant drugs and include drugs such as diazepam that are prescribed as medicines in the UK. Other benzodiazepines are not licensed or generally prescribed in the UK, such as alprazolam (Xanax) and etizolam.

[3] Methadone is an opioid medicine. Methadone is used for heroin withdrawal by reducing withdrawal symptoms and cravings.

[4] Apixaban is an anticoagulant used to reduce the risk of blood clots.

6. The first disclosure of domestic abuse came in December 2020 when Samantha said she was being abused by her partner James Jnr and his father James Snr, including physical and emotional abuse, neglect, and financial abuse. As a result, Samantha was referred to the Multi-Agency Risk Assessment Conference (MARAC) and adult social care.

7. During the scope period for this review (March 2023 to June 2024), and at the time of her death, Samantha was living with her partner James Jnr and his father James Snr. Samantha’s housing situation was reportedly complex, and she struggled to gain accommodation in her own right[5].

Summary Chronology

1. In August 2023 Samantha was arrested for a public order offence. During the arrest James Jnr threatened to throw metal dumbbells at police if they tried to get up the stairs. Whilst being booked into custody she reported she was between three and six weeks pregnant and reported to officers that both her and her partner had an issue with drugs.

2. The following day Samantha was conveyed to the Emergency Department by NWAS with a head injury. It was reported that an unknown offender had assaulted Samantha with a bat to the back of her head. Police informed Samantha that if she wished to report the assault to get back in touch with the police when she was better. The police received no further contact from Samantha.

3. In September 2023 Samantha was arrested and remanded in custody for a burglary offence. She was released early October 2023 and continued her methadone prescribing in the community with the support of Recovery Steps Cumbria. Samantha returned to using illicit substances in the community.

4. On the 23rd December 2023 Samantha was taken to hospital by ambulance following an assault with weapons. Samantha disclosed controlling and coercive behaviours with James Jnr injecting substances into her groin and taking her money. She disclosed physical abuse and shared details of injuries she had received. She said James Jnr had emptied her bank account leaving only £2 which increased her dependency on him and isolation. Samantha expressed a wish to leave but said she had nowhere else to go. A referral was made to housing for emergency accommodation and Samantha was provided access to a property. A DASH was completed, with a risk score of eight, and a referral was made to MARAC. Samantha was provided transport to the accommodation and during transfer had attempted to take the taxi driver’s phone. The taxi driver contacted the hospital as he was concerned about Samantha’s presentation and Emergency Department staff subsequently contacted police to request a welfare check and shared information regarding the disclosures made by Samantha.

5. Police spoke to Samantha but she would not disclose the name of the perpetrator for fear of repercussions and her new address being damaged. A crime of theft was recorded but the crime was finalised No Further Action.

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[5] Housing explained that Samantha was on Autobid, there are over a hundred bids on Cumbria Choice, and the system was generating the bids. However, the system does not have the capacity to filter out bids that the customer would not qualify for. A significant proportion of the bids were for properties subject to a Local lettings Policy, or Samantha would have been under occupying, and it would not have been affordable. Another issue was that a large proportion of the one bed properties that Samantha could have been allocated, were a sensitive let. This means that if a customer has certain convictions, they may not qualify.

At a later appointment with probation Samantha said she had been referring to James Snr and not her partner, James Jnr. She said James Snr had financially and emotionally abused her and she did not want to go back to their home.

6. Adult Social Care received a safeguarding report from police on the 3rd January 2024 detailing allegations of domestic abuse. The concern was triaged by the Adult Social Care safeguarding team and it was deemed that there was no further role for Adult Social Care as no care and support needs could be identified and police had investigated the allegation.

7. When Samantha was visited by housing at the accommodation, James Jnr was present. Samantha stated that he was her carer. Samantha attended the council offices the following working day, with James Jnr, who Samantha said was not living with her. Samantha said that her benefits were paid into James Jnr’s account, and that he had only assaulted her once, four years ago. Upon further questioning, it appeared that it was James Snr that she was referring to with regards to the assault. Samantha was linked in with the Crisis and Prevention Team. Consideration was later given to the fact that Samantha had both James’s at the accommodation, which triggered the decision to move her to accommodation where it would be easier for her to manage her front door.

8. A MARAC was held on the 23rd January 2024. Information shared at MARAC noted that Samantha had resumed her relationship with James Jnr and that he had been at the emergency accommodation with her. It was reported that James Jnr was now describing himself as her carer and services were struggling to get in contact with Samantha to offer support. The actions agreed at MARAC were as follows:

- Victim Support and Police to liaise with Probation and Recovery Steps to offer support to Samantha. Outcome – Samantha declined support from Victim Support.
- Women Out West to provide an update on involvement with Samantha, what they are currently supporting her for, if she is engaging well and how often she attends. Outcome – Women Out West reported that Samantha was first referred to them in October 2023. Samantha attended a registration appointment and said that she wished for support around accommodation as she was living with her partner’s father. A Duty to Refer was completed to the housing options as well as Cumbria Choice being set up for Samantha. Samantha attended the service again a week later and completed the Cumbria Choice application. Samantha was offered three further appointments and did not attend.

9. On the 2nd February 2024 Samantha was referred to move to the Home Group Rough Sleeping Accommodation Project (RSAP). Samantha agreed to accept the accommodation, signed the tenancy agreement (up to two years), rules of occupation and the support plans. On the 5th February 2024 the Crisis and Prevention Officer visited the RSAP scheme. However, Samantha took the keys and never returned. Samantha stopped engaging with Housing Options. Housing made several attempts to contact Samantha but were unsuccessful, updates were also provided to probation.

10. The DWP conducted a telephone Personal Independence Payment (PIP) review on 11th March 2024. The report confirmed that Samantha lived with her carer and her carer’s father, which she stated was temporary until she could find her own place. The report included that her carer helped her wash, cook, and to go out. The carer received carers allowance as they were looking after her 24 hours a day. Samantha stated that her carer would go through her finances with her as she could not understand what to do or when her bills were due, but that she used

a bank card to pay for items herself; Samantha’s PIP was paid into her carer’s account (James Jnr). The report further described how Samantha felt that she would not be able to cope without her carer. Following the review, PIP continued at the enhanced rate for daily living needs and was increased to enhanced rate for mobility needs.

