Safeguarding Adults Review

‘Rosa’

Final Report

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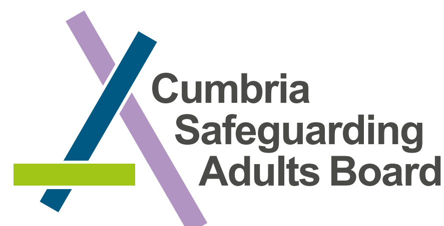

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Foreword

Family Statement for the Safeguarding Adults Review - Rosa

As Rosa's family, we welcome the opportunity to be involved with this Safeguarding Adults Review and thank all involved parties for their openness and contributions. We offer this statement in the hope that Rosa's story strengthens safeguarding practice for others who may be unable to protect themselves or make their voices heard without significant support.

Reading the review has been both painful and validating. It has brought back the reality of what Rosa experienced and the questions our family continues to live with while also confirming many concerns we held during her lifetime. It highlights opportunities where greater intervention, professional curiosity, and coordinated action may have made a difference.

We recognise that many professionals involved with Rosa cared about her wellbeing and tried to support her. We do not see this as a story of individual indifference, but of a system that did not consistently adapt to Rosa's vulnerabilities, circumstances, and lived reality, and was therefore unable to provide the protection she needed.

Rosa lived with a learning disability, progressive physical health needs, increasing dependence on others, and limited ability to advocate for herself. These vulnerabilities were known to services. We believe they should have prompted greater protection, stronger curiosity, and a more determined effort to understand what life was really like for her.

One of the hardest conclusions for our family is that Rosa was not invisible. Professionals were involved, assessments were undertaken, referrals were made, concerns were raised, meetings took place, and legal frameworks existed to protect her. Yet Rosa remained at risk.

Rosa's case shows that the existence and involvement of services alone is not enough. Safeguarding must be judged not by whether procedures were completed, but by whether the person was safer as a result.

We think it is also important to recognise the wider context. Disabled women can face increased risks of domestic abuse, coercive control, neglect, and exploitation. Dependence on others for care, barriers to communication, isolation, and limited access to support can make disclosure harder. In Rosa's case, many of these risk factors were known and should have prompted stronger multi-agency safeguarding responses.

A particular concern is the failure to communicate with Rosa in a way that enabled her to understand, feel safe, and express herself freely. Rosa's agreement with professionals may at times have been mistaken for understanding. She often wanted to please people and avoid conflict, particularly when frightened or unsure. Agreeing did not necessarily mean she understood, nor that she felt able to express a different view. Safeguarding required confidence that communication was meaningful, that Rosa had understood what was being discussed, and that advocacy, reasonable adjustments, and time were used to help her voice be heard. We do not believe this was sufficiently achieved and that greater learning is required in this area.

Trust was central. It cannot be built through a single visit or assessment, particularly where a person may be frightened, dependent on others, or subject to influence or control. For Rosa, effective safeguarding depended on professionals taking the time to communicate in ways she could understand, checking her understanding, and creating conditions in which she could speak openly and safely. We hope agencies reflect on how they build relationships with vulnerable adults whose communication needs may otherwise leave them unheard.

Professional curiosity is another key learning point. Concerns raised by family members, missed appointments, deteriorating health, barriers to professional access, unexplained issues, inconsistencies, and the risks associated with Brian may not always have met thresholds individually. Collectively, they painted a picture that warranted deeper enquiry and sustained follow-up.

Safeguarding decisions must be evidence-based, but professionals should also be supported to act when something does not feel right. Safeguarding should not end with a completed checklist or recorded concern; it should involve asking further questions, seeking additional information, and remaining open to what may be happening beneath the surface.

We are also concerned that attention appeared to focus mainly on Rosa's vulnerabilities, rather than fully exploring and following through on the risks posed by Brian, who was also known to services. Safeguarding should include robust consideration of influence, control, caregiving responsibility, coercion, neglect, or abuse, and those risks must not only be identified but actively pursued, tested, shared, and responded to across agencies.

Rosa's needs did not fit neatly within organisational structures. She had disabilities, health needs, care and support needs, and potential experiences of abuse and neglect. No single aspect of her life existed in isolation. Services needed to see Rosa as a whole person, with stronger integration between safeguarding, health, social care, domestic abuse, advocacy, and legal frameworks.

Standard procedures are not always enough for people with complex vulnerabilities. There must be flexibility to make reasonable adjustments, such as longer appointments, consistent professionals, adapted communication, advocacy, and practical arrangements that support safety, trust, and understanding. Rosa did not need services that worked for the average person. She needed services that worked for Rosa.

Most importantly, we want Rosa to be remembered as a person. She was loved by her family. She mattered. Her life had value. She was more than a safeguarding concern or a collection of professional records. She was a daughter, a niece, a family member, and a person who deserved to live safely, with dignity, respect, and the right support.

We are not seeking perfection, and we know no safeguarding system can remove all risk. Nor can this review change what happened. What we hope for is learning, accountability, and meaningful change. At times, compliance appeared to be mistaken for understanding, attendance for engagement, and completed procedures for protection.

The true test of safeguarding is not how well it works for those who can navigate systems independently, but how well it protects those who cannot. The measure of success should not be whether the system worked as designed, but whether the person was safe.

If there is one thing we ask of those who read this review, it is that they remember Rosa when they meet someone whose circumstances are complicated, whose voice is difficult to hear, or whose needs do not fit neatly within existing systems. Her legacy will be found in professionals choosing to communicate in ways that are genuinely understood, look deeper, listen longer, ask one more question, follow through on known risks, and act when something does not feel right.

While we cannot change Rosa's experience, we hope the learning from her life helps create a future in which vulnerability triggers protection, dependence prompts greater scrutiny, and safeguarding systems adapt to the individual. If Rosa's story helps even one vulnerable person to be seen, heard, understood, and protected, then her legacy will endure far beyond these pages.

Introduction

One of the statutory functions of a Local Safeguarding Adults Board is to arrange Safeguarding Adults Reviews. The aim of a Safeguarding Adults Review is to learn from individual experiences and produce findings and recommendations which are of practical value to individuals and organisations. Mandatory Safeguarding Adults Reviews must take place 'when an adult in its area dies as a result of abuse or neglect and there are concerns about how agencies worked together to safeguard the individual'. Safeguarding Adults Boards also have discretionary powers to conduct Reviews into any other cases involving adults with care and support needs where this will help "to promote effective learning and improvement action to prevent future deaths or serious harm occurring again" (DHSC, 2025).

The Safeguarding Adults Board should weigh up the type of review process that will achieve the aim of effective systems learning. Safeguarding Adults Reviews bring together different perspectives and experiences to produce evidence-based findings and recommendations.

Principles

Safeguarding Adults Reviews should be conducted in line with principles set out in paragraph 14.167 of the Care and Support Guidance:

- "There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice
- The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined
- Reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed
- Professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith
- Families should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively" (DHSC, 2025).

About the Reviewer

The Review started in April 2024, led by Independent Reviewer Cat Everett. Cat completed a significant amount of work on the review, including setting the terms of reference and key lines of enquiry, and had begun gathering evidence for the review in the form of Individual Management Reports and conversations with family members. However, due to unforeseen circumstances Cat Everett was not able to complete the review and a change of author took place in June 2025. The subsequent Review into Rosa's experiences has been led by Eliot Smith, an Independent Health and Social Care Consultant and experienced SAR Reviewer with a background in social work. Eliot has worked for both Local Authority and NHS services in different authorities in England and has no prior connection or knowledge of Rosa's case.

Individuals referred to in this report have been anonymised and where necessary identifying information has been disguised or omitted to protect confidentiality. The Safeguarding Adults Review has adopted the pseudonyms used in a parallel Domestic Abuse Related Death Review (DARDR).

Background

The case of Rosa was referred to Safeguarding Adults Board (SAB) on 23/08/2023 by People First independent advocacy due to concerns about the circumstances of her death. Rosa died after a deterioration in her physical health condition, Multiple Sclerosis. The neglect of her health and treatment, due to domestic abuse was believed to be a significant factor in her death. The case was referred to the Safeguarding Adults Board, and a mandatory review was commissioned.

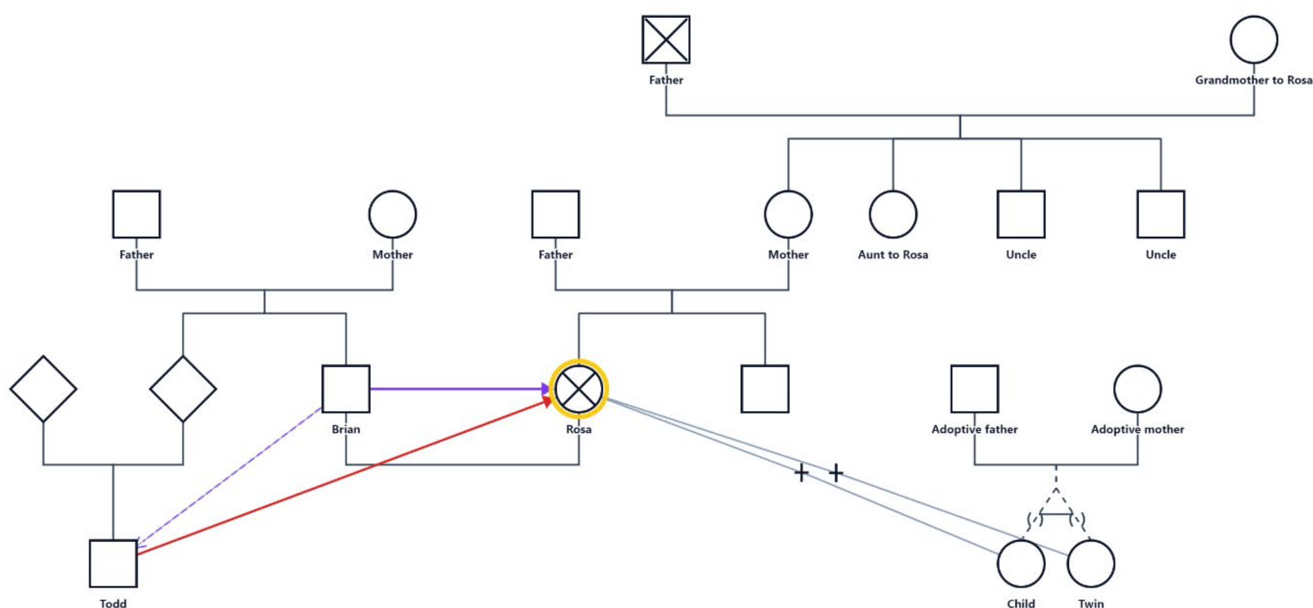
Parallel processes

Due to the circumstances of Rosa’s death, her case was referred for a Domestic Homicide Review (DHR) in September 2023. Domestic Homicide Reviews have since become “Domestic Abuse Related Death Review[1]” and Rosa’s review was completed under the DARDR framework. The reviews cover different areas of practice and are complementary reviews providing different perspectives on the safeguarding and domestic abuse systems in Cumbria.

