Safeguarding Adult Review
Overview Report

Review into the death of Brian, who died in August 2021 in Bristol

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Preface

The Independent Chair and Review Panel would like to express their sincere condolences to everyone impacted by Brian's passing and thank them for their support and contributions to this procedure.

A Safeguarding Adult Review (SAR) is a multi-agency statutory review designed to determine what the relevant agencies and individuals involved may have done differently to avert harm or death. For these lessons to be widely and correctly learned, it is necessary to determine what may be known from each person's death and for agencies to understand what happened in each case.

The Chair wishes to thank the panel and individuals who provided chronologies and material for their time, patience, and cooperation.

1. Introduction

1.1 Introduction

1.1.1 The review was initiated in response to the death of Brian (Pseudonym) in August 2021. On the 26th of August 2021, Avon and Somerset Constabulary referred Brian to the Keeping Bristol Safe Partnership (KBSP). Brian satisfied the criteria for a Safeguarding Adult Review (SAR) in March 2022, according to the KBSP Safeguarding Adult and Domestic Homicide Group, which received the referral.

1.1.2 According to Section 44 of the Care Act 2014, a Safeguarding Adults Board (SAB) has a statutory duty to organise a SAR when:
a) An adult with care and support needs has died, and the SAB knows or suspects that the death resulted from abuse or neglect, or an adult is still alive, and the SAB knows or suspects that they have experienced serious abuse or neglect.
b) And when there is reasonable cause for concern about how the Board, its members or others worked together to safeguard the adult.
Board members must work with and contribute to the SAR to identify lessons learned and ensure they are shared and utilised in the future.[1]

1.1.3 The group found that Brian was an adult with care and support needs and that neglect may have affected his death. Furthermore, there was reason to be concerned about how professionals collaborated to protect Brian.

1.1.4 It was also highlighted that there may have been familial domestic abuse, which would qualify this case for a domestic homicide review[2]; however, it was recognised that there would be more flexibility to suggest a safeguarding adult review with domestic abuse considered in terms of reference.

1.1.5 The group suggested that the KBSP Executive conduct a SAR in Brian's case and consider the six principles of safeguarding adults[3]:

Empowerment: Understanding how Brian was encouraged to participate in his care and make independent decisions.

Prevention: The learning gained will be applied to prevent future harm to others.

[1] https://www.legislation.gov.uk/ukpga/2014/23/section/44/enacted
[2] Domestic Homicide Reviews are multi-agency reviews commissioned by community safety partnerships into the deaths of adults which may have resulted from violence, abuse, or neglect by a person to whom they were related or with whom they had an intimate relationship or were a member of the same household.
[3] https://www.scie.org.uk/safeguarding/adults/introduction/six-principles

Proportionality: Agencies determine if the services offered to Brian are least intrusive and proportional to the risk.

Protection: The learning gained will be used to keep others safe.

Partnership: Agencies will aim to understand how well they collaborated and apply what they learned to improve partnership performance and safeguarding.

Accountability: Transparency and accountability are crucial for safeguarding procedures. For the review to explore and discuss the accountability of agency choices.

1.1.6 The review examined agency responses and support given to Brian, a resident of Bristol, before his death in August 2021.

1.1.7 In addition to agency engagement, the review looked at Brian's last four years of life (June 2018 - August 2021) to discover any relevant history, signs, or maltreatment before his death, if Brian received support in the community and any impediments to Brian receiving support. The review aims to identify suitable solutions to reduce the risk of harm.

1.1.8 This review process does not replace the criminal or coroner's courts nor serves as a disciplinary procedure. Instead, it aims to determine how agencies may improve their practices by learning from this review to prevent future deaths in similar circumstances.

