

1. Background

Chris was a 47-year-old man who died in March 2023. He lived alone in rented accommodation and had a longstanding diagnosis of paranoid schizophrenia, alongside a history of drug and alcohol misuse.

Chris had significant physical health needs, including osteoporosis, Barrett's Oesophagus, pressure ulcers, and deteriorating liver function linked to alcohol use. He was eligible for support under the Care Programme Approach (CPA) and Section 117 aftercare of the Mental Health Act and had been known to mental health services since the late 1990s.

2. Brief History and Key Events

Chris had decades of contact with mental health services, including periods of detention under the Mental Health Act and long-term community support. He experienced chronic self-neglect, struggled with his personal care, deteriorating physical health, and increasing alcohol use over many years.

Between 2020 and 2021, Chris was referred into Multi-Agency Risk Management (MARM) due to self-neglect and serious pressure ulcers, but this process was not sustained or effectively reviewed. Between 2022 and 2023, Chris had frequent contact with emergency services, missed appointments, refused treatment, and repeatedly made what were described as "unwise decisions" about his health. His mental health fluctuated, with hallucinations, paranoia, aggressive behaviour, and repeated requests for hospital admission. Despite escalating risks, opportunities to complete formal Mental Health Act and Mental Capacity Act assessments were missed at key points.

7. Further Information

MARM guidance [Multi-Agency Risk Management Guidance \(2025\) | Cambridgeshire and Peterborough Safeguarding Partnership Board](#)

MARM Training [Multi-Agency Risk Management Guidance | Cambridgeshire and Peterborough Safeguarding Partnership Board](#)

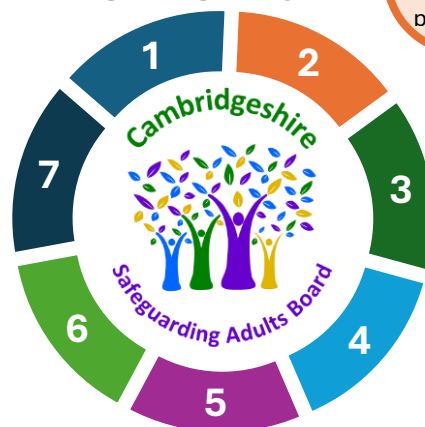
Self-Neglect [Self neglect | Cambridgeshire and Peterborough Safeguarding Partnership Board](#)

Mental Capacity [Mental Capacity Act Resources | Cambridgeshire and Peterborough Safeguarding Partnership Board](#)

Making a safeguarding Referral [Making a Referral | Cambridgeshire and Peterborough Safeguarding Partnership Board](#)

7 MINUTE BRIEFING

SAR CHRIS



3. Agency Involvement

Although many agencies were involved, the SAR identified that support was fragmented, with limited coordination across statutory frameworks such as CPA, Section 117, MARM, safeguarding, and Care Act assessments. There was also noted to have been inconsistent information sharing between emergency services, hospitals, GPs, and Adult Social Care.

6. Key Messages

- ✓ Self-neglect is a **form of abuse** and should trigger safeguarding responses.
- ✓ Repeated "unwise decisions" should prompt **consideration of mental capacity** and not automatically be accepted by practitioners.
- ✓ Behaviour that feels familiar or longstanding must **not be normalised** when risk is increasing.
- ✓ Mental health, physical health, substance misuse, and social care needs must be viewed **holistically**, and not in isolation.
- ✓ Multi-agency frameworks only protect people when they **are actively used, reviewed, and coordinated**.
- ✓ Professionals being curious, having supervision and being able to respectfully challenge are essential in working with long-term complex cases.

5. Positive Practice

- ✓ Frontline staff showed **commitment, persistence, and compassion**, often going to significant lengths to support Chris in the community.
- ✓ Practitioners attempted to involve Chris in decision-making and respect his autonomy wherever possible.
- ✓ There were examples of **good individual practice**, including efforts to encourage engagement, monitor medication, and prompt his attendance at appointments.
- ✓ Once Chris was admitted to hospital, his acute physical health needs were identified and treated, including appropriate use of DoLS when capacity was assessed as lacking.

4. Areas for Development

The SAR identified several key areas for learning:

- **Normalisation of risk:** Chris's self-neglect, hallucinations, aggression, and refusal of care became accepted by professionals as "just how he was," rather than as triggers needed for escalation for support.
- **Mental Capacity Act:** Repeated unwise decisions should prompt completion of formal capacity assessments. There is clear guidance signalling for this to be completed.
- **Mental Health Act:** Earlier assessment and intervention under the MHA should be considered
- **Self-neglect and safeguarding** should be consistently recognised and progressed through safeguarding pathways.
- **Multi-agency processes** (CPA, Section 117, MARM, Care Act reviews) should be coordinated and monitored effectively.
- **Information sharing** between agencies should be consistent, particularly following emergency service contacts and hospital attendances.
- **Management oversight and supervision** are essential to challenge drift and to ensure escalation.