Social history and family relationships

This Safeguarding Adults Review concerns Rosa, a woman in her thirties who suffered from Multiple Sclerosis, and a diagnosis of a mild learning disability. Rosa was married to Brian, and they lived together with Brian’s nephew, here referred to as Todd.

Figure 1: Genogram for Rosa



Rosa’s marriage to Brian was characterised by controlling and coercive behaviour, and financial abuse. Rosa had become estranged from her family, and it is alleged that she experienced medical neglect due to Brian’s control of her access to services and his cancellation of support and medical appointments. While there are concerns that Todd was also subject to Brian’s control, he was also reported to be psychologically abusive to Rosa, and that he inappropriately provided her with personal care. Rosa was also noted to have suffered from other injuries and bruising that remained unexplained.

[1] Domestic Abuse Related Death Reviews are statutory reviews, conducted under s.9 Domestic Violence, Crime, and Victims Act 2004.

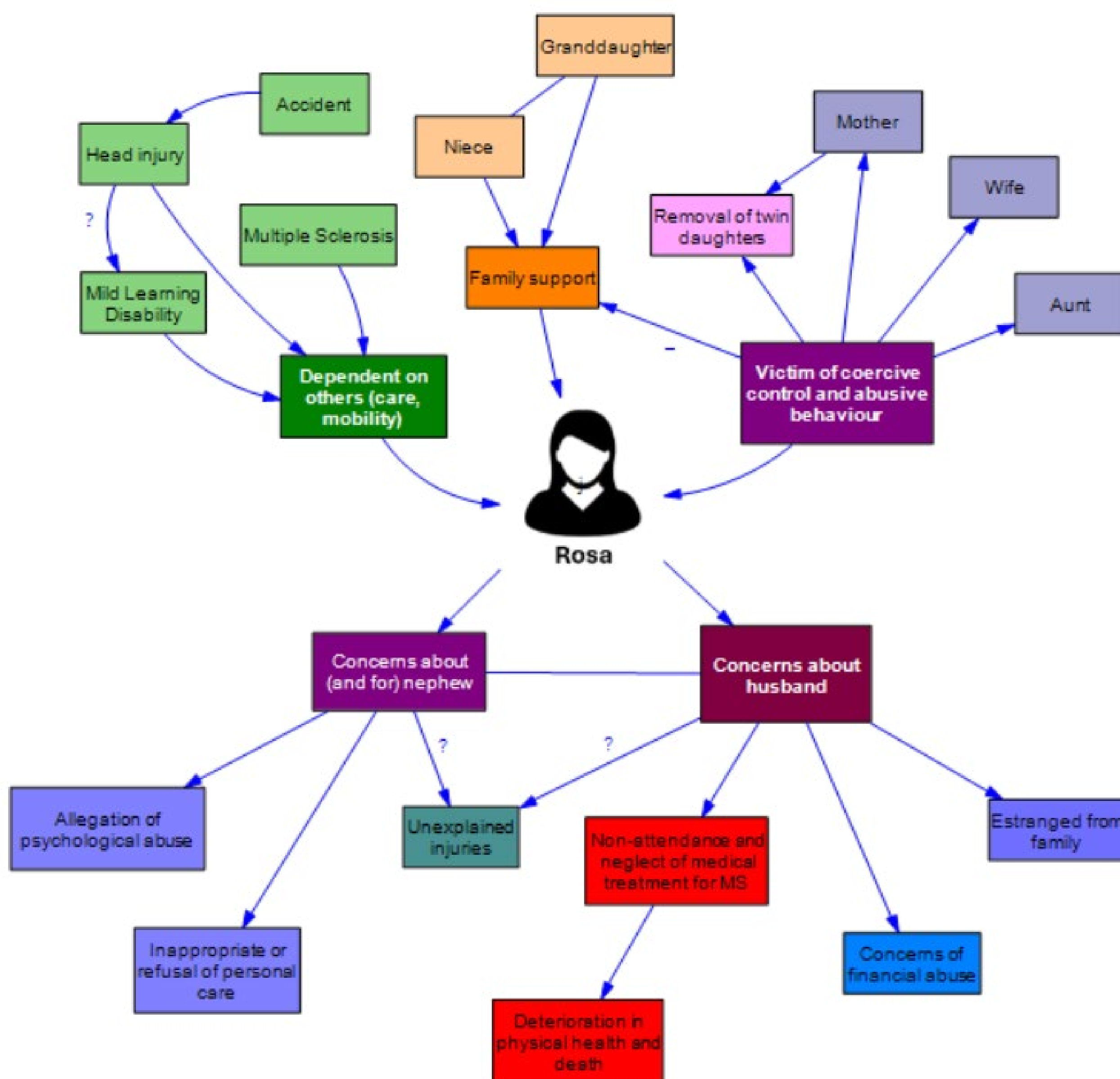
Key Lines of Enquiry (KLOE)

During the first Safeguarding Adults Review process, Key Lines of Enquiry (KLOE) were identified and used to frame initial organisational responses and evidence gathering. Seven Key Lines of Enquiry were identified covering a range of areas including Rosa's needs for support with communication, understanding information, and decision-making. Other areas included Brian's role as Rosa's carer, equipment, aids and adaptations to their property, and the intersections of domestic abuse and disability. The Key Lines of Enquiry considered the possible impact of the removal of Rosa's children, good practice, and any learning and changes already made.

Thematic analysis

The information and evidence gathered during the first part of the review was analysed to identify for themes and learning areas, relevant to the safeguarding system in Cumbria. Figure 2 provides a representation of Rosa's vulnerabilities and context.

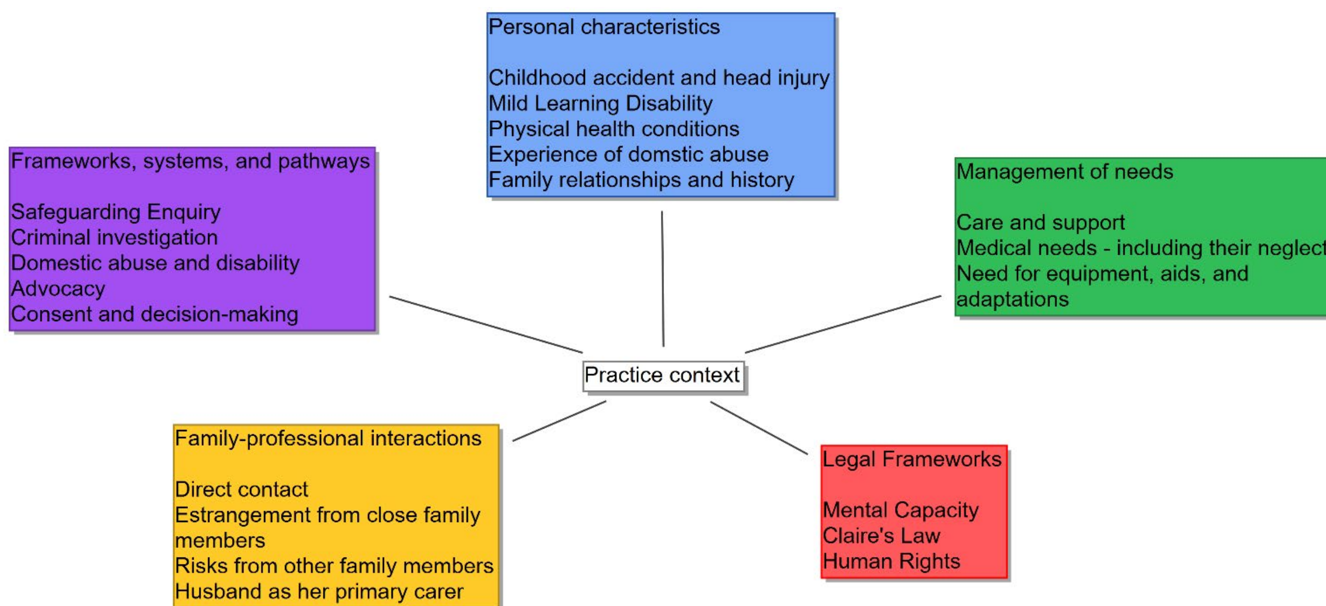
Figure 2: Vulnerabilities and context in the case for Rosa.



This visual representation highlights the connection between vulnerability and experiences of risk. Rosa had underlying health conditions that contributed to her dependence on others. Patterns of coercive control and abusive behaviours on the part of her husband and nephew exploited her vulnerabilities. Her experience of abuse was compounded by the estrangement of her family and the control of her access to alternative support systems.

Systems themes identified through Rosa's experiences were grouped using the SCIE typology for Safeguarding Adults Reviews, which provides a structured lens for systems findings. Figure 3 demonstrates the multi-dimensional nature of Rosa's experiences and the safeguarding system's response.

Figure 3: Practice context and learning areas in the case of Rosa



Safeguarding Adults Review (SAR) questions

The Safeguarding Adults Review (SAR) questions were intended to guide the next stages of the review, including practitioner engagement and analysis. The questions were framed to support a systems approach to learning, in line with statutory guidance, to promote reflection without blame.