1.1.9 Brian was discovered dead in August 2021 by his son Alan, with whom he shared a home. Natural causes of death (Bronco Pneumonia and Urosepsis) have been confirmed. There has been no coroner's inquest. The post-mortem revealed that Brian was not dehydrated, and no bruises, lesions, or sores were observed on his body. Brian was paralysed from the waist down following a back operation and diagnosed with type 2 diabetes. He relied on his son for his care needs and had carers twice daily; this increased to four times a day in June 2021.

1.2 Case Summary

1.2.1 One morning in August 2021, Alan called an ambulance to the house he shared with his father. Alan discovered Brian cold and unresponsive. When the paramedics arrived, they confirmed the death.

1.2.2 Brian spent much of the day in a chair in the living room; he had seen his GP the day before his death, and they said there was no reason to believe he would die the next day.

1.2.3 The carers had voiced safeguarding concerns over Alan's neglect of his father. In addition, nurses who had been denied access to Brian raised concerns.

1.2.4 The KBSP determined that Brian had care and support needs, and it was suspected that neglect had a role in his death.

1.3 Equality and Diversity

1.3.1 Age, gender, gender reassignment, marital status, race, religion/belief, pregnancy, sexual orientation, and disability were all considered by the review chair, author, and panel.

1.3.2 Age and disability are the relevant characteristics in this review. Following a back operation, Brian had paraplegia[4]. In addition, he was diagnosed with type 2 diabetes. The podiatrist and community nurses gave him input.

1.3.3 Brian was 81 at the time of his death; an examination of SARs[5] discovered that SARs were most frequently commissioned for persons aged 50-69, and Brian's age group was third in terms of the most SARs.

1.3.4 However, according to the data[6] for Safeguarding Adult Enquiries (Section 42: Care Act 2014), Brian's age group was the second most where enquires were made in Bristol, with 85 and up being the highest.

1.3.5 Brian had no control over the movement of his legs and used a urinal; Alan had purchased pads for Brian since, according to him, he was unable to use the urinal. Alan required support from carers due to his care requirements.

1.3.6 The paralysis put Brian at risk for pressure ulcers, thrombosis, bladder and bowel incontinence, and depression, resulting in a significant lifestyle adjustment.

1.3.7 Paid carers and Alan met Brian's personal care and well-being needs.

1.3.8 Persons reliant on others are at a higher risk of abuse[7]. Brian was dependent on Alan and his carers. However, healthcare professionals, including his GP, community nurses, a podiatrist, and a pharmacist, visited him. The health and social care

[4] https://www.spinalcord.com/paraplegia

[5] https://www.local.gov.uk/sites/default/files/documents/National%20SAR%20Analysis%20Final%20Report%20WEB.pdf

[6] https://digital.nhs.uk/data-and-information/publications/statistical/safeguarding-adults/2020-21#summary

[7] https://www.nhs.uk/conditions/social-care-and-support-guide/help-from-social-services-and-charities/abuse-and-neglect-vulnerable-adults/

professionals met with Brian alone, which may have enabled him to disclose abuse. However, it should be mentioned that concerns were expressed over Alan's alleged mistreatment of Brian. Brian lived with Alan and provided primary care for him. Therefore, it can be hypothesised that this may discourage Brian from exposing abuse, as the repercussions may require him to relocate to a care home or cause him to lose contact with his son. Brian never expressed concern regarding the care his son provided.

1.3.9 Brian was diagnosed with type 2 diabetes. In the United Kingdom, almost ninety per cent of people with diabetes have type 2 diabetes.[8] Diabetes can be managed with a healthier diet, increased physical activity, or weight loss. Brian was paralysed and inactive, yet Alan allegedly forced him to do weights before giving him water. Brian stated he had also become vegan and had not taken any medications since 2015. His blood sugar levels were not tracked, and the panel could not confirm that annual diabetic screenings had occurred as recommended by NICE[9]. During this time, Brian did not seek any medical attention that would have indicated he was having type 2 diabetes symptoms. He was seen by healthcare professionals who did not prescribe any diabetes treatment. However, he was offered diabetic eye screening appointments, which he did not attend. However, it should be acknowledged that he would have required to be transported to the appointments due to his need for assistance.

