



# **Christopher's Story – understanding the wider impacts of domestic abuse**

Sharing learning is a key priority of the Safeguarding Adults Executive Board (SAEB) and ensures that lessons in relation to safeguarding adults support direct practice and encourages a culture of continuous improvement.

This briefing summarises the key learning from a case involving domestic abuse within a same sex relationship. The case was referred for consideration of both a Domestic Homicide Review (DHR) and Safeguarding Adults Review (SAR) but did not meet the statutory criteria for either process. The SAEB has produced this briefing to share the important learning from 'Christopher's' case.

All staff and managers are encouraged to read and discuss this briefing in team meetings or supervision and reflect on its findings.

## **1: Background**

Christopher was in his early 60's and lived alone. He held a tenancy on a council property. Christopher had complex health conditions, which led to him requiring a package of care to support his independence. Christopher purchased care via a personal budget and then employed George as his carer.

Prior to becoming a carer, George was homeless, had no recourse to public funds and had complex mental health needs.

Christopher and George became intimate partners. Sadly, Christopher died suddenly from a heart condition. When he died, he was homeless and a victim / survivor of intimate partner violence. In the 18 months prior to his death, Christopher's vulnerability had significantly increased due to the impact of his substance misuse, his and George's deteriorating health, frequent moves across boroughs and domestic abuse.

Professionals struggled to link Christopher to appropriate services as questions around capacity varied.

## **2: Homelessness**

A plan was made for Christopher and George as a couple, but George's violence towards Christopher and also to other professionals and residents caused many breakdowns in hostels and temporary accommodation. Measures to keep Christopher safe were in place, though professionals would benefit from further training in this area.

Professionals tried extremely hard to prevent Christopher from suffering harm, although he was considered to be making 'unwise' decisions. Domestic abuse and harm minimisation frameworks, such as the Multi-Agency Risk Assessment Conference (MARAC) were in place, but the couple's moves between local authorities presented challenges for professionals trying to manage Christopher's risk.

## **3: Domestic abuse**

There were several case conferences about Christopher and George at MARAC. However, Christopher's moves to other boroughs presented difficulty for professionals following through actions in a timely way.

Professionals felt unable to implement a risk minimisation plan when Christopher was seen to be making choices about his relationship.

The question was raised as to whether 'male on male' violence was taken seriously enough given they were in a same sex relationship?

## **4: Themes**

The Community Safety Partnership identified the following themes:

- Personal budget oversight and safer recruitment
- Domestic abuse in same sex relationships
- Financial abuse
- Substance misuse
- Homelessness
- Cross borough victim referrals for services with victim awareness training to ensure dysfunctional dynamics between couples are fully understood
- Mental and physical health
- Differing legal frameworks for individuals in an intimate relationship
- Professional curiosity regarding Christopher's mental capacity and executive function.

## **5: How did professionals respond?**

There was increasing urgency about Christopher's safety and while professionals' meetings took place, not all actions were completed. Christopher's support worker's concerns were dismissed or not acted on.

## 6: Learning

Prior to Christopher's death, his support worker interacted with various services and local authorities to try to advocate for a comprehensive and appropriate support package for him. However, processes were slowed down or put on hold due to Christopher's and George's frequent moves across boroughs.

A greater emphasis could have been placed on Christopher's executive function rather than the focus on respecting his wishes, whilst also trying to balance risk with his right to be in a relationship (Article 8 of the Human Rights Act) with his right to life and to be protected (Article 2 of the Human Rights Act).

## 7: What would we do differently?

- Professional curiosity regarding how Christopher and George's relationship started
- Closer monitoring of personal budgets and the recruitment of Personal Assistants, for example, ensuring use of the Disclosure and Barring Service (DBS).
- Understand the wider impact of domestic abuse in same sex relationships and on an individual's health and wellbeing.
- Advocacy for the perpetrator as well as the victim / survivor.
- Consideration of health inequalities for gay men and substance use and poor physical health on risk.
- Making Every Adult Matter (MEAM) and ensuring a holistic approach is taken.

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