The SAR questions

1. **Personal characteristics –** How can safeguarding systems respond to and reduce risks linked to individuals’ vulnerabilities and dependencies, as seen in Rosa’s case?
2. **Frameworks, systems, and pathways –** What can we learn from Rosa’s experience about how safeguarding and domestic abuse pathways and systems respond to individuals with care and support needs who are at risk of domestic abuse?
3. **Management of needs –** What are the enablers and barriers to systems effectively assessing and responding to individuals care and support needs, including access to medical treatment, social care support, and appropriate equipment, aids, and adaptations?
4. **Family-professional interactions –** What can we learn from Rosa’s case about how safeguarding systems navigate complex family dynamics, including barriers to direct contact, informal caregiving roles, and the impact of estrangement?
5. **Legal Frameworks –** What helps or hinders effective use of legal frameworks around mental capacity, safeguarding, domestic abuse, and human rights, for individuals with complex needs who are at risk of abuse and neglect?

Methodology

The methodology section describes how the review addressed the SAR questions – what further information was needed and how it was gathered. The Safeguarding Adults Review methodology was based on the following assumptions:

- **Assumptions about the case:** It was assumed that Rosa’s experiences were a fair representation of practice in Cumbria.
- **“Safeguarding Adults Reviews are not a reinvestigation of incidents or performance”:** That the purpose of the Safeguarding Adults Review (SAR) was “not to hold any organisation or individual to account” (DHSC, 2025).
- **Reliability of documentary evidence:** It was assumed that the evidence provided to the review was provided as an honest and accurate account of events.
- **Practitioner’s views and opinions:** The views and opinions of practitioners were taken as heard, and reflected professional’s subjective opinions and recollections.
- **‘People come to work to do a good job’:** It was assumed that practitioners who work with people with care and support needs are committed, compassionate, and that they ‘come to work to do a good job’; any practice failings are therefore likely to be a result of systemic issues or influences.

- **Anti-oppressive practice:** An individual's protected characteristics and experience of discrimination or oppression can reveal insights into the wider context of social, economic, and political structures.
- **Systems-focused learning:** It was assumed that practice was influenced primarily by the system in which professionals worked. Safeguarding Adults Reviews therefore adopt a systems focus to generate findings from individual experiences that are more generally applicable.

Gathering evidence

For this Safeguarding Adults Review the author used qualitative research methods, including qualitative data analysis (QDA) software, to learn lessons from Rosa's experiences that are evidence-based and to reduce hindsight and outcome bias.

The Review built on the evidence collected by the first SAR author. The time frame considered was from August 2021 until the date of her death. This period was selected to capture the period from which it was known that Rosa was not being brought (or was denied) medical input and remained untreated prior to her admission to hospital in June 2023. Agencies were asked to include in their submissions any other relevant information prior to the review period for consideration.

A practitioner learning event was held to listen to the expertise and experiences of professionals who worked within the system. Professionals engaged in an open and reflective manner, providing valuable insights into how Cumbrian system worked. In line with statutory guidance, the learning event attempted to involve professionals fully to "contribute their perspectives without fear of being blamed for actions they took in good faith" (DHSC, 2025). In addition to the learning event an anonymous practitioner survey was administered. Survey questions were adapted from those proposed following engagement with family members, whose input has been greatly appreciated.

A multi-agency SAR panel was also established by the Safeguarding Adults Board to provide oversight and governance of the Safeguarding Adult Review.

Cross-cutting themes

The analysis of evidence, practitioner reflections, and Rosa's lived experience highlighted a number of crosscutting themes. These themes reflect system-level influences that shaped how agencies understood risk, engaged with Rosa, and responded to the complexity of her circumstances. They are presented here as the context for the findings that follow.

Intersectionality and Compounded Vulnerability

Rosa's experiences demonstrate how disability, chronic health conditions, gender, and social isolation increased Rosa's vulnerability and limited her access to support. Disabled adults experience significantly higher rates of domestic abuse than non-disabled adults, and disabled women are particularly at risk.

In Rosa's case, her mobility needs, learning disability, and estrangement from family created conditions in which coercive control could operate unchecked. This pattern reflects wider evidence that perpetrators may exploit disability to exert control, restrict access to services, or engineer social isolation. These factors acted as a structural amplifier of risk and influenced the system's ability to recognise and respond to abuse.

Fragmentation Between Safeguarding and Domestic Abuse Systems

Practitioners described uncertainty and inconsistency in how safeguarding and domestic abuse pathways align in cases involving adults with care and support needs. Challenges included delays in naming domestic abuse explicitly, navigating parallel procedures, and coordinating safeguarding enquiries with domestic abuse mechanisms such as the Multi-Agency Risk Assessment Conference (MARAC). These issues reflect broader systemlevel factors: differing statutory definitions, separate governance arrangements, and variations in culture and practice.

As a result, Rosa did not consistently experience an integrated, dual system response, and risk management was not always co-ordinated across safeguarding and domestic abuse frameworks.

Barriers to Accessing Lived Experience

A recurring theme was the difficulty in gaining direct access and engagement with Rosa to understand her wishes, lived experience, and perspectives on her care and support. Professionals depended on family members, in particular Brian, which created a filtered and at times inaccurate picture of Rosa's needs and circumstances.

Blocked access, cancelled visits, and limited opportunities for private conversations reduced the ability to explore risk, confirm consent, and form the relationships necessary for safe and person centred practice.

System Pressures, Rigidity, and Fragmented Pathways

Agencies reported operating within a context of rising demand, reduced capacity, and organisational pressures. Evidence provided to the review described how these pressures can undermine the timeliness of assessments, quality of referrals, the effectiveness of reflective supervision, and general coordination across health and social care. When stretched, systems tend to revert to rigid processes, tighter eligibility criteria, and increased reliance on informal carers.

While this may be manageable when carers are supportive and able, in Rosa's case it compounded risk and contributed to gaps in oversight. These pressures made it more difficult for practitioners to escalate concerns, maintain personcentred approaches, or sustain proactive safeguarding responses.

Complexity of Family Dynamics, Coercive Control, and Disguised Compliance

Rosa's experiences reflected relational dynamics that were difficult for professionals to navigate, including coercive control, disguised compliance, and the emotional impact of blocked access. Rosa's case demonstrates how coercive control, disguised compliance, and complex family dynamics can significantly obscure risk. Apparent cooperation masked patterns of coercion and control and compromised Rosa's autonomy, while Todd's role in providing informal care further complicated the picture.

Practitioners highlighted challenges in maintaining curiosity and challenge within these dynamics. Emotional and relational barriers, uncertainty about the proportionality of interventions, and concerns about damaging fragile engagement all influenced how professionals responded. These findings reinforce the need for shared, multiagency ownership of risk and structured support for practitioners.

Challenges in Applying Legal Frameworks in Complex Circumstances

Rosa’s case illustrates the practical and ethical challenges of applying statutory frameworks, particularly those concerning mental capacity, safeguarding, domestic abuse, and human rights. The limitations of certain legal provisions contributed to a gap between safeguarding concerns and criminal justice outcomes, reflecting wider national debate about the ability of safeguarding legislation in its current form to tackle the perpetrators of abuse or neglect.

Lessons learned and Findings

Findings are conclusions and insights drawn from the learning from an individual’s experiences. Safeguarding Adults Reviews aim to produce findings that are of practical value and that enable “lessons to be learned from the case and those lessons applied to future cases to prevent similar harm occurring again” (DHSC, 2025). The findings in this report are structured against the Safeguarding Adults Review Questions.

SAR Question 1: Personal characteristics

How can safeguarding systems respond to and reduce risks linked to individuals’ vulnerabilities and dependencies, as seen in Rosa’s case?

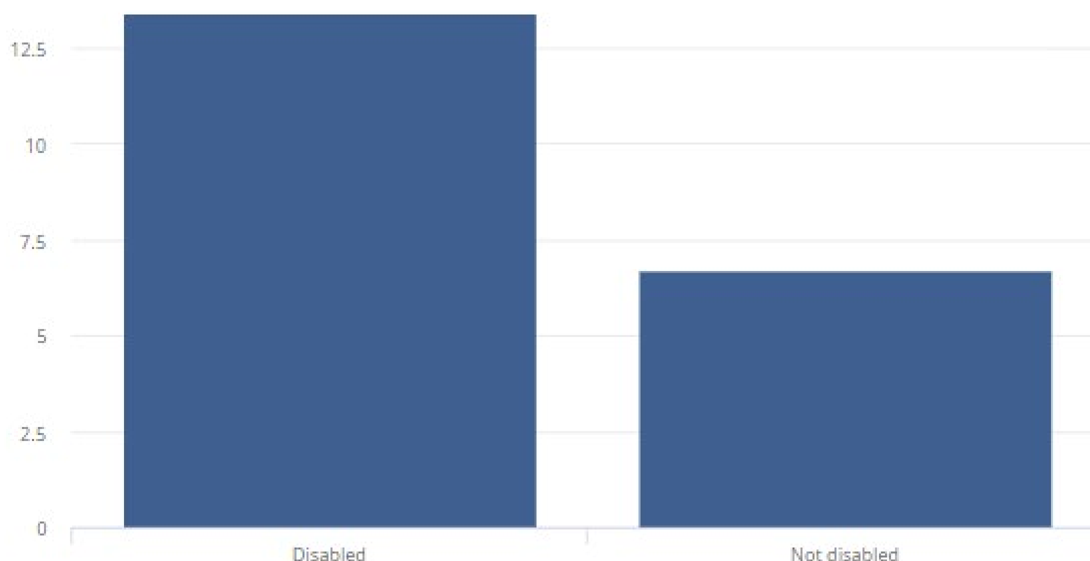
Background – learning from evidence

This question considers the context of Rosa’s personal characteristics and how services responded to her individual needs and circumstances. Of particular interest for safeguarding systems is the intersectionality of gender, disability, and domestic abuse. Domestic abuse is well-known to disproportionately affect women and represents a gendered crime. For the year ending March 2025 the Crime Survey for England and Wales estimated prevalence rates of 9.1% for women and 6.5% for men, equating to 2.2 million women and 1.5 million men.