1.3.10 Diabetes UK[10] reports that some individuals can reverse diabetes with a particular diet and weight loss. Brian was not overweight, and the post-mortem found his Body Mass Index[11] healthy.

1.3.11 Due to his age and disability, Brian falls into the vulnerable group for safeguarding.

1.4 Terms of Reference/ Key Lines of Enquiry

1.4.1 This review attempts to identify the lessons learned from Brian's case and to respond to those lessons to prevent safeguarding-related deaths.

1.4.2 The terms of reference are included in Appendix 1.

1.4.3 KBSP commissioned a thematic review concerning self-neglect[12]. The review contained recommendations similar to those in this review:

[8] https://www.diabetes.org.uk/diabetes-the-basics/types-of-diabetes/type-2?gclid=Cj0KCQiA-oqdBhDfARIsAO0TrGHEy9Nf_FS575Po0FkkxXq6zMVGE53HPAOga-QPJaO-1RkFD1wPVO0aAhOwEALw_wcB
[9] https://www.nice.org.uk/guidance/ng28/ifp/chapter/what-your-diabetes-care-team-will-do
[10] https://www.diabetes.org.uk/diabetes-the-basics/type-2-reverse#:~:text=Some%20people%20have%20lost%20a,those%20aiming%20or%20diabetes%20reversal.
[11] https://www.nhs.uk/live-well/healthy-weight/bmi-calculator/
[12] https://bristolsafeguarding.org/media/wjdjkxw1/themat-1.pdf

- Information and support for informal carers, including medication, dietary requirements, and the carer's ability to meet the adult's care needs.
- Carers assessment
- Think family approach
- Self-neglect resource

1.4.4 The critical question to be addressed by the review was:

- What can agencies learn from the case about the effectiveness of care and support of adults dependent on others to attend to their needs, and where families/carers decline additional support or refuse entry to health care professionals?

1.4.5 The Safeguarding panel agreed on the following questions concerning Brian:

- How did agencies assess Brian's capacity, did they share assessments, and how did this impact the care Brian received?
- How was the principle of making safeguarding personal achieved? For example, did agencies consider Brian's wishes and feelings when providing care and treatment?
- Did agencies consider aspects of coercion and control by Brian's son?
- Did the son's refusal to allow agencies into the home impact professional practice?
- Were the assessments and decisions carried out appropriately and timely?

1.5 Methodology

1.5.1 A hybrid methodology combining root cause analysis and practitioner events was employed for a comprehensive and targeted review.

1.5.2 The first meeting of the review panel took place on the 28th of June 2022, during which panel members presented brief details concerning their agency's encounter with Brian.

1.5.3 The panel set the review term between 6th of June 2018 and Brian's death in August 2021. The panel decided that this time frame accurately reflects the challenges discovered during scoping and consultation with relevant agencies.

1.5.4 The panel met a total of six times.

1.5.5 A practitioner event discussed the work undertaken with Brian and the report.

1.5.6 All panellists were invited to share their thoughts on the recommendations they believed should be included in the final report. The panel discussed each of these recommendations.

1.6 Involvement of Family, Friends, Neighbours and Wider Community

1.6.1 The chair and review panel recognised the critical role Brian's family might play in the review.

1.6.2 To engage the family, the chair called Alan and sent him a text and a letter. However, no response was returned.

1.6.3 The panel knew he had a daughter who resided abroad, an ex-wife, and a regular visitor - William. However, the panel lacked contact information for the other members. In addition, William was 97 years old and frail. Consequently, Brian's voice is limited to agency recordings.