11. On the 8th April 2024 Samantha was taken to hospital by ambulance; she had taken plant food and amphetamines, and had been found by police. Samantha left the hospital prior to being assessed.

12. On the 11th April 2024 Samantha had an appointment with Recovery Steps. Recovery Steps asked Samantha’s GP to see her as they were concerned about her physical state and presentation. Recovery Steps and the GP offered to refer Samantha to accident and emergency but she declined. Recovery Steps and the GP expressed great concern about the risks of the substances Samantha was taking, the unknown contaminants, and high risk of death. Samantha was given nasal naloxone to keep on her person and she confirmed she had injectable naloxone at home too[6].

13. The GP noted comments from the hospital about money worries and concern that James Jnr and Snr were coercive and controlling. James Jnr was called into the room at the end of the consultation and safety netting/999 information was given to him, however he was more worried about his sore knee, even when told of Samantha’s high risk of death from her present drug use.

14. On the 21st April 2024 Samantha attended the Emergency Department. She had a four day history of reduced urine output and bowel movements, with distended abdomen. She also reported that she had fallen down stairs four days ago. Samantha was admitted with concerns of acute kidney failure. Samantha was wanting to go home and see her partner, and said the risks to her did not outweigh her not seeing her partner. Samantha self-discharged. Samantha attended the Emergency Department on the 9th May 2024 with urinary issues. She was catheterised but was not able to pass urine.

15. On the 17th May 2024 probation referred to MARAC. Samantha had attended an appointment with a broken arm and swollen ankle and leg. She said she had fallen downstairs twice and snapped her wrist twice in the same place. When asked about domestic abuse, she said no, however she was not convincing with her answer. She then said she would discuss it when she was feeling better in herself, implying there was physical abuse. Samantha had lost weight and was very unkempt, she said there was no hot water or heating in the property and she had not bathed for over two months. Probation reported that Samantha never seemed to have money; she lived with her partner and his father and there had been concerns in the past around domestic abuse from them. Samantha’s case was referred to Victim Support on the 20th May 2024.

16. Probation also raised a safeguarding concern with Adult Social Care. The concern was triaged by a Duty Social Worker for the Mental Health Social Work team. The outcome was no further action as there was a plan in place for police response and the case to be referred to MARAC for multi-agency consideration.

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[6] Naloxone is a medicine that rapidly reverses an opioid overdose. Naloxone can quickly restore normal breathing to a person if their breathing has slowed or stopped because of an opioid overdose.

17. Recovery Steps also referred to MARAC on the 23rd May 2024, highlighting concerns relating to Samantha's broken wrist, financial exploitation and her increasingly intoxicated presentation. Recovery Steps also increased face to face contact with Samantha to three times weekly support, close monitoring and support around the risks she faced.

18. The MARAC was held later tater that month and agreed the following actions:

- MARAC to contact Riverside to ascertain if [the address] is one of their properties and if so request an update on tenants, any issues/ASB at the address. Outcome – none recorded.
- Riverside to confirm if [the address] is one of their properties, who is recorded as being tenants and are there any issues at the address. Riverside to report any safeguarding concerns to Adult Social Care. Outcome – none recorded.
- Recovery Steps to liaise with Samantha's GP regarding information shared by NCIC that Samantha is in Acute Renal Failure and request she is offered support for this. Outcome - the GP confirmed they were aware of this and would support Samantha by bringing her in for a physical health review.
- Probation to attempt to find out what benefits James Jnr was claiming/who he is currently claiming Carers Allowance for then update Police/MARAC. Outcome – James Jnr said he was not receiving Carer's Allowance for his father.
- Police to share an update with MARAC after visiting Samantha with Probation on 4th June. Outcome – Samantha had been provided with a phone by police. She had missed several appointments due to James Jnr not updating her and professionals not being able to contact her without first going through him. Samantha had been provided with safeguarding advice and asked if she had experienced any physical or sexual violence; she said no. Samantha reported having no access to her money, that she is given a small amount but James Jnr used the rest.

19. On the 4th June 2024 Samantha attended an appointment, with Probation, Recovery Steps and Police, under the influence. She said she was using Benzodiazepines. She denied physical or sexual abuse from James Jnr or his father but did acknowledge verbal abuse and said her partner threatened violence. Samantha said she received £1500 per month in benefits and that this money went into her James Jnr's bank account. She said she was 'sick' of living in her current property due to the condition.

20. On the 5th June 2024 police recorded that Samantha lived with James Jnr and James Snr. James Jnr was Samantha's carer but there was a lack of care being given to Samantha. She presented unkempt and had not washed for nearly two months. There was no hot water at the property. Officers had not been to the property and could not describe its state but Samantha had reported there were rodents in the property. It was also recorded that Samantha was extremely depressed and had thoughts of suicide. Samantha was verbally abused by both men a daily basis but Samantha stated that there was no physical or sexual abuse. Samantha was being financially abused as she did not get access to money that was paid into James Jnr's account and he had control of her money; this was then used by James Jnr for drugs and gaming. Samantha wanted her own property to get away from James Jnr and Snr. Her health was suffering physically and mentally. Samantha did not answer the phone to professionals, James Jnr always answered and Samantha was not able to talk in private. The information was discussed at morning Vulnerable Adult triage and it was requested the information be shared with Adult Social Care. A crime for Controlling Behaviour was recorded, although this occurred post Samantha's death.

21. On the 6th June 2024 Adult Social Care received a safeguarding report from police in line with similar concerns that were documented within probation's safeguarding concern from the 20th May 2024. Due to two concerns being raised in short succession alleging similar events, the concern was progressed to a safeguarding enquiry. A plan was agreed with Probation and Recovery Steps that Adult Social Care would attend planned appointments with professionals known to Samantha. Numerous attempts were made to see Samantha to gather information and complete enquiries. However, Samantha did not attend the planned appointments that Adult Social Care attended, the last attempt documented as 8th July 2024. Agencies involved with Samantha were reportedly communicating regularly in an attempt to support her.