The intersection of gender, domestic abuse, and disability

Estimates from the Crime Survey for England and Wales showed that 13% of people aged 16 years and over with a disability were victims of domestic abuse for the year ending 2025; significantly higher than for people without a disability, 6.7% (ONS, 2025). In the preceding year in Cumbria, 21,500 adults experienced domestic abuse and of those an estimated 5,000 (23%) were disabled. Based upon those proportions, disabled women would have made up approximately 3,400, or 16%, of victims of domestic abuse in Cumbria (Community Safety Partnership, 2025). Yet, historically, studies suggest that domestic violence practitioners and organisations have identified difficulties in meeting the needs of disabled adults, and that there has been a lack of awareness of domestic abuse in many disability organisations (Hague et al., 2011). The rate of domestic abuse within the population of disabled people in the UK is significantly higher than for non-disabled people.

Figure 4: Proportion of disabled and non-disabled people who were victims of domestic abuse[2]



The intersection of disability and gender compounds this vulnerability considerably. Systemic barriers and fragmentation of services can increase the challenges faced by disabled women who are at risk of domestic abuse. A more recent scoping review recognised that disabled women experienced the same barriers to living with escaping from and seeking support to deal with domestic abuse, with additional challenges related to experience of disability. These included perpetrators exploiting an individual’s disability, and wider social attitudes, norms, and notions of disability-related vulnerability, all leading to a greater risk of abuse and further alienation (Walter et al., 2024). This discourse is repeated in the domestic abuse statutory guidance which includes a section on the intersection of domestic abuse and disability (Home Office, 2022). The guidance provides an example related specifically to Learning Disability, where a “state of social isolation does not arise out of nowhere” and is rather “engineered by the domestic violence perpetrator… to increase his control over her” (ibid.).

Learning from Rosa’s experience

Examples of Rosa’s experience of domestic abuse are well documented in the DARDR.
The impact of her disability and health conditions placed her at increased risk. In the context barriers to service provision and the failure to address both domestic abuse and disability needs meant that she was at risk of losing out on both counts, a risk that resonates with wider evidence (Hague et al., 2011). Financial abuse was widely reported across research studies, often taking the form of exploitation of disability support income payments and housing, using the money for other expenditures including alcohol, and partners claiming carers’ allowance maintaining a low-level but consistent control of disabled women’s lives which could be hard to recognise (McCulloch et al., 2018). Perpetrators may also use neglect as a form of coercion and control, denying access to care, support for daily living, adaptations and equipment, and access to medicines or medical care and treatment. Rosa’s own experience of being left in her wheelchair for extended periods of time, and being provided or denied inappropriate intimate care, would fall into this category.

[2] Source: (ONS, 2025)

Table 1: reflections of practitioners on their experiences

Reflection on barriers	Reflections on what is needed
Lack of knowledge across sectors	Cross-education on intersectionality Training on gender, disability, and domestic abuse
Practitioner values and attributes	Empowerment and being person-centred Perseverance and persistence Patience: "it takes time to enable a person to disclose fears / abuse" Empathy, personal warmth Creativity
Multi-agency working	Communicating together Systems for information sharing Joint working, shared actions and outcomes Role and accountability
Frameworks	Safeguarding policy and procedure Training on intersectionality
System cultures	Cultures of curiosity Addressing unconscious bias "Safeguard the safeguarders"

While safeguarding systems were engaged to guide responses to Rosa's experiences of abuse and neglect these systems were unable to effectively protect Rosa from harm. Individual systems challenges and barriers can be seen in the context of wider societal issues: in relation to the social model of disability, gender, and domestic abuse. There is a critical need to respond to the lived experiences of disabled women and the prevalence of violence against individuals who need specialist support for needs arising from domestic abuse and disability. This includes accessible refuges, better joint-working across safeguarding and domestic abuse services, and improved expertise, training, and development.

Finding 1: Gender, disability, and domestic abuse

Learning

Disabled people face significantly higher rates of domestic abuse than non-disabled people, and the intersection with gender compounds this vulnerability considerably. Disabled women are among the most at-risk group for experiencing domestic abuse in the UK, yet the specialisation of disability and domestic abuse services can mean neither is well-placed to address the needs of the other.

Intended impact

Improved expertise across systems needs to improve:

- Awareness of domestic abuse in services and systems designed to support and advocate for disabled adults.
- Awareness of disability within services and systems designed to address domestic abuse.
- Awareness across all services and systems of the intersectionality of gender, disability, and domestic abuse.

Recommendation

1. Reducing barriers to access for disabled people: domestic abuse providers should review the accessibility of domestic abuse services in the context of disability and other protected characteristics and report their findings to Cumbria Safeguarding Adults Board and Cumberland Community Safety Partnership.
2. Training and development: For the Safeguarding Adults Board and Community Safety Partnership to lead on cross-delivery of Safeguarding and Domestic Abuse Training programmes to address expertise shortfall.
3. Bringing people together: A combined safeguarding and domestic abuse conference or event to bring practitioners together to enhance partnership working.

SAR Question 2: Frameworks, systems, and pathways

What can we learn from Rosa's experience about how safeguarding and domestic abuse pathways and systems respond to individuals with care and support needs who are at risk of domestic abuse?

Background – learning from evidence

Frameworks for safeguarding and domestic abuse should be seen as complementary but are often overlapping, or mutually exclusive. Historically, safeguarding systems – those designed to respond to the abuse and neglect of adults with care and support needs, developed and evolved into separate systems to those designed to support victims of domestic abuse who may or may not have care and support needs. The Care Act 2014, and the Domestic Abuse Act 2021 both place safeguarding adults and domestic abuse on a statutory footing but with separate strategic arrangements and governance mechanisms. Locally, arrangements and partnerships for safeguarding and domestic abuse are provided through Cumbria Safeguarding Adults Board[3] and Cumberland Community Safety Partnership[4] under Safer Cumbria. This SAR Question considers to what extent safeguarding and domestic abuse systems join up to support and protect individuals with care and support needs who experience domestic abuse.

Defining domestic abuse

The statutory definition of domestic abuse is set out in section 1 Domestic Abuse Act 2021:

S.1 Definition of "domestic abuse"

(2) 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.

(3) 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.

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3 Safeguarding Adults Boards are established under s.43 Care Act 2014 with the objective of coordinating and ensuring the effectiveness of local safeguarding arrangements.

4 Domestic Abuse Local Partnership Boards are established under s.58 Domestic Abuse Act 2021. According to the organisational structure the Cumberland Community Safety Partnership sits alongside the Safeguarding Adults Board.

Already, there are inconsistencies within statutory guidance. Domestic abuse, and (separately) domestic violence are referred to in the statutory guidance to the Care Act 2014, the Care and Support Guidance (DHSC, 2025) however the definitions and dual use of terms abuse and violence are outdated and demonstrate how these systems remain separate. It is noted that the guidance is being updated[5] to reflect other changes in statute, and while differences are mostly in the context of language and style rather than substance, updating the Care and Support Guidance may bring greater clarity and consistency.

In addition to separate legal frameworks and statutory guidance, responses to safeguarding and domestic abuse are governed by different operational procedures. Safeguarding enquiries are administered by the Local Authority, who hold responsibility for decision-making, and who can make, or cause others to make enquiries into the abuse or neglect of an adult with care and support needs in their area. Domestic abuse procedures form a part of community safety, represent crimes, and are often police-led with Independent Domestic Violence Advocacy. High risk domestic abuse cases may also be subject to a Multi-Agency Risk Assessment Conference (MARAC). Each approach is essentially multi-agency in nature and are victim-centred and risk-focused.

Governance and cooperation

The Domestic Abuse Strategy 2025 – 2030 suggests that approximately 23% of victims of domestic abuse in Cumbria were disabled. While disability does not necessarily indicate care and support needs, the risk-first approach to safeguarding would suggest that this is an issue of some prevalence. Despite this, there is limited evidence of a strategic, joined-up approach to supporting and safeguarding disabled victims of domestic abuse, despite the calls for greater attention to disability in the Domestic Abuse Statutory Guidance (Home Office, 2022). Statutory guidance is clear that both safeguarding and domestic abuse procedures should be used when a victim of domestic abuse had care and support needs – or when an individual with care and support needs is a victim of domestic abuse (Home Office, 2022).

Learning from Rosa's experience

Did Rosa benefit from a joined-up approach of safeguarding and domestic abuse procedures?

Evidence from practitioners and Rosa's experience is that domestic abuse can often be missed, or mis framed, for example experiences of neglect or harm within familial caring relationships may be labelled as "carer stress", "relationship conflict", or "challenging behaviour". Where services users may have mental impairments (engaging mental capacity concerns) or where there are issues of engagement, professionals may appear to follow service users' experiences, becoming dependent on family carers for access and for information about the health and wellbeing of the service user or patient. Incisive comments from professionals on safeguarding and domestic abuse frameworks highlight the "importance of naming domestic abuse early and explicitly, even when it sits alongside care needs". Rosa's experience echoed known issues in the response to coercion and control of disabled women, that perpetrator-carers were able to pilot their care, that professionals struggled with applying mental capacity legislation (and conflated consent with autonomy, freedom of choice, and self-determination), and that protective actions failed to take into account the individual's experience of care and support, communication abilities, and disability.

[5] The last update was in July 2025 however did not include domestic abuse.

Reflections on safeguarding and domestic abuse systems recognised that strong responses are achieved through multi-agency processes, creativity, and a dual system approach. In the case of Rosa this would have involved the use of safeguarding procedures alongside domestic abuse procedures, such as the MARAC. For professionals to be able to take strong action in cases of safeguarding and domestic abuse, these processes must be joined up and interconnected. This means that specialists in safeguarding and domestic abuse should work together (both strategically and operationally) to create bespoke support and intervention plans that can hold the complexity of intra-familial power dynamics, disability, care and support needs, mental capacity and mental impairment, and the impact of coercion and control by an individual's intimate partner, carer, or family member.

Finding 2: The connectedness of safeguarding and domestic abuse systems

Learning

Evidence and guidance suggests that safeguarding and domestic abuse systems should work together and be complementary in their impact, yet there remain inconsistencies from statutory guidance, to policy, and local implementation. There is a need for guidance to offer consistency in defining and responding to domestic abuse, and for local strategies and operating procedures to create a consistent framework for practice in Cumbria. The DARDR and the SAR provide an opportunity for strategic partners to coordinate their response to recommendations.

