Who was Christopher

Christopher was a 31 year old white man who was placed by the London Borough Barking and Dagenham (LBBD) in supported accommodation in Redbridge in February 2021. Christopher was diagnosed as having a mild learning disability and autism spectrum disorder. On the 31 August 2022 he moved out of the accommodation and sadly his body was then found in the River Thames on the 5th September 2022. The Coroner recorded the cause of death as unascertained.

This SAR was undertaken by the Redbridge SAB with input from Barking and Dagenham SAB. The full report can be found here: [RSAB-SAR-Christopher-Overview-Report-June-2025-Final.pdf]

Recommendations and Actions

There are a number of learning actions being taken forward by various organisations involved with Chrisopher. Assurance work and meetings are taking place so that agencies can feedback on improvements in practice.

Key Findings

Legal frameworks: Mental Health Act was considered but not used appropriately. Legal advice was not always sought when consent was withheld. Need for clearer escalation pathways when legal thresholds are met.

Systemic and structural learning: Assurance framework developed to monitor improvements. Need for regular audit, feedback loops and leadership oversight. Importance of cross-borough collaboration and shared learning.

Christopher's Experiences

The Probation Service engaged with Christopher in person on 15 occasions during the period from September 2021 to August 2022. There is no indication in any of these visits that Christopher was suffering harm or at risk. Although it was difficult to engage with him due to his autism and other learning difficulties. Christopher faced some challenges in his life and on two occasions was placed in circumstances where he responded with aggression and this led to a criminal conviction.

Safeguarding Adult Review (SAR) 'Christopher'

7 Minute Briefing

Key Findings

Commissioning and provider oversight: Provider went out of business, and records were lost. Placement was later deemed unsuitable (dual children/adult service). Need for due diligence, especially for out-of-borough placements. Importance of contingency planning and record retention.

Medication and health needs: Medication decisions were appropriately considered but not always well documented. Physical health needs were not consistently assessed or followed up.

Key Findings

Hearing the voice of the individual: Agencies struggled to engage Christopher directly. Alternative engagement methods (e.g. advocacy) were underutilised. Lack of consistent recording of Christopher's voice and preferences. Need for better use of Care Act advocacy and informal support networks.

Robust, person-centred assessment and care planning: Assessments lacked depth in exploring Christopher's broader life goals. Care plans focused on basic needs but missed holistic planning. Reviews were sometimes virtual or missed due to Christopher's absence. Risk assessments were not consistently integrated across agencies.

Safeguarding practice: Missed opportunities to raise safeguarding concerns. Need for clearer thresholds and responses under Section 42 of the Care Act. Importance of recognising vulnerability even when the person is the alleged perpetrator. The Complex Cases Group could have been utilised.

Key Findings

Mental capacity and consent: Decisions about Christopher's capacity were not always clearly recorded. Refusals to engage were often accepted without deeper exploration. Need for better documentation and escalation when consent is withheld.

Did not attend procedures: These were not robust enough to trigger follow-up or risk reassessment. Missed appointments were not always escalated or explored in depth.

Communication and co-ordination: Communication gaps between agencies, especially across borough boundaries. Lack of shared understanding of roles and responsibilities. Need for better coordination during transitions. Importance of multi-agency meetings.

Redbridge Safeguarding Adults

BARKING & DAGENHAM SAFEGUARDING ADULTS BOARD