22. On the 11th June 2024, Samantha attended a probation appointment, with police and Recovery Steps. It was reported she looked better than previously and she denied any sexual or physical abuse. Samantha had previously said she would be willing to go to refuge outside of the area but at this appointment she said she had changed her mind. Probation phoned housing options who said they would look into temporary accommodation but also encouraged Samantha to consider bidding on properties.

23. On the 27th June 2024 Samantha attended an appointment with probation. Samantha appeared to be under the influence and disclosed using plant food and pregabalin. She said she did not care if she did not wake up. Samantha had not attended hospital for her wrist and was in physical pain. She described 'horrendous' living circumstances, living in a damp and mouldy, rat infested home with no heating, water, food and 'constant bullying from James's dad'. Probation provided an update to all agencies via email.

24. Following a missed appointment in early July 2024, probation emailed all agencies asking if anyone had heard from Samantha. Samantha made contact a few days later to advise she had been forgetting everything, including to eat and drink. Samantha agreed to report the following day. Adult Social Care also attempted to contact Samantha, and they attended the Women's Centre that she was known to attend but Samantha was not there.

25. Later on the same day that Adult Social Care attempted to locate Samantha at the Women's Centre, and that Probation had had telephone contact with her, Samantha was taken to the Emergency Department where she subsequently died.

Analysis

1. The analysis will address the terms of reference and the key lines of enquiry within them. In doing so it will examine how and why events occurred, information that was shared, the decisions that were made, and the actions that were taken or not taken. It will consider whether different decisions or actions may have led to a different course of events. It will also highlight examples of good practice.

Response to domestic abuse disclosures and concerns

2. In December 2023 Samantha disclosed physical abuse and financial abuse, and behaviour that amounted to coercive and controlling behaviour. Good practice was demonstrated by the hospital, to whom she disclosed, in completing a DASH and referring to MARAC based upon professional judgement, in the absence of a visible high risk (the DASH would have indicated a visible risk of 'standard'). Good practice was also shown by the hospital who referred to housing, and by housing who provided immediate emergency accommodation to Samantha.

In the weeks leading up to the Christmas shut down period, arrangements were made by Cumberland Housing to ensure that there was an empty property in case a domestic abuse victim presented Out of Hours. This was a fully furnished property with basic food and toiletries included.

3. Police officers attended the emergency accommodation but Samantha would not disclose who her partner was. Nevertheless, a vulnerable adult safeguarding report was generated; a domestic abuse report could not be generated as details of the suspect could not be obtained and no DASH was completed. This ultimately led to the crime being filed as no further action due a perceived lack of support from Samantha.

4. Police reflected that once James Jnr had been identified, there was sufficient reasonable suspicion to arrest him, however this did not happen. This was explored with the officer as part of the review, who stated that they were a very new officer at the time, being in their initial ten weeks of being on the front line.

5. Best practice is that new officers would have one, perhaps two, tutor constables during this period, but this did not happen on this occasion due to staffing shortages. In addition, the officer had around nineteen crimes to investigate (this is a high number on average). However, there was supervisory sign-off from a sergeant and an inspector before the matter was closed. Cumbria Police stated that it is incumbent on tutors, supervisors and managers to review crimes, such as in this case, to ensure the correct disposal decisions are being made.

6. As it was the Christmas closure period, any further referrals, support or risk assessments by Cumberland Housing were delayed until the offices reopened on the 2nd January 2024. It was unknown at the point that Samantha presented, whether a risk assessment had been completed by the hospital, highlighting a missed opportunity by the hospital to share this information, particularly with housing.

7. There was a delay of one month from referral, to the MARAC taking place. Whilst MARACs are held weekly, a week was lost over the Christmas period due to bank holidays and staff leave, which inevitably caused a backlog in cases being heard. However, whilst it is unlikely that the delay had any significant impact on Samantha in this case, it may well have an impact on other high risk victims of domestic abuse. There therefore needs to be recognition of the 'pressure points' to resources that occur throughout the year e.g. Christmas/New Year and Easter, and an emphasis on agencies to minimise risk through robust safety planning.

8. Further good practice was demonstrated by Cumberland Housing when, following it becoming apparent that James Jnr and Snr were at the emergency accommodation, consideration was given to moving Samantha to accommodation where it would be easier for her to manager her front door. Furthermore, when Samantha denied domestic abuse, the allocation of crisis and prevention support was not closed.

9. Probation and Recovery Steps identified a high risk of domestic abuse in May 2024 following Samantha's attendance with injuries, weight loss and unkemptness, and appropriately referred to MARAC. Again, good practice was shown in the identification of high risk based upon professional judgement and not just relying on the visible risk, as is often the case.

10. Following the MARAC, police recorded that Samantha was being verbally and financially abused, Samantha's physical and mental health was suffering, and she was depressed and had thoughts of suicide. The information was discussed at the Vulnerable Adult triage and

it was requested the information be shared with Adult Social Care. A crime for Controlling Behaviour was recorded, although this occurred after Samantha's death. Recognition of coercive and controlling behaviour is explored further below.

11. There was further confusion arising in relation to who the perpetrator was in this case, with James Jnr sharing the same name as his father and Samantha sometimes referring to James Snr as the perpetrator of specific incidents. James Jnr was clearly the perpetrator of domestic abuse; he neglected Samantha whilst claiming to be her carer, isolated her from professionals and potentially friends and family, economically abused her and made her dependent on him through the supply of illicit substances. What role James Snr played is unclear. It is possible that James Jnr utilised him in his control over Samanatha, and James Snr may have been vulnerable himself and at risk from James Jnr. What is evident is that there was a lack of curiosity in this respect, particularly when Samantha alleged that abuse was from James Snr not James Jnr.