1.7 Contributors to the Review

1.7.1 The following agencies and their contributions to this review:

Agency and Profile	Contribution- Chronology/IMR/Letter/Other
Avon and Somerset Police	Chronology
Bristol City Council Adult Social Care	Chronology and Summary Report
Bristol Community Health *Bristol Community Health provided community health and care services in Bristol until 31st March 2020 and no longer operates.* *BNSSG ICB are the data owners and have provided the chronology for this review*	Chronology
Bristol, North Somerset and South Gloucestershire Integrated Care Board *In Bristol, North Somerset, and South Gloucestershire, the NHS, local government and the voluntary sector have been working in partnership for many years to improve care, provide more joined-up services, and agree and plan for local people's needs. Because of this, we received formal Integrated Care System (ICS) status in December 2020.* *From 1 July 2022, our ICS became a statutory (legal) entity under The Health and Care Act 2022.*	Chronology and Independent Management Review (GP)

Personal Care Provider *We provide personal care and support to people in their homes—Social Services, Health Authorities, and private individuals commission services.*	Chronology and Independent Management Review
Sirona care and health *We are funded by the NHS and local authorities, a not-for-profit social enterprise. They are commissioned to provide health care services.*	Chronology and Independent Management Review

1.8 The Review Panel Members

1.8.1 The Panel members for this review were the following:

Name	Role	Organisation
Parminder Sahota	Independent Chair & Author	P.S Safeguarding LTD
Christina Turner	Safeguarding Adults Practitioner	Sirona care and health
Jenny Thompson	Interim Designated Professional/Nurse for Safeguarding Adults	Bristol, North Somerset and South Gloucestershire Integrated Care Board
Lorena Evans	KBSP Safeguarding Partnership Coordinator	Keeping Bristol Safe Partnership
Rebecca Dible	KBSP Statutory Review Officer	Keeping Bristol Safe Partnership
Su Parker	Detective Inspector, Major Statutory Crime Review Team	Avon and Somerset Police
Tracey Judge	Head of Service N&W Locality; Safeguarding Adults, DoLS and Young Adults Service	Bristol City Council – Adult Social Care
Santosh Chaston	Director	Personal Care Provider

1.9 Chair and Author of the Overview Report

1.9.1 Parminder Sahota is an independent author who has worked in Safeguarding and Domestic Abuse for the past ten years. She completed Root Case Analysis Training in 2014, SCIE Learning Together Training in 2016 and DHR Chair training by Advocacy

After Fatal Abuse in 2021. She is a Mental Health Nurse who has worked in the NHS for over 20 years, specialising in crisis work and working with persons diagnosed with a personality disorder. She is currently employed by a National Health Service Trust as the Director of Safeguarding, Prevent, and Domestic Abuse Lead.

1.9.2 Parminder Sahota is independent of all agencies involved and had no prior contact with family members or the Keeping Bristol Safe Partnership.

1.10 Parallel Reviews

1.10.1 No parallel reviews.

2. Background Information

2.1. The Facts

2.1.1 In August 2021, Alan discovered Brian's body at their home. The coroner concluded the death a natural cause (Bronco Pneumonia and Urosepsis): Brian had significant health problems and was paralysed from the waist down. He depended on Alan for care and received twice-daily visits from carers, increasing to four times daily.

2.1.2 Brian's carers expressed numerous safeguarding concerns over the care he received from Alan. The family had a history of refusing entry to healthcare personnel. The carer also expressed concern regarding the status of the home, which was allegedly messy and filthy. The house had no hot water, and Brian was reportedly forced to wear damp, mouldy clothing. Brian was left without food or water for extended periods. His carers alleged that to observe Alan seize his water and demand that he completes activities such as bathing and dressing before drinking. As a result, Brian displayed symptoms of dehydration. A strategy meeting was scheduled. Unfortunately, this did not take place due to Brian's untimely death.

2.1.3 In addition to the issues voiced by Brian's carers, numerous agencies have identified safeguarding concerns in recent years. Brian and Alan declined more assistance after being referred for safeguarding.