Intended impact

This finding is intended to advocate for closer connectedness between safeguarding and domestic abuse systems – from national statutory guidance to local policy and local practice.

Recommendation

1. **Care and Support Guidance:** re-draft the paragraphs in the Guidance on definitions of abuse, neglect, and self-neglect to address domestic abuse, vulnerability factors, exploitation, and trauma. The Safeguarding Adults Board should escalate this recommendation via national safeguarding networks in line with the SAR Escalation Protocol 2026.

2. **Cumbria Safeguarding Adults Board and the Cumberland Community Safety Partnership** should coordinate their strategic responses to the Safeguarding Adults Review and Domestic Abuse Related Death Review to ensure that safeguarding and domestic abuse procedures are complementary.

3. **Policy and practice:** Where an individual with care and support needs experiences domestic abuse, both safeguarding and domestic abuse systems should be used to guide responses engaging professional expertise from both systems together for the adult at risk.

SAR Question 3: Management of needs

What are the enablers and barriers to systems effectively assessing and responding to individuals care and support needs, including access to medical treatment, social care support, and appropriate equipment, aids, and adaptations?

This section focuses on two interconnected system issues: first, how consent, access and understanding of lived experience shaped the response to Rosa's needs; and second, how system pressures and organisational rigidity affected practitioners' ability to deliver foundational assessment and care-management practice.

Background – learning from evidence

This question addresses the challenges in responding to an individual's health and social care needs within the context of multiple health conditions, vulnerabilities, and family systems and relationships. Many parts of the health and social care system are governed by legal and policy frameworks which address areas such as needs assessments, mental capacity, and safeguarding. These legal frameworks are considered in SAR question 5.

Health and social care – a multi-agency system

It is generally accepted that complex systems may be thought of as a collection of interrelated and connected parts working together for a shared goal or common function. The health and social care system is a complex system, made up (primarily) of a partnership between the NHS and Local Authorities representing hundreds of organisations at central, national, regional, and local levels (NHSE, 2024). The interrelatedness of the different parts of the system means that the actions of one organisation or professional will have an (often reciprocal) impact on other organisations and professionals – even without direct communication between them.

For systems to be at their most effective the different parts of the system should work well together, should be aware of their shared goal, and there should be a degree of coordination, either active or passive. In this case the shared goal would be the provision of medical, health, and social care interventions to meet Rosa's needs, arising from her health conditions and social circumstances. Reflections of professionals involved in the review note that enablers to effectively meeting individual needs include "positive working relationships with a clear understanding of each other's roles and the interconnectivity. Pragmatic proportionate approaches and teamwork to overcome potential barriers of resource capacity and service pressures, access challenges, jargon, and silo working" referencing active coordination between professionals or organisations, while others focused on the development of strong, interconnected pathways – representing passive coordination through agreements about role and responsibility.

Care needs assessment

NHS healthcare is delivered free at the point of delivery through a centralised system devolved to local Integrated Care Systems. Rosa's health services, coordinated through her GP practice, included general and specialist provision focused on particular needs and health conditions. Where Rosa's health impairments gave rise to social care needs these are provided under the Care Act 2014 which governs assessment of need and provision of services. Equipment and home adaptations are available privately or with support from Local Authority Occupational Therapy services. In this way Local Authorities and NHS Trusts should work together to ensure a joined up and complementary approach to addressing the health or social care needs arising from an individual's health conditions or disabilities.

Learning from Rosa’s experience

Rosa’s experience reveals a myriad of barriers that compromised the smooth running of the multi-agency health and social care system, preventing organisations from working together to assess and respond to Rosa’s needs that arose from her health conditions, personal circumstances, and experience of disability and domestic abuse. These barriers relate to personal interactions and consent, organisational pressures and subsequent rigidity, the impact of prolonged neglect and poor care, and a failure of services to fully understand and appreciate Rosa’s lived experience.

Consent, refusal, and barricading of care

Assessing and meeting health and social care needs necessarily follows a relational interaction between services users, family members, and professionals. Behind even the simplest treatment or intervention there is a process of transaction: the offer and the acceptance or refusal of a health or social care act based upon negotiation, dialogue, and consent. Consent supports assessment and care planning – the interface between the individual and the complex multi-agency system, determining what care and treatment will take place, how, and by whom. In the delivery of health care, support, and treatment, consent is fundamental; professionals rely on the agreement or acceptance of the individual to provide care, treatment, and support. Except under exceptional circumstances professionals are unable to act without it[6]. Informed consent relies on:

- The provision of sufficient information.
- Mental capacity to make the specific decision.
- Freedom from influence – i.e., consent must be freely given.

From the age of 16 years old[7], it is assumed that a person has mental capacity (s.1 MCA 2005) to make decisions; with sufficient information and free from undue influence it is assumed that a person will be able to agree to care or treatment themselves and no one else can consent on their behalf. Consent is linked to, but not the same as choice where consent is about agreeing where choice implies more of a proactive decision and exercise of autonomy and self-determination. While this distinction maybe appear to be a case of ‘counting angels on the head of a pin’, the practice of accepting Brian’s consent or refusal of care and treatment on Rosa’s behalf without independently confirming her wishes further undermined her autonomy.

In Rosa’s case, family members frequently communicated with services on her behalf, including giving or declining consent for interventions. Their interpretations became substitutes for Rosa’s own views, despite evidence of coercion, control, and restricted autonomy. This created an inaccurate picture of what Rosa understood, wanted, or experienced. The cumulative effect was a narrowing of the system’s visibility: Rosa’s voice, choices, risks, and daytoday experience were filtered through individuals who may have been causing her harm. Rosa’s experiences and the impact on her of Brian’s role in her care, support, and treatment decisions is at the centre of this review. As a result of the care provided within her family Rosa had reduced activity, long periods sitting in her wheelchair, lack of, or inappropriate, personal care, and barricading of input from professionals. Rosa’s mobility and general physical wellbeing deteriorated.

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[6] Except in emergency life and death situations, or following specific legal procedures, for example best interests’ determinations under Mental Capacity Act 2005, or where an individual is detained under a qualifying section of the Mental Health Act 1983.

[7] Or younger if a child is assessed as Gillick competent (“Gillick v West Norfolk and Wisbech Area Health Authority [1986] AC 112,”)

Rosa became increasingly dependent on Brian and Todd, and isolated from other informal supports, her family, and the professional network. A greater emphasis on consent, on confirming Rosa's views and opinions could have given a clearer picture of her lived experiences and her needs in context, informing care and support plans and treatment options and focusing not only on what was recommended, but what would be realistic in practice. Information from family should be taken into account but not relied upon as an alternative or proxy for the individual's own story. These patterns prevented practitioners from forming a coherent understanding of Rosa's lived experiences.

Finding 3a: Lived experience, planning, and consent

Learning

Rosa's experience demonstrates how safeguarding and care-management systems become ineffective when practitioners cannot reliably access individuals to understand their needs, verify consent, or explore a person's lived experience directly. Reliance on Brian's information about her needs, wishes, and consent / refusal of care created a distorted picture of her circumstances. This undermined person-centred assessment, masked risk, and prevented timely intervention.

Intended impact

To ensure that person-centred approaches, direct confirmation of lived experience and consent remain at the centre of health and social care practice. Strengthening direct professional engagement and improving the quality of consentrelated practice is essential for safeguarding systems to recognise, interpret, and act on risk.

Recommendation

1. **Strengthen direct contact:** Organisations should ensure all assessments involve direct, private contact with individuals[8], and that professionals challenge or escalate barriers to access.
2. **Consent:** Agencies should reinforce practice around obtaining and verifying informed consent, including assessing for undue influence, distinguishing consent from compliance, and avoiding reliance on family members as proxy decisionmakers.
3. **Lived-experience focused planning:** Practitioners should use tools, supervision, and reflective practice to ensure care planning is grounded in the adult's own views, experiences, and needs rather than assumptions or thirdparty accounts.

[8] 'Direct' contact means contact with the individual, rather than 'indirect' contact via a family member.

Capacity, resources and rigidity

The learning about the management of Rosa’s needs is not about dramatic whole-system change, but about making use of, and supporting the existing expertise and commitment of professionals working across health and social care. It is about doing the basics, working together, and escalating appropriately when professionals are being blocked from understanding an individual’s lived experience. Enablers of good foundational practice may include:

- Person-centred practice.
- Organisational and team support around sound assessment and treatment practice.
- Supervision: individual, reflective, peer, and safeguarding.
- Increased knowledge and emphasis on consent and personal autonomy.
- Systematic analysis of Rosa’s lived experience and implications for meeting needs.
- Escalation to multi-disciplinary processes, panels, and safeguarding.

Many organisations and professionals increasingly face significant external pressures, austerity, reduced capacity, and scarce resources. When services become overstretched there is risk that in order to manage demand, policies and procedures can become rigid and eligibility criteria rigorously applied. There may be an unconscious shift from a person-centred approach to a reliance on the individual and their informal support networks to manage needs and risks. Where informal supportive networks are robust, capable, and benevolent (as in many cases) a reliance on informal carers can become commonplace and unspoken business as usual.

This argument was well-summed up in the evidence presented to the review, recognising that is such circumstances: “systems are often hindered by passive referrals, unclear ownership of risk, fragmented pathways between health and social care, and capacity constraints that slow down assessments or equipment provision” (survey response). Taken together, these barriers demonstrate how foundational assessment, consent, coordination, and escalation processes are compromised when practitioners cannot reliably access or understand the lived experience of the adult.

Finding 3b: System pressures and the foundations of practice

Learning

Organisations experience resource pressures, organisational rigidity, and fragmented pathways, increasing the tendency to rely on informal carers which risks undermining effective multi-agency practice. When services are stretched, eligibility thresholds tighten, coordination becomes inconsistent, and practitioners struggle to escalate concerns or maintain personcentred approaches. These pressures contributed to fragmented responses, delays in assessment, unclear ownership of risk, and missed opportunities to intervene when Rosa’s condition deteriorated.

Intended impact

To strengthen the capacity of health and social care systems to deliver consistent, high-quality foundational practice even when facing complexity, coercion, or external pressures.