Risk Assessment

12. In addition to DASH's, other risk assessments were undertaken by the various agencies involved. Probation completed a Pre-Sentence Report in September 2023, pending Samantha's appearance at Crown Court. A police check was requested to inform the report which outlined concerns about domestic abuse of a 12 month period, this only outlined one domestic abuse incident from June 2023 involving a verbal altercation. There were no further formal checks requested on the Order. Similar checks took place in November 2023 with regards to James Jnr which identified the same verbal argument, and an incident whereby he was in possession of a metal bar at home. Probation reflected that these checks should have been repeated more regularly.

13. There were regular risk assessments being undertaken by Recovery Steps, including completion of the Recovery Steps Mortality Risk Assessment factors, which aims to identify individuals at heightened risk of drug related death. Risk assessment identified risk including self-neglect linked to substance abuse, unmanaged physical health needs, high risk drug use, intoxicated presentation, financial exploitation, homelessness and domestic abuse. However, the assessments did not fully document the links between the ongoing risks or the impact on her ability to access support. There were also a number of recorded conversations with Samantha about the significant risk of her ongoing substance, with personalised Rescue Planning being undertaken with her, which aimed to reduce the risk of her drug use.

14. Whilst Recovery Steps' risk assessments included safety planning, there was no evidence that these assessments were shared with other partner agencies supporting Samantha, nor is there evidence of RSC receiving these via other agencies.

Safeguarding Adults

15. Agencies raised safeguarding concerns with Adult Social Care in December 2023, May 2024 and June 2024. The concerns raised in December 2023 and May 2024 were not progressed to enquiries on the basis that no care and support needs were identified, police had investigated the allegations, and the case was to be heard at MARAC. However, police investigations and MARAC are not a substitute for safeguarding enquiries and do not negate the duty upon the local authority to undertake an enquiry.

16. Section 42 of the Care Act 2014 sets out the duty to undertake safeguarding enquiries where the local authority has reasonable cause to suspect that an adult in its area has needs for care and support, is experiencing, or is at risk of, abuse or neglect, and as a result of those needs is unable to protect themselves against the abuse or neglect or the risk of it. The purpose of such enquiries is to establish the facts, ascertain the adult's views and wishes, identify what help they require to stay safe, prevent further harm, hold perpetrators to account, and promote well-being. The local authority also has the power to undertake a non-statutory enquiry when the statutory criteria is not met, and therefore this could also have been considered in this case.

17. The duty to make safeguarding enquiries was met as Samantha had care and support needs by virtue of her substance use which affected her ability to manage daily tasks, access services, and increased her risk of abuse and exploitation. There was clear evidence that she was experiencing abuse and that she was likely unable to protect herself from that abuse. This meant there were missed opportunities to try and safeguard Samantha at an earlier interval.

18. However, the upon receipt of a concern, Adult Social Care would have been reliant on the referrer to clearly convey Samantha's vulnerabilities and need for care and support, regardless of whether she was receiving any such care and support. It is understood that safeguarding referrals are made verbally, making it easier to refer. Written referrals may provide the opportunity to more clearly convey such vulnerabilities and needs; Adult Social Care are currently developing an online form. Furthermore, a recent Thematic SAR undertaken in Cumbria has recommended exploration of electronic referrals.

19. It is also important that Adult Social Care ask the right questions when receiving safeguarding concerns in order to illicit the potential care and support needs. Practitioners need to consider and establish how the conditions which potential victims are subject to, and their lived experience, might affect their ability to protect themselves.

20. There was a known history, with previous safeguarding concerns being raised in 2018 which had led to a safeguarding enquiry. Adult Social Care reflected that upon receipt of concerns in January and May 2024 there was a lack of evidence as to whether previous referrals and information had been taken into account when decisions were made not to progress through safeguarding procedures.

21. In addition, at the MARAC in January 2024 information was shared that James Jnr was Samantha's carer. This would have indicated that Samantha may have had care and support needs and this in turn should have triggered further assessment in accordance with section 9 of the Care Act 2014.

S9 (1) Where it appears to a local authority that an adult may have needs for care and support, the authority must assess—

a) whether the adult does have needs for care and support, and

b) if the adult does, what those needs are.

22. The safeguarding concern raised in June 2024 was progressed to safeguarding enquiry, although it is unclear why on this occasion a decision was made to progress when previous concerns had not been. A plan was agreed with Probation and Recovery Steps and numerous attempts were made to meet with Samantha, however, these were unsuccessful. There were missed opportunities to include other agencies who were working with Samantha and hold further multi-agency safeguarding discussions when these attempted contacts with Samantha were unsuccessful.

Coercive controlling behaviour

23. Coercive and controlling behaviour is a pattern of behaviour by a person towards another person that is designed to exert power and control, and causes the victim to fear violence or experience serious alarm or distress that has a substantial adverse effect on their day-to-day activities. It is often subtle, involving psychological tactics and manipulative behaviour. Coercive and controlling behaviour is a criminal offence under the Serious Crime Act 2015, and has further strengthened by the Domestic Abuse Act 2021.

24. James Jnr coerced and controlled Samantha through various means. He restricted her access to finances, attended appointments with her/waiting outside for her and he supplied and administered drugs to her. In addition, there were reports of physical assaults and psychological abuse. There was also suggestion that James Snr was utilised to exert coercion and control. This behaviour made Samantha totally reliant and dependent upon James Jnr and made it extremely difficult for her to leave.

25. Coercive and controlling behaviour was acknowledged at the January 2024 MARAC however, it was not recorded or investigated as a crime. The reason for this is detailed above. Throughout the remainder of the scoping period coercive and controlling behaviour was not explicitly recognised, acknowledged or responded to suggesting a possible lack of confidence in this area and challenges around pursuing victimless prosecutions.

Informal carers who cause harm

26. Samantha and James Jnr both reported that James Jnr was Samantha's carer. This information was shared with agencies at the January 2024 MARAC. James Jnr was also in receipt of Carers Allowance. The Care Act 2014 states that a carer is 'an adult who provides or intends to provide care for another adult (an "adult needing care")'.[7] For the purposes of being eligible for Carers Allowance a carer is defined as a person over 16 years of age, providing at least 35 hours of care a week. The carer must not be earning more than £196 a week (after tax) and the cared for person must be in receipt of one of the qualifying benefits. The type of care being provided can include things like helping with washing and cooking, taking the person to appointments, helping with household tasks, like managing bills and shopping. However, there are no checks undertaken by the DWP in respect of the care reportedly being provided.

