Christopher

Christopher was a white, British, 39-year old man who had been living in Brighton and Hove for a number of years until he passed away in March 2017. The cause of death was heroin toxicity.

Christopher had a learning disability and he experienced anxiety, as well as longstanding issues with substance misuse. His mental health was frequently fragile and he had had a challenging upbringing, having limited contact with his family as an adult.

He was described as having a chaotic lifestyle, spending periods of time effectively homeless as well as living in a number of temporary settings and with self-neglect and self-harm both occurring. Christopher was known to criminal justice services as both a victim and perpetrator and could be difficult to engage and work with.

Introduction

Safeguarding Adults Reviews are undertaken when an adult in the local authority area with care and support needs either dies, or suffers serious harm, as a result of abuse or neglect and there is a concern that partner agencies could have worked more effectively to protect the adult.

The purpose of a Safeguarding Adults Review is to learn lessons about how professionals and organisations work together and to seek to identify improvement actions.

Learning Briefing

Brighton & Hove SAB Safeguarding Adults Board

Prior to his death Christopher was supported by a range of professionals and agencies from both statutory and the non-statutory organisations. A referral was received retrospectively by the Brighton and Hove SAB and a Safeguarding Adults Review commissioned in order to consider the care and support arrangements that were in place and whether there were learning opportunities for how agencies could have worked more effectively to protect Christopher.

In addition to more general areas such as multi-agency communication and collaboration and how his individual needs were generally met there were a number of specific areas that the review focused on; these included whether statutory processes and local policies and procedures in relation to safeguarding and mental capacity were appropriately considered, how Christopher's anxieties and history of trauma were responded to, how risk was managed and the impact of his homelessness on his wellbeing.

Four Key Learning Points

1) Use and understanding of capacity assessments as part of the safeguarding process – understanding of safeguarding duties across the system

The review identified that there was no use of formal safeguarding processes or recorded capacity assessments to support Christopher during the review period. This was partly because those who were working directly with him had limited experience of these processes.

Whilst there have been significant improvements by the core agencies involved since Christopher passed it was also identified that professionals involved these processes more intermittently may continue to struggle.

2) Understanding of Self-neglect – links to mental health and substance misuse

The review identified that whilst at times Christopher appeared to be able to look after himself there was also evidence that at times he struggled with day-to-day tasks and that some neglect may have occurred because he was unable to care for himself. The lack of formal consideration of capacity meant that self-neglect was never identified as a potential safeguarding issue.

Whilst there is greater overall knowledge and understanding around self-neglect in the time since Christopher passed away identifying self-neglect, particularly when influenced by factors such as mental health and substance misuse, remains challenging for professionals.

3) Relevance of Trauma based practice - links to the homeless experience

The review noted that Christopher displayed a number of symptoms typical of someone who had, or was experiencing, trauma. He had a difficult upbringing and as an adult he experienced issues such as homelessness, substance misuse, self-neglect and self-harm, which may have been responses to trauma.

Agencies constantly sought to find out 'What was wrong with Christopher', rather than 'What happened to Christopher' and there is a need to reduce the tendency to judge, or blame people for psychological, or behavioural reactions to experiences that include threat or violence and consider the cumulative effects of these experiences.

4) Services for homeless people – reactive not proactive?

The review identified that there are a high number of homeless people within Brighton and Hove and that like Christopher many of them are probably traumatised. With services slow to respond to his frequent accommodation changes it is essential they are pro-active in being able to rapidly respond to people who are homeless or transient in supporting safety and wellbeing.

It was noted that there have been improvement here, particularly in Housing, but that if services generally do not respond until people are in settled accommodation then it is likely they will not receive the interventions they require.

Conclusions

The review concludes that Christopher received a significant level of support from a range of agencies over the two years prior to his death. However, despite evidence of self-neglect and his ability to care for himself and make safe decisions there were assumptions made about his capacity to make safe decisions and a reluctance to intervene or to challenge Christopher's view of the world.

The Independent Reviewer made five recommendations to the Safeguarding Adults Board in relation to the key issues that have been identified and these focus on the knowledge and understanding of statutory processes, training and service development.

You can read the full SAR Christopher report here on the BHSAB website.

What Can You Do?

Reading

Refresh your knowledge and understanding by reading the Brighton and Hove SAB learning briefings on Mental Capacity and Multi-agency Safeguarding that follow audits previously undertaken here and on self-neglect in the Sussex Safeguarding Procedures here.

Listening

We hope you're attending the Brighton and Hove and East Sussex SAB 2021 Conference this month, which includes a workshop on Trauma-Informed Practice. Alternatively look out for training opportunities on the Wave or through your own organisation in areas such as self-neglect, Mental Capacity or trauma-informed practice.

Talking

We encourage you to share this briefing to promote discussions with colleagues. This could be an opportunity to talk as a group about people that you're supporting experiencing issues such as complex and multiple needs, self-neglect or multi-agency working and to share approaches, resources and learning.

Doing

We hope this briefing can contribute to your ongoing professional development. This could be practical, such as expanding professional curiosity about those you are working with, developing your knowledge of other services or relationships with multi-agency colleagues.