**Who was Steven?**

*“It would have helped if I was given time to speak. Spend time speaking to the people that love them so you have a better understanding of their back grounds, why they are behaving in certain ways. People don’t self-destruct for no reason.” [Sophie]*

Steven was a 37 year-old, white British man, described by his wife Sophie as:

“**A ball of energy who was very loving, caring and extremely funny… a beautiful soul, very sensitive, and a soft person.”**

Steven experienced a traumatic childhood, which included early exposure to drugs. Despite this, Steven was intelligent, hardworking, and generous. He built a business, loved cooking, and was a devoted father. Steven struggled with mental health issues and addiction throughout his life, and at times experienced homelessness. Sophie said: “**He just did not have the correct help.”**

**What Happened?**

It was known by professionals that Steven would often climb onto high buildings when he was struggling with his mental health. In February 2024, Steven tragically died after         experiencing a mental health crisis and falling off a building from a height. Emergency services tried to save him, but his injuries were too severe.

His death was ruled by the Coroner as accidental.

 **Why Was a Safeguarding Adult Review (SAR) Done?**

The review was carried out to understand what happened in Steven’s life and how services responded to him. It aimed to learn lessons to improve practice and future support for people in similar situations. **It was not about blaming anyone.**

 **What Did the Review Look At?**

The review looked at:

* How well professionals understood Steven’s life and needs.
* Whether his mental health, addiction, and homelessness were properly recognised and supported.
* How services worked together.
* Whether his family was involved in his care.
* What could be done differently in future.

 **Key Findings and Learning**

1. **Steven’s Story Was Not Fully Understood**
	* Many professionals focused only on the immediate crisis (e.g., drug use or mental health episodes) and didn’t always explore his background or trauma.
	* Time pressures and lack of joined-up working made it harder to build a full picture of Steven’s needs.
	* Understanding Steven’s experience of trauma was essential to his recover and seeking the right support.
2. **Missed Opportunities to Safeguard Steven**
	* No formal safeguarding concerns were raised, even though Steven showed signs of self-neglect and vulnerability.

*“Professionals should recognised and understand that even strong males are vulnerable and need help to keep themselves safe. Safeguarding needs to be better. Families can’t always do it by themselves, they need help and have the time to be listened to.” [Sophie]*

* + Some professionals didn’t realise that addiction and homelessness can be signs of needing care and support. The focus appears to have been on his addiction – the other concerns were considered to be consequential.
1. **Support Was Not Always Coordinated**
	* Steven was often left to seek help on his own.
	* He wasn’t referred to specialist teams that could have helped with his addiction and homelessness. The onus remained on Steven to seek drug support, mental health support and to address his homelessness independently.
	* Services didn’t always share information or follow up on referrals.
2. **Family Was Not Properly Involved**
	* Sophie tried to get help for Steven but felt ignored. Sophie described how she would beg for help at the hospital and said that she felt that no one was listening to her. Sophie felt that she knew him best.

*“I would like professionals to engage with families more and give them time to talk.” [Sophie]*

* + Professionals didn’t always ask for or record consent to involve family members in care planning.
1. **Understanding of Addiction Needs**

*“I’m hoping there will be a better understanding of ‘triggers’ which make their loved ones behave the way they do.” [Sophie]*

* Steven’s addiction was powerful and complex, but some professionals lacked training in how to respond.
	+ Some professionals lacked training in how addiction affects people.
	+ There’s a risk of [**Unconscious Bias**](https://safeguardingadults.salford.gov.uk/media/p3ogvtc2/ssab-7-mb-unconscious-bias.pdf)—judging people based on their addiction rather than understanding it as a health issue. This is being highlighted in other SARs.

Sophie explained that Steven would often say **“Do you think I’m having fun? Do you think I want to be like this? Do you think I’m happy? Do you think I want to leave our son? Do you think I want to lose my business?”**

1. **Homelessness Was Not Always Recognised**
	* Steven sometimes stayed with friends or returned home briefly, which may have hidden the fact that he was homeless.
	* Professionals are not consistently exploring their legal Duty to Refer those who are homeless or threatened with homelessness to housing services
2. **Positive Practice**
* Emergency services often responded quickly and compassionately.
* Some assessments captured Steven’s trauma and needs well.
* There are good services in Salford, but they weren’t always used effectively in Steven’s case.
1. **Next Steps and What Will Change?**

The review recommends:

* Better training for professionals on trauma, addiction, and safeguarding.
* Improved systems for sharing information and making referrals.
* More support for involving families in care.
* Clearer understanding of homelessness and how to help.
* Action plans have been created to improve services and prevent similar situations in future.

For a copy of the full report please visit the SSAB website ([Published SARs and other reviews | Salford Safeguarding Adults Board](https://safeguardingadults.salford.gov.uk/sars/safeguarding-adult-reviews-sar/published-sars-and-other-reviews/))