27. Being a carer can give somebody complete control over the cared for person's day to day activities and resources, creating a power imbalance, dependency upon the carer and isolation. However, domestic abuse by carers often goes unnoticed due to the trust placed in caregiving relationships, yet an increasing number of domestic homicide reviews feature carers and caring responsibilities. In the latest DHR Analysis, fourteen per cent of perpetrators were or had been carers[8]. Recent research has stated that the issue of carers as perpetrators of domestic abuse is overlooked, 'perhaps because they often don't fit the traditional patterns of abusive relationships and the complexities of the caring role can make standard safety interventions unsuitable.'[9]

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7 Care Act 2014, s10(3)

8 Quantitative+Analysis+of+Domestic+Homicide+Reviews+2022+_+2023.pdf

9 Warburton-Wynn, A. (2022). 'Carers and domestic abuse – the elephant in the room?' The Journal of Adult Protection 25(3)

28. James Jnr's role as carer for Samantha was overlooked in this case. Samantha had told the DWP that James Jnr was her full time carer and that he provided day to day support including prompting 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 help to manage finances.

29. Agencies cited that they were unclear about the nature of James Jnr's caring role and the support that he provided. The Care Act 2014 places a duty upon local authorities to assess the needs of carers[10] but no carers assessment was undertaken or offered. This is a recurring theme; the latest Home Office analysis found that only two of the ten intimate partner perpetrators who were or had been carers were provided a carer's assessment under the Care Act 2014[11]. Whilst carers have the right to decline a carers assessment, had one been offered and if James Jnr had participated, it would have helped agencies understand the nature of his caring role and the potential additional barriers Samantha faced.

30. A greater understanding of James Jnr's caring role would have also supported agencies to challenge that role. Agencies referred to Samantha neglecting herself, but as James Jnr was her carer he was actually neglecting her. Given that James Jnr was clearly not providing the level of care cited, the DWP could have been alerted and the financial incentive removed. However, James Jnr's role of carer went unchallenged, likely due to the use of language.

31. There were regular concerns from many of the agencies involved about Samantha's access to her own money and James Jnr having complete control; these concerns dated back to 2018. Economic abuse is often misunderstood but it is a key tactic used by perpetrators of domestic abuse to control their partner. Economic abuse incorporates a range of behaviours which allow a perpetrator to control someone else's economic resources or freedoms. Not only does it include denying or restricting access to money, or misusing another person's money, it can also include restricting access to essential resources such as food, clothing or transport, and denying the means to improve a person's economic status (for example, through employment, education or training). When a victim has no access to money and other economic resources, the barriers to escaping domestic abuse can seem insurmountable.

32. Cumberland Housing had offered Samantha support to get her benefits paid into her account only, and Adult Social Care were of the impression that this was being addressed, however Samantha declined this support. Agencies should have referred to the DWP of the concerns and sought advice from them with regards to alternative payments methods.

33. The UK Parliament's Work and Pensions Committee has reopened an inquiry into the safeguarding arrangements of the DWP due to concerns over the treatment of vulnerable benefit claimants. The inquiry, which began in July 2023, aims to evaluate the DWP's approach to safeguarding and determine if it needs a statutory duty to protect the wellbeing of vulnerable claimants. The inquiry has been prompted by reports of numerous deaths linked to DWP's actions and has called for a review of the department's internal process reviews and its guidance on safeguarding. The inquiry will seek to understand how the new government intends to support those who find it difficult to interact with the benefit system and will consider the challenges faced by vulnerable claimants, including the need for additional support and safeguarding measures. Locally, the DWP continues to provide assurances to the Safeguarding Adults Board, is reviewing the approach it takes to safeguarding and is working to introduce and publish a DWP wide 'safeguarding approach'.

[10] Care Act 2014, s10

[11] Quantitative+Analysis+of+Domestic+Homicide+Reviews+2022+_+2023.pdf

34. Cumberland Community Safety Partnership have also identified through a number of DARDRs undertaken locally, that carer suitability assessments have not been undertaken and recognise that this is not standard practice for the DWP. There are already recommendations for the DWP to consider this nationally, ensuring that suitability is re-assessed regularly in conjunction with Social Care and Health Providers.

Multi-agency frameworks

35. The primary multi-agency framework utilised in this case was MARAC. A MARAC is a meeting where information is shared on the highest risk domestic abuse cases. They are attended by representatives from police, health, child protection, housing, independent domestic violence advisors, probation and other specialists from the statutory or voluntary sectors. They share all relevant information they have about a victim, discuss options for increasing the victim’s safety, and create a co-ordinated action plan. The primary focus of the MARAC is to safeguard the adult victim but it will also make links with others to safeguard children and/or other vulnerable adults, and manage the perpetrator’s behaviour. At the heart of the MARAC is the working assumption that no single agency or individual can see the complete picture of a victim’s life but they all may have insights that are crucial to the victim’s safety.

36. There was some criticism of the month delay in the referral reaching a MARAC meeting in January 2024. The delay was primarily due to the Christmas and New Year period which unavoidably affects service provision as a result of reduced staffing levels and subsequent backlog. It is recognised that holiday periods create a significant pressure for agencies. It was also queried whether this delay had any impact on Samantha, however whilst it appeared not to have had a significant impact on Samantha, there is potential for such delays to have a significant impact on the risk to other victims of domestic abuse.

37. Whilst some agencies stated that the MARAC was effective, others felt that there was too much weight put on the MARAC to be the forum to agree a safety plan. MARACs are held weekly in Cumberland but it was acknowledged that MARACs provide a time limited slot for each case to be discussed, it is therefore not a replacement for ongoing multi-agency approaches and coordination or other multi-agency frameworks.

38. The actions agreed at the two MARACs focused on gathering further information, and although updates were provided, there was no sense of what further action would be taken in response to the information acquired. The MARAC, and the actions agreed, did not appear to meaningfully or explicitly seek to reduce the risk the risk to Samantha or hold James Jnr to account.