2.1.4 Due to Alan's obstruction of care, the hospital reported a safeguarding concern for Brian in 2018.

2.1.5 Bristol Community Health additionally asserted that the rehabilitation team expressed a safeguarding concern following Brian's discharge from a care home to his own home in 2018.

2.1.6 Due to Alan's hostile behaviour, Sirona's records advised all carers to visit in pairs. Alan routinely declined visits from the Community Nurses.

2.1.7 Over the past years, Brian's GP received neglect reports from carers. According to reports, contradictory information existed. Alan, for instance, was described as loyal and attentive. The GP had no direct evidence of neglect or abuse, simply what the carers stated, although they observed a facial bruise. Brian received a visit from his GP the day before he passed away. The GP indicated no signs that he would die the next day.

2.1.8 When a neighbour complained that yelling could be heard from Brian's home, police were dispatched to the house. Even though it was evident that the relationship was strained, Brian and Alan refused assistance from the police since they believed they were already receiving enough. There were no allegations or disclosures of criminal conduct. A BRAG vulnerability assessment was undertaken, resulting in a green score (low vulnerability).

2.2 Background Information about Brian

2.2.1 Brian was a 81-year-old white British male who lived alone in a one-bedroom flat he owned. In 2016, Alan moved into Brian's flat to take care of Brian. Brian's flat is on one floor and is entered through five steps to the main shared front door.

2.2.2 Brian had two children: his daughter living abroad, and his son Alan.

2.2.3 Brian was a physical education teacher and had spent many years of his adult life in abroad.

2.2.4 Brian received a care package in February 2017; however, Alan assumed responsibility for his care due to the expense.

2.2.5 Brian was admitted to a therapy bed at a Nursing home in November 2017 for rehabilitation following his August 2017 hospitalisation. Brian developed bilateral cellulitis of the lower limbs. Cellulitis is an inflammation of the skin and subcutaneous tissue.[13]

2.2.6 Before his admission, Brian had spent almost nine days in a riser recliner when his chair broke, and he was forced to call the fire brigade for assistance.

2.2.7 Throughout his stay in the nursing home, Brian declined therapy. However, he and Alan asserted that Brian had not received rehabilitation, resulting in immobility.

[13] https://www.nhs.uk/conditions/cellulitis/#:~:text=Cellulitis%20is%20usually%20caused%20by,is%20too%20small%20to%20notice.

2.2.8 The physiotherapist who visited Brian's home observed that the surroundings were untidy and dirty. The physiotherapist and occupational therapist discussed urinary incontinence treatment possibilities. Brian declined a catheter, and a minor pressure area was observed on his right buttock. According to the therapists, Brian had little potential for recovery.

2.2.9 In February 2018, Brian was discharged from the nursing home with two carers to see him in the morning. However, Brian and Alan declined this support. Ten days later, they agreed for two carers to visit for 30 minutes in the afternoon, with Alan supporting Brian between visits. Alan, however, informed the social worker and community nurses that he had no intention of doing so.

3. Key Events

3.1 **July 2018** – Due to the contractures affecting Brian's legs, the physiotherapist reported in a letter to the GP that physiotherapy would not be beneficial.

3.2 **August 2019** – The pharmacist visited Brian at his home and spoke with Alan, who, according to the pharmacist, had strong views on pharmaceuticals and was vehemently opposed to the current medical practice and medications. Brian refused the flu vaccine and displayed some verbal aggression.

3.3 **December 2019** – The GP recorded that Brian refused to have his genitalia washed and enquired whether this was due to discomfort. Alan requested barrier cream.

3.4 **June 2020** – Personal Care Provider requested that the community nurses review Brian and treat his sacral sore as necessary. Due to Alan's verbal hostility, the Single Point of Access (triage for all community nurse referrals) indicated that visits must be conducted in pairs.