This includes improving system coordination, maintaining flexible responses, and ensuring risks are shared rather than left with individual practitioners.

Recommendation

1. **Sound foundations in practice:** Organisations should reinforce training, supervision, and team support around person centred assessment, care planning, consent, and holistic evaluation of need.
2. **Improve system connectivity:** Health and social care services should clarify pathways, roles, and responsibilities to reduce fragmentation and strengthen active and passive coordination[9].
3. **Timely escalation:** Agencies should maintain clear, multiagency escalation procedures for situations where access is blocked, concerns intensify, or needs are not being met despite repeated professional involvement.
4. **Address system rigidity:** Organisations should review how resource pressures and demand management may unintentionally restrict proactive safeguarding responses, and identify opportunities for more flexible, needsled practice.

SAR Question 4: Family-professional interactions

What can we learn from Rosa's case about how safeguarding systems navigate complex family dynamics, including barriers to direct contact, informal caregiving roles, and the impact of estrangement?

Background – learning from evidence

Abuse and neglect often occur in relationships of dependence and unequal power relations. When these relationships involve intimate partners or family members assessment and intervention can be challenging, requiring an in-depth understanding of both the individual's needs and the networks and environment in which they're needs will be met.

Gathering a sufficient understanding of an individual's experiences, especially in the context of family carers and interdependent relationships can be a challenge in itself. Adults at risk, or in controlling or coercive relationships may be cautious about talking about their experiences, or reluctant to undermine or talk negatively about their partner-carer, especially if they are also worried about who would look after them if their relationship ended.

One of the terms that has gained prevalence (or notoriety) in Safeguarding Reviews across child and adult safeguarding is that of professional curiosity. Professional curiosity is defined as "the capacity and communication skill to explore and understand what is happening within a family rather than making assumptions or accepting things at face value" (CSAB et al., 2022). Professional curiosity is recognised by many professionals as a key skill, but also one that can be very hard to attain (Phillips et al., 2024). For professionals there are numerous challenges to being professional curious. These include accumulating risk, confirmation bias, the rule of optimism reinforced by values of positive regard and trust, disguised compliance, judgements

[9] This is about 'passive' referrals where (usually written) information or referrals are sent and then closed without follow up to check if the information has been received and acted upon. Clear pathways and agreements may indicate when such an approach is appropriate or not.

about “knowing but not knowing”, uncertainty (versus risk[10]), and managing tension[11]. Professional curiosity – being able to ask increasingly probing questions to go beyond face value responses – also requires a high degree of rapport and a relationship of trust. Trust, or mistrust in professionals or people in a position of authority can be influenced by a variety of factors, not least previous experiences, history, personal and cultural characteristics which may be shaped by private and public perceptions. Judgements on failures of professional curiosity may also place blame or responsibility on service users who have failed to be open and honest about their personal experiences within a family setting or personal relationship. One of the criticisms of professional curiosity terminology is that it can work against professionals and service users, rather than highlighting underlying systemic barriers to developing trust and rapport.

In this context professionals needed more than curiosity to address disguised compliance and the isolation of Rosa from her family and professionals seeking to support her. There is a need to recognise the underlying barriers. Research identifies three types of barriers: structural, relational, and emotional. These barriers reflect practice realities for professionals, including time and resources, the relational context in which practice takes place, and recognises the emotional burden and work undertaken by professionals. There may also be external or hidden challenges that reflect services users’ personal characteristics, previous experiences, vulnerabilities and stressors. An example of this may be in Rosa’s muted response to uniformed police who attempted to share information about Brian under the Domestic Violence Disclosure Scheme (Clare’s Law).

Table 2: Examples of barriers to professional curiosity

Structural barriers	• Lack of time: to get to know service users to know what questions to ask, to interpret the answers, and time to act. • Time to develop the knowledge and skills to be professionally curious. • Isolation: a lack of inter-agency working and poor communication or information sharing. • Cultural barriers: cultural knowledge and experiences, see model of Social GRRRAAACCEEESSS (Burnham, 2018).
Relational barriers	• Professional curiosity relies on good relationships with services users, especially as professional curiosity itself risks damaging relationships. • Reciprocal and mutual trust: where professional curiosity can break trust, an unwillingness to break trust on the part of the professional is a barrier.
Emotional barriers	• The emotional difficulty of being professionally curious: professional curiosity requires a high level of emotional awareness. • “The performance of emotional labour and critically reflective practice in the context of insufficient time, high workloads, difficulties in training, and issues around information sharing”. • Cognitive dissonance – supressing true emotions and reactions to the possibility or suspicion of abuse and neglect while using ‘surface acting’ to maintain rapport, trust, and relationship with people alleged to have caused or be causing harm.

Source: (Phillips et al., 2024)

[10] It is generally accepted that risk is a probability-based concept and therefore can be ‘quantified’ to an extent, where uncertainty represents what is unknowable and is therefore entirely unmanageable.

[11] Taken multiple sources and subject of a joint learning session: (CSAB et al., 2023)

Once professionals have gathered information and formed a view of the circumstances and lived experience of services users they then move to considering how to respond and what action to take. From a rights-based perspective, intervening in an individual's relationships may engage or even breach the right to privacy and family life (Article 8, HRA 1998) even if in the interests of safety and risk. While the right to life (Article 2 HRA 1998) would take primacy[12] over the qualified right to privacy the balance of risk and proportionality is not always clear what level of intervention is proportionate. Professionals are called upon to balance rights and risks and in order to do so should seek to understand, in depth, the experiences of the individual deemed to be at risk. This involves assessment and gathering information about a person's circumstances, decisions, and risk, and if actions are taken, being able to articulate clear and cogent reasons for interfering in an individual's personal relationships. This is where working together becomes such a vital part of practice. Whether during information gathering stages or deciding on what actions to take, professionals need not work in isolation and may draw on others' knowledge, experiences, and expertise. This could be internally through reflective supervision and managerial support, in a multi-agency setting, or by bringing in other agencies, such as advocacy.

Learning from Rosa's experience

A sign that there were barriers to developing trust and rapport with Rosa could be seen through her relationships – with other family members, and with professionals. Rosa had become estranged from her close and extended family, increasing her vulnerability and isolation. This is not an uncommon experience in cases of coercion and control, Brian also influenced Rosa's decisions about care and support and her relationships with professionals. A feature of Rosa's case was the appearance of concordance and engaging with professionals demonstrated by Brian, and Todd to reduce or deter the involvement of professionals. Throughout the chronology there are examples of 'disguised compliance'. This is present in responses regarding rent arrears, money advisors, medical appointments, OT visits (and interventions), physiotherapy, and with Rosa's MS nurse.

The learning from Rosa's experiences emphasises the importance of creativity, mutual support across agencies, and an integrated or multi-agency approach. Information from organisations and professionals involved in her care amplifies the findings of research. Feedback recognised that safeguarding systems can "struggle with complex family dynamics because practitioners absorb a significant amount of emotional labour particularly when contact is blocked, informal caring roles are unclear, or supportive relatives are estranged. Workers can feel they are the only ones holding risk, which can lead to over-responsibility and frustration when families resist engagement or minimise concerns. Effective navigation relies on shared ownership across agencies, clear communication, and structured supervision that distributes risk rather than leaving individual practitioners to "carry" it alone".

[12] Article 8 rights to privacy and family life are qualified rights – the state could engage such a right if proportionate, and in line with a legal process.

Finding 4: Multi-agency responses to complex family dynamics

Learning

If finding 1 is about awareness and knowledge in the context of intersectionality, and finding 2 is about the connectedness of safeguarding and domestic abuse systems, then this finding is about **taking action** within complex family relationships to protect individuals at risk of abuse and neglect within domestic environments. This means building a picture of individual's needs, family dynamics, and social system. A person-centred approach is critical, identifying safe spaces for direct face to face contact focused on establishing rapport and understanding a person's lived experiences. Multi-agency close working is essential to both assessing and understanding, and also to risks management, strategy and planning. A rights-based framework can help to balance needs, privacy, family life, and risk. This requires time as well as a high degree of professionalism, training and skills and a safe space for reflection within supervision.

Intended impact

This finding intends to strengthen the safeguarding system's ability to take timely, proportionate, and coordinated action in cases involving complex family dynamics, coercive control, and disguised compliance.

Recommendation

1. **Multi-agency policy and protocols:** Multi-agency processes should ensure that curiosity is a shared multi-agency responsibility rather than delegated to the 'professional'.
2. **Organisational support:** All organisations to ensure that practitioners have access to training, reflective supervision, and tools and guidance, addressing professional curiosity, disguised compliance, coercive control, and rights-based practice.

SAR Question 5: Legal frameworks

What helps or hinders effective use of legal frameworks around mental capacity, safeguarding, domestic abuse, and human rights, for individuals with complex needs who are at risk of abuse and neglect?

This SAR question addressed the legal frameworks that underpin safeguarding and domestic abuse practice. This section provides a brief introduction to the key legal frameworks and explores how these were applied in practice.

Background – learning from evidence

Safeguarding Adults

The main legal framework governing safeguarding adults is the Care Act 2014 and its statutory guidance, the Care and Support Guidance. The Care Act 2014 was enacted in 2015 and has guided safeguarding for over 10 years. The Care Act 2014 built on the previous Department of Health 'No Secrets' guidance and contains specific powers and duties on Local Authorities to

make, or cause, enquiries as well as local strategic arrangements through Safeguarding Adults Boards, and Safeguarding Adults Reviews. The Care Act 2014 placed safeguarding on a statutory footing placing an enquiry duty of the Local Authority:

S.42 Enquiry by local authority

(1) This section applies where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there)—

(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.

(2) The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult’s case (whether under this Part or otherwise) and, if so, what and by whom.

As an adult with care and support needs Rosa was entitled to the protections that safeguarding legislation can offer. This includes a flexible approach under Making Safeguarding Personal; an approach that should be person-led, and outcome-focused. Safeguarding means working within the person-led parameters without losing sight of the outcomes of an “adult’s right to live in safety, free from abuse and neglect” (DHSC, 2025).