39. Some areas of the country have implemented ‘Complex MARACs’ or ‘MARAC Plus’ for cases which repeatedly come to notice at locality MARAC level and cases which hold an additional level of complexity where the parties being discussed may have compounding disadvantages and vulnerabilities. These cases generally require a higher level of agency strategic oversight, as MARAC action planning has not able to effectively reduce domestic abuse risk. Cumberland do not have a MARAC Plus or Complex MARAC, which may have been beneficial in Samantha’s case given her multiple disadvantage and vulnerabilities. Again, this highlights the need for a multi-agency approach and coordination, and utilisation of other multi-agency frameworks.

40. SafeLives have produced guidance for MARACs for managing cases involving substance misuse and other complex needs, acknowledging that cases involving complex substance misuse and/or mental health issues are relatively common. The guidance provides tips for researching cases, sharing information and action planning. This includes identifying a single point of contact for the victim (usually the IDVA but could be someone with specialist knowledge or an established relationship with the victim), attendance by core agencies with consistency in representation, and consideration of a professionals meeting as an action from MARAC, to bring all relevant agencies working together as a multi-disciplinary team.[12]

41. It was also noted that the GP was not aware that any MARACs had taken place, with the last recorded MARAC meeting for Samantha being recorded by the practice in 2020. The ICB confirmed that MARAC notifications for all cases are being sent to GPs since 1st January 2025.[13] However, there is an outstanding issue of the level of detail being received by GPs, which is usually just the names of the affected parties. It was also confirmed that no written minutes are taken, the meeting is recorded and any agency would need to access that recording to acquire the further detail.

42. As discussed above, the safeguarding framework was available in this case, however, concerns were not progressed to an enquiry until June 2024, one month prior to Samantha's death.

43. Outside of the multi-agency forums available there was evidence of good multi-agency working, particularly between Recovery Steps, the GP and Probation. Recovery Steps and Probation had multiple daily contacts when risk began to escalate, during the last few months of Samantha's life. Recovery Steps also retained close working links with Samantha's community pharmacy, often ensuring vital contact to assess Samantha's presentation and prescribing safety. There was also evidence that other agencies were able to utilise these services in an attempt to support Samantha.

44. In addition, Samantha's care at RSC was managed via shared care arrangements with the GP practice. This proved effective in ensuing communication between Recovery Steps and primary care, access to hospital discharge information and arranging speedy access for Samantha to required medication and GP review. In addition, there were also arrangements in place for appointment letters, such as fracture clinic and Hepatology, to be copied to Recovery Steps, thus supporting an understanding of Samantha's health needs and opportunities to remind and prompt Samantha of appointments.

45. The GP practice reflected that more should have been done to bring and discuss Samantha at the practice Integrated Care Community complex MDT, in particular regarding her increasing risk of death in the latter months of her life. However, the panel noted that had this forum been utilised it would likely not result in any additional actions. The forum is hosted by NCIC, is predominantly a health conversation and does not include wider partners; given the joint approach by the GP and Recovery Steps, the Integrated Care Community complex MDT would have had no added value.

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[12] Guidance-for-Maracs-managing-cases-with-complex-needs.pdf

[13] Notifications are being sent to GPs in respect of the victim, perpetrator and any children. In addition to MARAC, notifications are sent in respect of all Prevent and MAPPA level 3 cases.

46. However, there were also reports of information being received by various agencies third or fourth hand, and information not being shared in a timely way with some information being received by agencies after Samantha's death. The receiving agencies were often unclear about who was acting on what information and what action had already been taken. Information was often shared between a group of practitioners, by email, in an attempt to do something but this lacked coordination. This further highlighted the lack of overall coordination and need for additional multi-agency forums to share information, to agree and review actions.

Impact of substance misuse

47. Samantha had been using substances since meeting James Jnr when she was around sixteen years of age and she reported that he had 'got her started'. In terms of substance misuse risk, Samantha was reviewed in line with Recovery Steps' RAG rating tool and was assessed as red, meaning her presenting needs posed a high risk to her health and wellbeing. Samantha was identified at high risk of drug related death via the Recovery Steps Mortality Risk Assessment process. Samantha received individual rescue planning aimed at reducing the risk of fatal overdose, she was issued with Naloxone (opiate reversal medication), which was regularly reviewed, and there was evidence of regular discussion held with Samantha outlining the risks associated with her use. Samantha continued to use substances during her treatment with Recovery Steps.

48. Samantha was offered regular face to face appointments with Recovery Steps and the service maintained frequent telephone contact with her. Samantha was also monitored via her community pharmacy and there were arrangements in place to share concerns and not dispense without support from Recovery Steps if Samantha presented intoxicated. Samantha attended Recovery Steps on an ad hoc basis, often attending to access unplanned support when required. Samantha's contact with the service was increased to three times weekly attendance in June 2024 to ensure there was frequent contact with her to assess her presentation and needs.

49. Samantha was prescribed methadone via shared care provision and collected this on a daily supervised basis. Medical reviews were overseen and undertaken via shared care GP, with the support of her Recovery Steps Recovery Coordinator. Samantha's drug use impacted her ability to keep safe and well which was recognised by Recovery Steps and documented in risk assessments. However, the interplay between substance use and domestic abuse was not explicitly recognised or explored.

50. The relationship between domestic abuse and substance misuse is significant. It has been found that people who have used illicit drugs are three times more likely to have reported being a victim of domestic abuse[14]. Research has found that men using substances committed more intimate partner violence than men with no substance use[15]. Where drugs and alcohol are involved in domestic abuse, much of the evidence suggests that it is not the root cause, but rather a compounding factor, sometimes to a significant extent[16]. Whilst there is evidence that drug and alcohol use by perpetrators increases the frequency of violence and the seriousness of outcomes, it is important for professionals to remember that this does not mean drug and alcohol use causes domestic abuse.