3.5 **June 2020** – The following day, at 1400hrs, the community nurses visited Brian's home following the referral. Alan answered the door and informed the nurse that his father was seated in a chair and would need to be in bed for an assessment. He instructed them to arrive before 1100hrs. Alan asserted that his father did not have a pressure ulcer and only had a mark; hence the nurses were unnecessary.

3.6 **June 2020** – The next day, the community nurses confirmed that Brian had a friction graze on his left buttock. The dressing was applied, and the pressure relieving equipment was inspected. They observed that Brian received care three times daily, with Alan aiding.

3.7 **June 2020** – During subsequent visits by the community nurses, Brian was advised that he would need a mattress to prevent the risk of pressure sores. Nonetheless, he declined. He was determined to have the capacity to make this decision.

3.8 **July 2020** – Personal Care Provider requested that the community nurses assess an open bleeding wound on Brian's bottom. Alan would not allow the nurses to see Brian after 1100hrs, so they were recommended to arrive before 1100hrs. The carers said that Alan had ordered and requested they apply turmeric cream; the carer declined and instead used the barrier cream left by the community nurses.

3.9 **July 2020** – Following a request, community nurses attempt a visit two days later. Alan denied them access, explained that he contacted the nurses when needed, and denied that the carers would have requested the visit. Alan stated that he would only permit prearranged meetings with his father. The case was discussed at the community nurse zonal meeting,[14] and it was agreed to discharge Brian.

3.10 **November 2020** – The podiatrist and podiatry assistant paid a visit. Brian and Alan initially declined the diabetic review and claimed that Brian did not have diabetes. However, podiatry treatment was administered, and a sixteen-week return was scheduled.

3.11 **November 2020 –** According to the carer, Alan was impolite to her; he urged her not to wear a mask, but she felt comfortable wearing one when dealing with urine and faeces. The carer advised Alan that if he objected to her wearing a mask, she would not return. Instead, Alan informed her he had contacts which would result in her not working in this country again. The carer was upset. She did, however, return to provide care to Brian.

3.12 **January 2021** – A member of the public called the police using the 999 number. They heard screaming, yelling, and furniture banging emanating from Brian's home. Officers were sent and discovered that Brian and Alan had been involved in a verbal altercation.

3.13 The police conducted background checks and filed an adult at-risk form for Brian, including a (Blue, Green, Amber, and Red vulnerability rating) green rating, noting the living situation and the twice-daily presence of carers.

3.14 Brian and Alan did not agree to a referral for safeguarding, yet a referral was made due to Brian's physical health and dependence on Alan. This was recognised as best practice. Adult Social Care verified that no further action was taken in response to the referral.

3.15 **April 2021** – The podiatrist and assistant returned and entered using the key safe. Alan apologised for not answering the door because he mistook them for 'census people[15]'.

[14] Meetings where nurses can discuss complex patients or those, they have concerns with senior nurses and other nursing teams from across the area.
[15] Census officers were visiting households that had not responded to the national census at this time.

3.16 **June 2021** – The carer contacted the single point of access to request a nurse visit since the sore on Brian's bottom had worsened, he was bleeding, and no dressings were available at home.

3.17 **June 2021** – The nurses attend the following day following the request. Initially, Alan was upset that the visit had not been scheduled. However, the nurses said their attempts to reach Brian on his mobile phone and landline were unsuccessful. Alan attempted to call the numbers, but there was no connection. Therefore, Brian consented to the nurses contacting Alan if they could not reach him. A full assessment was conducted; Brian reported having stopped taking medication in 2015 and started a vegan diet, which made him feel well and less tired. It was observed that Brian received care four times per day. Brian's sacral wound was superficial, and he declined a dressing; barrier cream was administered.

3.18 **August 2021** – (two days before Brian's death) Alan contacted the single point of access to request a urinary catheter for his father as Brian was experiencing difficulty and soreness. A clinician from the single point of access contacted Alan the following day (one day before Brian died). He reported that his father could not use the urinal and was getting a sore groin from being wet. Alan purchased pads and spoke to Brian's GP to discuss a catheter. The clinician explained the risks of catheterisation. However, Alan believed his father required this. Alan agreed for the community nurse to assess Brian for a catheter and redness in his groin.