Domestic Abuse

The Domestic Abuse Act 2021 was made law on 30 April that year and brought in a number of changes, also elevating some aspects of previous guidance into primary legislation:

- A legal definition of domestic abuse, including children as victims in their own right.
- Strategic functions, such as the Domestic Abuse Commissioner and Domestic Abuse Local Partnership Boards.
- Domestic Abuse Protection Orders.
- Special measures in criminal proceedings.
- New offences such as controlling or coercive behaviour.

There also remain additional frameworks in case law, such as the Domestic Violence Disclosure Scheme (DVDS), also known as “Clare’s Law”. This enables police to disclose information to a victim or potential victim of domestic abuse about their partner’s or ex-partner’s previous abusive or violent offending. The scheme has two elements: the “Right to Ask” and the “Right to Know”. A disclosure under this scheme was considered by adult social care and police, but it was unclear whether she was able to engage with this – due to mental capacity, past experiences, and a mistrust of services based upon her own experiences and the influence of Brian who carefully managed Rosa’s access to professionals and others’.

Mental capacity – legal frameworks for decision-making and autonomy

The Mental Capacity Act 2005 provides the main legal framework for decision-making, providing a standard assessment and definition of a lack of mental capacity in relation to a particular decision at a particular time, and enshrining through principles:

- The assumption of capacity.
- A requirement to provide practicable steps to support autonomous decision-making.
- Protections against arbitrary findings of a lack of capacity based upon unwise decisions.
- Best interests' considerations for decisions or acts for an individual who does lack mental capacity.
- The preference of options that are less restrictive on individual human rights and personal freedoms (s. MCA 2005).

In addition to provisions on lack of capacity, best interests' and restraint, the Mental Capacity Act 2005 introduced the criminal offence of ill-treatment or wilful neglect of a person believed to lack capacity (s.44 MCA 2005). The Mental Capacity Act 2005 also re-created Court of Protection within the Family Division of the High Court[13]. The Court of Protection can:

- Decide whether a person has mental capacity over a to make a particular decision for themselves.
- Make declarations, decisions or orders on financial or welfare matters affecting people who lack capacity to make these decisions.
- Appoint a deputy to make ongoing decisions for people lacking capacity to make those decisions.
- Decide whether a Lasting Power of Attorney (LPA) or Enduring Power of Attorney (EPA) is valid.
- Remove deputies or attorneys who fail to carry out their duties.
- Hear cases concerning objections to register an LPA or EPA.

In 2007, the Mental Health Act 2007 amended the Mental Capacity Act 2005, creating the Deprivation of Liberty Safeguards to address the so-called Bournewood gap[14]. The Deprivation of Liberty Safeguards (DoLS) were designed as the legal procedure to protect the human rights of individuals kept under restrictive care arrangements to which they could not consent by virtue of a lack of mental capacity – arrangements that would otherwise represent a deprivation of their liberty under Article 5 (European Convention of Human Rights, Human Rights Act 1998).

Human Rights

The Human Rights Act 1998 was passed to directly incorporate the European Convention on Human Rights (ECHR) into domestic UK law. The Human Rights Act 1998 requires public authorities to act in a way that is compatible with the European Convention and provided citizens with the opportunity to defend their human rights in UK courts – although there is still recourse to

[13] As a superior court of record, the Court of Protection is able to enforce its orders, punish contempt, and can set precedents

[14] HL v UK 45508/99 [2004] ECHR 471

appeal to the European Court of Justice in Strasbourg. Key rights under the convention include the rights to life (article 2), the prohibition of torture and inhuman or degrading treatment (article 3), the rights to liberty (article 5), and the right to privacy and family life (article 8).

Learning from Rosa's experience

Rosa's experience demonstrates the challenges professionals face in balancing rights and legal frameworks that at times can appear conflicting. In many situations involving safeguarding and domestic abuse, protective actions may have consequences for human rights which need to be balanced and weighed up. Especially in situations where an individual's autonomy and decision-making are subject to coercion or control by another, it is important that protective interventions that engage, for example, the right to privacy and family life, are proportionate to the risk and likelihood of harm. In such cases, professionals may be working across a complex web of legislation to protect rights and freedoms, personal choice and autonomy, wellbeing, and protection from becoming victims to abuse and crime.

Rosa's experiences demonstrates very well some of the challenges in applying legal frameworks when assessments are complex and the way forward is not clear. Many of the assessments and decisions surrounding mental capacity, consent, and autonomy were finely balanced. Taking mental capacity as an example, Rosa may have had mental capacity for some decisions, but not for others also varying across time and context. Depending on the outcome of individuals mental capacity assessments and the implications of the decision for human rights, the legal framework and process also differed. When Rosa was in hospital and deemed to lack mental capacity into her care arrangements, the assessment and authorisation under Deprivation of Liberty Safeguards was necessary in order for her to stay in hospital under care arrangements that amounted to an engagement of her right to liberty. The effect of the DoLS authorisation was that Brian was prevented from removing her from hospital. While this offered Rosa a period of respite from harm, the purpose of a DoLS authorisation is care and treatment, focused on a person's best interests' but with no specific powers of protection, injunctive relief, or the ability to act against Brian or Todd.

Protecting victims and tackling the perpetrators of abuse

Anyone at risk of domestic abuse, adults with care and support needs, including those who may lack mental capacity in relevant areas of decision-making, is entitled to the protections of the law, however there are often significant challenges in delivering protection to potential victims, and justice to perpetrators. Recent analysis of a decade of the Care Act 2014 has advocated for further powers to protect adults with care and support needs though calls for powers of entry, protection orders, and stronger provisions to tackle the perpetrators of abuse or neglect (Preston-Shoot et al., 2024). Existing legislation is enquiry focused but largely toothless, with the exception of a small number of rarely used offences.

Where provisions do exist there are often legal and operational hurdles which undermine their existence. For example, the less-prosecuted s.44 (MCA 2005) offence of ill-treatment or wilful neglect was not considered in the case of Rosa and in general is rarely used. Post-legislative scrutiny on the Mental Capacity Act 2005 found that the offence was seen as convoluted and complex with significant barriers to use, from retrospectively proving a lack of mental capacity, defining wilful neglect, interpretation of the statute, and poor drafting of the offence. The numbers of prosecutions and convictions under section 44 (MCA 2005) have fallen significantly since its enactment. During the period 2017 to 2024 numbers of prosecutions and convictions fell from 92 prosecutions resulting in 43 convictions in 2017, to just 14 prosecutions and only 5 convictions

in 2024. Requests for a review of section 44 (MCA 2005) offence, for example by the House of Lords Select Committee on the Mental Capacity Act 2005 have failed to materialise or achieve any substantial change in practice or frameworks.

Finding 5a: Section 44 MCA 2005: Ill-treatment and wilful neglect

Learning

Rosa's case is an illustration of the challenges in applying legal frameworks designed to protect vulnerable individuals from harm. Section 44 Mental Capacity Act 2005 criminalises ill-treatment or wilful neglect of a person who lacks capacity but is rarely used in practice and not well-aligned to safeguarding realities for adults experiencing coercive control. Rosa's experience highlights how the limitations of s.44 leave a gap between safeguarding concerns and criminal justice outcomes, particularly where the victim's autonomy is compromised and the abusive dynamics are subtle, cumulative, and relational rather than overt.

Intended impact

To strengthen the safeguarding system's capability to act on the criminal ill-treatment and wilful neglect of individual's whose mental capacity is impaired, through a review of the legal framework including whether section 44 (MCA 2005) in its current format is fit for purpose.

Recommendation

1. **Escalate concerns regarding the effectiveness and usability of s.44 MCA 2005:** The Safeguarding Adults Board should raise this issue through national safeguarding and legal networks, contributing to ongoing discussions about reform of the offence and review of the barriers to prosecution and potential legislative amendment.
2. **Local mitigating actions:** Locally, health, social care, and criminal justice partners should raise the awareness of the existence of the s.44 MCA 2005 offence (and related offences) and ensure that they are considered as part of safeguarding enquiries where there is evidence of neglect, coercion, or undue influence that may reach a criminal threshold.

A combination of frameworks

Effective use of legal frameworks requires professionals to have a good understanding of how the Mental Capacity Act, Care Act safeguarding provisions, domestic abuse legislation, criminal law, and human rights considerations intersect – there is no single route. There is a tendency for professionals to default to the legal frameworks with which they are familiar – for example, health and social care staff preferring social care law, where other legal options or offences are overlooked. Evidence provided to the review based upon Rosa's experiences noted that one of the barriers to practice is a common assumption that social care law, the Court of Protection, or recourse to the Inherent Jurisdiction of the High Court[15], can resolve all complex cases of risk. In practice, legal frameworks, such as those for safeguarding children, adults and domestic abuse, tend to be primarily victim-focused, with limited powers to address or track patterns of risk posed by the perpetrators of domestic abuse. The Domestic Abuse Act 2021 introduced Domestic Abuse Protection Orders, and for some convicted domestic abuse offenders, Multi-Agency Public Protection Arrangements (MAPPA) play a role; Domestic Violence Disclosure Schemes (DVDS) can help, but by themselves, these are not effective at reducing reoffending by the majority of

[15] For more information on inherent jurisdiction see the 39Essex Chambers guidance note (Ruck-Keene et al., 2024)

alleged perpetrators. The statutory guidance to the Domestic Abuse Act 2021 (Home Office, 2022) advocated the use of perpetrator panels but there is limited evidence or data about their impact. The announcement of a public domestic abuse register for convicted perpetrators in Ireland, known as Jennie's law, resonates with the experiences of Rosa, and concerns about the risk of reoffending by Brian. There has been much debate about whether a UK register would be effective. The announcement of Jennie's Law renews calls for action to address the risks posed by perpetrators and to protect current and future victim-survivors: through "better resourcing, training and collaborative multi-agency working to proactively reduce risk, supported by rigorous risk assessment and effective digital infrastructure at a national level" (Hadjimatheou & Hamid, 2024).

Safeguarding enquiry

One framework that may support a broader and more inclusive consideration of legal options for individuals at risk is the enquiry under section 42 (Care Act 2014). While many enquiries will be practice and intervention-based rather than purely legal-focused, there are situations, like Rosa's, where completing an enquiry – to determine "whether any action should be taken in the adult's case and, if so, what and by whom" should include a scoping of legal options from a range of perspectives, relying on specialist expertise where necessary. The addition of dedicated 'legal options meeting' may not only draw in the relevant expertise but also empower curious professionals to consider a wider range of frameworks, encouraging creativity and thinking outside the box.