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[14] ONS. (2016), Compendium: Intimate Personal Violence And Partner Abuse. Office for National Statistics

[15] A Systematic Review of Risk Factors for Intimate Partner Violence

[16] IAS report Alcohol, domestic abuse and sexual assault.docx

51. Whilst a question about drug and alcohol use is included in the DASH risk assessment, and therefore recognises it as a high risk factor, it has been suggested that the question does not do justice to the potential significance of drug and alcohol problems in domestic abuse[17]. Whilst some victims may use substances to self-medicate to manage the psychological effects of domestic abuse, some perpetrators control victims by increasing their dependence on substances before restricting their access to them, as was apparent in Samantha's case.[18]

Capacity to make decisions

52. Mental capacity refers to a person's ability to make informed decisions for themselves. A person has the mental capacity to make decisions when they are able to understand the relevant information about a decision, they can remember that information long enough to make the decision, they can weigh the pros and cons to reach a conclusion, and they can express their decision, whether by speaking, writing, or other means[19]. However, mental capacity can be compromised by an impairment or disorder of the mind or brain, this can include conditions such as dementia, a learning disability, mental health condition or a brain injury. Intoxication from drugs or alcohol can also affect someone's mental capacity, either long or short term (fluctuating capacity), although being intoxicated does not automatically mean that someone lacks capacity.

53. Whilst starting from the assumption that a person has mental capacity, if there is reasonable belief that someone may lack capacity to make a specific decision, a mental capacity assessment should be undertaken in accordance with the Mental Capacity Act 2005. If it is found that a person lacks capacity then the decision is made in their best interests.

54. NCIC were the only agency to formally assess Samantha's capacity. Her capacity was assessed in relation to her refusing treatment, and she was found to have the capacity to make that decision. NWAS stated that they had, prior to the scoping period, assessed Samantha's capacity and found that her capacity fluctuated as a result of substance misuse and had made the decision to convey her to hospital in her best interests. No other agencies formally assessed Samantha's mental capacity to make decisions during the scoping period. This review would not be able to establish retrospectively whether Samantha did or did not have mental capacity to make decisions during the period, but there is evidence to suggest that there may have been reasonable belief that she may have lacked capacity, thus triggering the need to assess.

55. Even when people have mental capacity, as determined by the Mental Capacity Act 2005, their ability to make decisions can still be compromised, for example, as a result of coercion or undue influence. There is evidence to suggest that Samantha's decision making was compromised, if not by an impairment of the mind or brain as a result of substance misuse, by the coercion and control exerted by James Jnr, and possibly his father, James Snr.

56. Establishing Samantha's mental capacity would have also been important as the Mental Capacity Act 2005 prescribes the ill-treatment or wilful neglect of a person who lacks mental capacity as an offence. As Samantha's carer, James Jnr may have been liable had it been established that she lacked mental capacity. Police stated that on the basis of the assumption of capacity, the police do not carry out the five question capacity checks. Samantha had not,

[17] Alcohol-Concern-AVA-guidance-on-DA-and-change-resistant-drinkers.pdf (avaproject.org.uk)

[18] Stark, E. (2007). Coercive Control: How Men Entrap Women in Personal Life. Oxford University Press.

[19] Mental Capacity Act 2005

to the police’s knowledge, had a capacity assessment, nor had she said she did not have capacity. Therefore, from the perspective of the police the offence of ill-treatment or wilful neglect was not an issue.

57. In cases where the Mental Capacity Act 2005 does not apply, inherent jurisdiction can be considered. Inherent jurisdiction refers to the power of the High Court to make decisions and orders in situations where no specific statutory authority exists but where intervention is necessary to protect individuals, especially those who are vulnerable. The High Court can issue a wide range of orders, including preventing an undesirable association (e.g. stopping contact with someone harmful). It is therefore an option that could have been considered to assist in Samantha’s protection, following multi-agency discussion and legal advice.

58. Samantha’s lived experience is also an important factor in considering her ability to make decisions. Samantha had experienced trauma as a child through adverse childhood experiences and had been in a relationship with James Jnr from a young age. It is highly likely that she had little experience of making decisions for herself. Ultimately, there were a number of factors which affected Samatha’s ability to make decisions, and even if she had capacity as per the Mental Capacity Act, she still required appropriate support to make decisions.

Engagement

59. Samantha’s engagement with services was a significant theme for agencies working with her. Samantha often did not attend appointments, declined services and was difficult to make contact with her, with reports that James Jnr had taken Samantha’s phone, answered her phone and occasions when professionals called Samantha’s number the voicemail was for James Jnr. Professionals also found it challenging that Samantha would often change her mind, specifically around offers of housing and refuge.

60. Samantha made regular reference to struggling to access her community pharmacy daily. Samantha was not at the pharmacy which was most accessible to her, and was accessing a pharmacy which was a significant distance from her address. This was due to Samantha being “banned” from at least two pharmacies due to shoplifting and verbal aggression. Other alternative pharmacies were full to capacity and unable to accommodate managing her prescription. It was clear this made engaging in prescribed treatment more difficult for Samantha and she found this very challenging.

61. Police found Samantha’s intoxication and substance misuse an impediment to gaining a coherent report of crime from her. This was most apparent when uniformed officers’ responded in December 2023. Upon review of body worn footage it could be seen that officers were trying to gain a coherent account from Samantha, but that it was very difficult due to Samantha’s demeanour as she appeared to be heavily under the influence of drugs and/or drink.

62. There were examples of good practice by the police, with responses tailored to Samantha’s needs, including face to face contact away from her address and pre-planned meeting with Samantha at a Recovery Steps, probation and housing appointments. However, there were also examples which did not support engagement, where there was little consideration for Samantha’s needs, for example, making it incumbent on Samantha to contact the police should she wish to report the assault (January 2024). Police recognised that placing the onus on a victim, who led a ‘chaotic lifestyle’ and used substances, to recontact the police was not best practice and counter to effective safeguarding. The Officer in Charge subsequently closed the investigation due to non-contact and sent a letter to Samantha informing her the investigation

would be closed if the Officer in Charge had not heard back by the 12th January 2024. There appeared to be no consideration of Samantha's ability to read or comprehend such a letter, nor for the possibility of somebody else intercepting the letter.