3.19 **August 2021** – (two days before Brian's death), While providing Brian with personal care, the carer reported to their organisation that his groin and penis were infested with worms. They also said he was considerably dirtier than a week ago; he was depressed, seldom spoke, appeared confused, and slept in a filthy bed with bruises on his face. The organisation sought a house call from the GP.

3.20 **August 2021** (one day before Brian died), The GP made a house call; Brian indicated that he felt well and had no problems. The GP enquired about Brian's medications, to which he responded that they contained toxins and nitrates. Alan informed the GP that the nurses ceased administering the medicines six years ago. The GP regarded the flat as rather untidy, Alan was attentive and cooperative, and Brian was examined by the GP alone. The assessment revealed oedema in the thighs and pelvis and a small pressure ulcer on the sacrum. A call was made to the community nurses regarding the pressure ulcer to acquire blood and urine samples. The GP's notes suggest that the GP would report the carers' safeguarding concerns and address them with the community nurses and safeguarding staff.

3.21 The same day, the single point of access received a call from Brian's GP expressing safeguarding concerns related to Brian's pressure area care and catheter. The GP had raised a safeguarding concern related to Alan, whom he believed was withholding Brian's care. In addition, the carers alleged Brian had to work for water

by lifting weights. The carers had also noted Brian had a rash and found maggots. The GP reported that Alan had instructed Brian to no longer take medication.

3.22 **August 2021** – (One day before Brian's death) Adult Social Care requested police presence at a strategy meeting after Brian's care team voiced concerns. Unfortunately, the meeting did not occur due to Brian's unexpected death.

3.23 **August 2021** – The ambulance service notified the police of the unexpected death. The officers responded and complied with the Sudden Death Policy, and the completed report was forwarded to the Sergeant. No suspicious circumstances were discovered by paramedics or the police when the case was initially filed. However, upon receiving information from Brian's GP, Detective Inspector and the Coroner reviewed the matter. No additional police action would be taken. The coroner ruled that Bronchopneumonia and Urosepsis were the natural causes of death.

4. Practice Episodes and Analysis

4.1 Practice Episode One: Balancing the choice between alternative and conventional treatments

4.1.1 The practice episode discusses Brian and Alan's perspectives on alternative medicine.

4.1.2 Alternative medicine is substituted for conventional practice.[16] In the UK, around 9 million people use complementary or alternative medicine.[17]

4.1.3 According to a 2010 House of Commons report[18], homoeopathic cures fared no better than placebos.

4.1.4 NHS England recommended in 2017 that GPs[19] and other prescribers discontinue providing it. It said: "There is no good-quality evidence that homoeopathy is effective as a treatment for any health condition". At the same time, the National Institute for Health and Care Excellence (NICE) does not recommend using homoeopathy for any clinical condition. However, the practice remains popular among some patients seeking alternative or complementary therapy.

4.1.5 Brian ceased taking prescribed medicine in 2015; according to the GP's records, the last prescription was issued in September of that year.

[16] https://www.nhs.uk/conditions/complementary-and-alternative-medicine/
[17] https://collegeofmedicine.org.uk/complementary-medicine-roundup-december-2017/#:~:text=In%20the%20UK%2C%20it's%20estimated,practitioners%20and%20150%2C000%20medical%20doctors.
[18] https://publications.parliament.uk/pa/cm200910/cmselect/cmsctech/45/4502.htm
[19] https://www.england.nhs.uk/wp-content/uploads/2017/11/sps-homeopathy.pdf

4.1.6 The carers observed worms in Brian's groin area. The GP recorded that they were maggots but did not observe them. Maggot therapy is a recognised method for removing necrotic, sloughy, or diseased tissue from a wound. They can also keep a wound clean.[20] However, this should only be used in a clinical setting with specially bred maggots. This therapy was not prescribed to Brian, and it was unclear how the maggots or worms were procured or applied.