Finding 5b: Legal options meetings

Learning

There is a tendency for professionals to (understandably) rely on legal frameworks with which they are most familiar. When faced with the complexities of experiences that may engage multiple legal frameworks and areas of legal practice, professionals did not have or use a structured forum to bring together the range of expertise to explore, test, and weigh-up different options. This reflects the wider systems issues: (1) that complex cases require legal thinking that spans multiple jurisdictions and statutory duties for which there is no mechanism for multi-legal analysis, and (2) that the current system is not effective at tracking the patterns of risk posed by alleged perpetrators of domestic abuse.

Intended impact

To increase the range of legal options and remedies considered in complex cases through a structured forum that draws on appropriate expertise.

Recommendation

1. **Mechanisms for identifying and addressing the reoffending risk posed by alleged perpetrators:** The Department of Health and the Home Office should review the impact of perpetrator panels and interventions and take action to develop mechanisms to support the identification and management of risks posed by perpetrators of domestic abuse.
2. **A multiagency legal options meeting for complex safeguarding cases:**
   The Safeguarding Adults Board should develop a protocol for convening a legal options meeting where cases involve intersecting concerns relating to domestic abuse, mental capacity, coercive control, human rights, or significant barriers to access.

Conclusion

The Safeguarding Adults Review aims to be systems-focused but grounded in the experiences of Rosa, a woman who died in her thirties in the context of declining health conditions, her needs for care and support from others, and her experience of domestic abuse at the hands of those who should have been caring for her – her husband and nephew.

Rosa's experiences highlight the intersectionality of disability, chronic health conditions, gender and social isolation, with coercion and control, exploitation and domestic abuse. Her case shines a light on local and national issues and disjointed safeguarding and domestic abuse systems, with separate legal frameworks, governance arrangements, and differences in culture and practice. The review recognises the compassion and commitment of professionals and their dedication to the people they work with day-in and day-out. The findings of the review also highlight some of the difficulties faced by professionals, the system pressures, complexity of safeguarding practice, and the challenge of remaining curious.

The recommendations in this report are intended to be of practical value, and to support change. Findings seek to raise awareness of the interface between gender, disability, and domestic abuse, and to improve the connectedness of safeguarding and domestic abuse systems. Recommendations consider lived experience, consent, and prioritising experience-focused planning, while acknowledging the systems pressures and the scarcity of resources. The review seeks to strengthen a culture of curiosity and improve accessibility and joint working. Finally, the review identifies action that is needed at a national level: including changes to guidance, to legal frameworks, and mechanisms to address the future risks posed by those who harm, control, and abuse others.

The Safeguarding Adults Review should be read alongside the Domestic Abuse Related Death Review (DARDR) authored by Nicki Norman OBE. The findings and recommendations from both reviews offer important perspectives on safeguarding and domestic abuse systems. It is hoped that the findings from the reviews will indeed be of practical use to organisations and professionals, and that, as her family write:

"The learning from her life helps create a future in which vulnerability triggers protection, dependence prompts greater scrutiny, and safeguarding systems adapt to the individual. If Rosa's story helps even one vulnerable person to be seen, heard, understood, and protected, then her legacy will endure far beyond these pages".

This is not the end of Rosa's story.

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Summary of recommendations

Finding	Intended impact	Summary of recommendation	Lead	Suggested measures
Finding 1: Gender, disability, and domestic abuse	Improved expertise across systems needs to improve: • Awareness of domestic abuse in services and systems designed to support and advocate for disabled adults • Awareness of disability within services and systems designed to address domestic abuse • Awareness across all services and systems of the intersectionality of gender, disability, and domestic abuse.	**1.** Reducing barriers to access for disabled people: domestic abuse providers should review the accessibility of domestic abuse services in the context of disability and other protected characteristics and report their findings to Cumbria Safeguarding Adults Board and Cumberland Community Safety Partnership	CSAB CCSP Providers	Accessibility audit
		2. Training and development: For the Safeguarding Adults Board and Community Safety Partnership to lead on cross-delivery of Safeguarding and Domestic Abuse Training programmes to address expertise shortfall	CSAB CCSP	Training attendance Delegate feedback
		3. Bringing people together: A combined safeguarding and domestic abuse conference or event to bring practitioners together to enhance partnership working.	CSAB CCSP	Delegate feedback
Finding 2: Safeguarding and domestic abuse systems	This finding is intended to advocate for closer connectedness between safeguarding and domestic abuse systems – from national statutory guidance to local policy and local practice.	**1.** Care and Support Guidance: The Safeguarding Adults Board should escalate this recommendation via national safeguarding networks: re-draft the paragraphs in the Guidance on definitions of abuse, neglect, and self-neglect to address domestic abuse, vulnerability factors, exploitation, and trauma.	CSAB	

Finding	Intended impact	Summary of recommendation	Lead	Suggested measures
		2. Cumbria Safeguarding Adults Board and the Cumberland Community Safety Partnership should coordinate their strategic responses to the Safeguarding Adults Review and Domestic Abuse Related Death Review to ensure that safeguarding and domestic abuse procedures are complementary.	CSAB CCSP	Strategy, protocol, joint strategic statement
		3. Policy and practice: Where an individual with care and support needs experiences domestic abuse, both safeguarding and domestic abuse systems should be used to guide responses engaging professional expertise from both systems together for the adult at risk.	CSAB CCSP	Policy statement
Finding 3a: Lived experience, direct contact, and consent	To ensure that person-centred approaches, direct confirmation of lived experience and consent remain at the centre of health and social care practice. Strengthening direct professional engagement and improving the quality of consentrelated practice is essential for safeguarding systems to recognise, interpret, and act on risk.	**1.** Strengthen direct contact: Organisations should ensure that all assessments involve direct, private contact with individuals, and that professionals challenge or escalate barriers to access.	All	Organi-sational safeguard-ing Policy statements
		2. Consent: Agencies should reinforce practice around obtaining and verifying informed consent, including assessing for undue influence, distinguishing consent from compliance, and avoiding reliance on family members as proxy decision makers.	All	Practice audit

Finding	Intended impact	Summary of recommendation	Lead	Suggested measures
		3. Lived-experience-focused planning: Practitioners should use tools, supervision, and reflective practice to ensure care planning is grounded in the adult's own views, experiences, and needs rather than assumptions or third-party accounts.	All	Practice / Care plan audit
Finding 3b: System pressures and the foundations of practice	To strengthen the capacity of health and social care systems to deliver consistent, high quality foundational practice even when facing complexity, coercion, or external pressures. This includes improving system coordination, maintaining flexible responses, and ensuring risks are shared rather than left with individual practitioners.	**1.** Sound foundations in practice: Organisations should reinforce training, supervision, and team support around personcentred assessment, care planning, consent, and holistic evaluation of need.	All	Training resources Delegate feedback Supervision self-assessment
		2. Improve system connectivity: Health and social care services should clarify pathways, roles, and responsibilities to reduce fragmentation and strengthen active and passive coordination.	ASC, NHS CSAB	Pathway, protocol, policy statement
		3. Timely escalation: Agencies should maintain clear, multiagency escalation procedures for situations where access is blocked, concerns intensify, or needs are not being met despite repeated professional involvement	CSAB CCSP All	Escalation Protocol
		4. Address system rigidity: Organisations should review how resource pressures and demand management may unintentionally restrict proactive safeguarding responses, and identify opportunities for more flexible, needs-led practice.	All report to: CSAB CCSP	Organisa-tional Report

Finding	Intended impact	Summary of recommendation	Lead	Suggested measures
Finding 4: Multi-agency responses to complex family dynamics	This finding intends to strengthen the safeguarding system's ability to take timely, proportionate, and coordinated action in cases involving complex family dynamics, coercive control, and disguised compliance	**1.** Multi-agency policy and protocols: Multi-agency processes should ensure that curiosity is a shared multi-agency responsibility rather than delegated to the 'professional'.	CSAB CCSP	Policy statements
		2. Organisational support: All organisations to ensure that practitioners have access to training, reflective supervision, and tools and guidance, addressing professional curiosity, disguised compliance, coercive control, and rights-based practice.	All report to: CSAB CCSP	Organisa-tional self-assessment Reports to Boards
Finding 5: Section 44 MCA 2005: Ill-treatment and wilful neglect	To strengthen the safeguarding system's capability to act on the criminal ill-treatment and wilful neglect of individual's whose mental capacity is impaired, through a review of the legal framework including whether section 44 (MCA 2005) in its current format is fit for purpose.	**1.** Escalate concerns regarding the effectiveness and usability of s.44 MCA 2005: The Safeguarding Adults Board should raise this issue through national safeguarding and legal networks, contributing to ongoing discussions about reform of the offence and review of the barriers to prosecution and potential legislative amendment.	CSAB	
		2. Local mitigating actions: Locally, health, social care, and criminal justice partners should raise the awareness of the existence of the s.44 MCA 2005 offence (and related offences) and ensure that they are considered as part of safeguarding enquiries where there is evidence of neglect, coercion, or undue influence that may reach a criminal threshold.	Police ASC All report to: CSAB	Mitigation plans Reports to Boards

Finding	Intended impact	Summary of recommendation	Lead	Suggested measures
Finding 5b: Legal options meetings	To protect both current and future victim-survivors, and to increase the range of legal options and remedies considered in complex cases through a structured forum that draws on appropriate expertise.	**1.** Mechanisms for identifying and addressing the reoffending risk posed by alleged perpetrators: The Department of Health and the Home Office should review the impact of perpetrator interventions and take action to develop mechanisms to support the identification and management of risks of future domestic abuse posed by alleged perpetrators. **2.** A multiagency legal options meeting for complex safeguarding cases: The Safeguarding Adults Board should develop a protocol for convening a legal options meeting where cases involve intersecting concerns relating to domestic abuse, mental capacity, coercive control, human rights, or significant barriers to access.	CSAB Partners Legal expertise	Protocol