63. Housing reported that engagement was poor from the start. Housing established that Samantha had a good working relationship with Probation, so there were frequent calls with Probation to ensure that she had been seen. Good practice was also shown buy housing, whereby standard practice would be that a refusal of an offer of housing would result in a case being closed and no further duties being owed, Samantha also breached her licence by having both James's present at the accommodation and she denied domestic abuse. However, the Crisis and prevention team continued to try and support Samantha and look for alternative Housing Options for her. The reason for this was an understanding by housing that Samantha had multiple and complex needs, including being care experienced. They said that there was always a suspicion that there was more going on than they could evidence.

64. There were further examples of effective multi-agency working to promote engagement, especially between Recovery Steps, the GP, probation and police. These services had developed an effective communication group (via email), to provide speedy and regular updates in respect of contact with Samantha and identified risks. Actions were also implemented to enable appointment letters were shared with Recovery Steps to support Samantha's attendance at appointments.

65. Agencies also attempted to undertake joint appointments at various locations including Recovery Steps hubs, the GP practice and other community locations. In addition, the co-location of services, such as Recovery Steps Hepatology clinics, demonstrated further attempts to engage Samantha and other service users who may find it difficult to access healthcare services. This approach was also reflected in Samantha's substance care being managed via shared care between her GP and Recovery Steps, which aimed to increase communication between addiction services and primary care, avoid duplication of appointments and ensure coordination of healthcare needs.

66. Agencies reflected that even with all of the above actions to support engagement, there continued to be barriers to Samantha accessing services. Samantha had multiple presenting needs that impacted her ability to engage with contacts offered and navigate healthcare pathways. These included living with addiction, unmanaged physical health needs and experiencing domestic abuse.

Trauma Informed practice

67. Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as harmful or life threatening. While unique to the individual, generally the experience of trauma can cause lasting adverse effects, limiting the ability to function and achieve mental, physical, social, emotional or spiritual well-being.

68. Trauma informed practice aims to increase practitioners' awareness of how trauma can negatively impact on individuals, and their ability to feel safe or develop trusting relationships. It aims to improve the accessibility and quality of services by creating culturally sensitive, safe services that people trust and want to use. It seeks to prepare practitioners to work in collaboration and partnership with people and empower them to make choices about their health and wellbeing. Trauma-informed practice acknowledges the need to see beyond an individual's presenting behaviours and to ask, 'What does this person need?' rather than 'What is wrong with this person?'.

69. With specific reference to domestic abuse, it is possible that Samantha did not recognise herself as a victim. Many victims of domestic abuse do not immediately recognise they are being abused, especially in cases of emotional, psychological, economic, or controlling behaviours, even though legal definitions cover a broad range of harmful actions. Samantha often denied experiencing different types of abuse, particularly coercive and controlling behaviour, but would then go on to describe behaviour by James Jnr which was coercive, controlling and abusive.

70. In undertaking this review it became evident that there were missed opportunities by professionals working with Samantha to fully comprehend her lived experience and trauma, and how this might have impacted upon her ability to access and engage with services. There were missed opportunities to identify barriers to access and engagement, and how these barriers could have been minimised or removed for her.

Conclusion

1. Samantha had been in a relationship with James Jnr her entire adult life. He had reportedly introduced her to drugs and she had likely experienced domestic abuse and coercive control throughout the lifetime of their relationship together. Samantha had experienced trauma and adverse experiences throughout her life as a child and an adult, and likely had an impact on her understanding of what a ‘normal’, healthy and safe relationship looked like.
2. This review into the death of Samantha has highlighted the complex interplay of domestic abuse, substance misuse, mental health challenges, and social disadvantage. Despite the involvement of multiple agencies and professionals, significant barriers remained in identifying and addressing the risks faced by Samantha. The review found that while there were examples of good practice, such as the use of professional judgement in risk assessment and multi-agency referral, there were also missed opportunities for safeguarding, information sharing, and coordinated action.
3. A recurring theme was the lack of professional curiosity regarding the role of informal carers, particularly where the carer is a perpetrator of abuse. The assumption that James Jnr’s caring role had been adequately assessed led to missed opportunities for intervention. Economic abuse and coercive control were present but not always recognised or acted upon, and the reliance on MARAC as the primary multi-agency framework sometimes resulted in delays and insufficient risk management.
4. The review has also identified the need for trauma-informed approaches, and greater consideration of individuals’ ability to make decisions when there is substance misuse and coercion and control present. The lessons from Samantha’s case have already informed local learning events and practice improvements, with ongoing efforts to embed these changes across agencies.

Lessons Identified

1. This section summarises the lessons drawn from Samantha’s case and how those lessons should be translated into recommendations for action. It will also include narrative of service changes since scoping period, whether or not these arose from immediate learning from Samantha’s death, and any actions already taken in response to other DARDRs and SARs undertaken locally where similar themes have been identified.

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

3. 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 in order to gauge impact of identified learning improvement and embedding into practice.

Risk Assessment

4. 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.

Safeguarding Adults at Risk

5. The review has 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[20], 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.

6. 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 Jr and Snr. Civil orders are easier to secure than criminal convictions, yet behaviour is often logged as nuisance and left for police to deal with.

[20] Safeguarding Adult Reviews (SARs) | Cumbria Safeguarding Adults Board

7. 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.

Coercive Controlling Behaviour

8. 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'[21] to increase practitioner understanding and awareness of coercive controlling behaviour.

Making decisions

9. 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 has highlighted that in respect of assessing mental capacity in accordance with the Mental Capacity Act 2005, therefore 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 of substance misuse 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.

10. 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.

Informal Carers

11. There was a lack of curiosity about James Jnr's 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 Jnr 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.

Multi-agency Forms

12. There was a reliance on MARAC to address and manage risk. 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.

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

13. 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.

Trauma-informed approaches

14. 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.

Recommendations

The following recommendations recognise learning from other DARDRs and SARs undertaken locally, and the ongoing work being undertaken to address recurring themes, and so such recommendations are not repeated here.

1 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).

2 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.

3 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.[22]

4 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

[22] 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.