4.1.7 Alan had purchased turmeric cream to substitute for the community nurse's supply. Research has not established the health advantages of turmeric.[21] However, turmeric is used to treat various ailments; turmeric cream is widely available at most health food stores, claiming that it can aid in wound healing.

4.1.8 A day before Brian's death, the GP enquired about his thoughts on medication, to which he replied, "They are full of poisons and nitrates." Alan mentioned that the nurse had discontinued the prescription six years prior. Nurses do not prescribe medication, so they cannot cancel a prescription.

4.1.9 The practitioners spoke of diverse backgrounds and cultures routinely using alternative medicines and noted that Alan was into homoeopathy. They discussed the necessity of ensuring capacity is assessed when discussing medication.

4.1.10 The GP at the practitioner event confirmed they would discuss alternative medicine together with mental capacity and observed that patients typically use both conventional and alternative medicine concurrently.

4.1.11 In addition to supporting patient choice, the possibility of liaising with a homoeopathic doctor was advised to address alternative medicine and strengthen the engagement of the patient.

4.1.12 Brian reported feeling better and having more energy after adopting a vegan diet; his post-mortem revealed no anomalies in his blood testing, indicating no diabetes-related issues.

4.2 Practice Episode Two: Alan's engagement with services

4.2.1 The second episode focuses on Alan's verbal aggressiveness towards healthcare workers.

4.2.2 Due to Alan's verbal hostility, the single point of access recorded that community nurses should visit in pairs.

[20] https://www.chelwest.nhs.uk/your-visit/patient-leaflets/tissue-viability/maggot-therapy#:~:text=Maggot%20therapy%20involves%20the%20use,considered%20prone%20to%20re%2Dsloughing.
[21] https://www.nccih.nih.gov/health/turmeric

4.2.3 During the carer's visit, Alan threatened the carer that he could stop her from working, and the pharmacist described him as hostile.

4.2.4 According to the Health and Safety Executive, nine out of ten workers have been injured due to workplace violence. Within public services, Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 indicates that the health and social care sector accounts for more significant incidents.[22]

4.2.5 Alan disliked nurses because he believed they did not know what they were doing and was upset with their visit timings, according to the nurse at the event.

4.2.6 All practitioners mentioned having access to assistance following a difficult visit.

4.2.7 The panel discussed gender, the role of informal carers, and how stereotypes of what a carer should be may exist and influence our impressions of them.

4.2.8 A study[23] on this found that male carers would take on the role as an occupation, attending to responsibilities with a logical mind and keeping parts of emotional care in the background. In contrast, female carers were more sentimental and put emotions first.

4.2.9 It revealed that male carers were task-oriented and more likely to use enforcement measures to ensure the care receiver cooperated, whereas female carers were seen as more caring.

4.3 Practice Episode Three: Coercion and control

4.3.1 The Government definition of controlling or coercive behaviour[24] is: *Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation, intimidation, or other abuse used to harm, punish, or frighten their victim. Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.*

4.3.2 In January 2021, the police were summoned to the address due to yelling and screaming. Regarding this, they raised a safeguarding concern to adult social care.

4.3.3 The GP expressed concern that Alan may be pressuring Brian not to take his medication, which also generated a safeguarding concern for adult social care.

[22] https://www.hse.gov.uk/statistics/causinj/violence/work-related-violence-report.pdf
[23] https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-021-06736-2
[24] https://www.cps.gov.uk/legal-guidance/controlling-or-coercive-behaviour-intimate-or-family-relationship

4.3.4 The carers describe Alan as denying him water and telling him to work weights before he could drink. He would also require that Brian perform workouts before receiving personal care. Alan stated that this was his method for working with his father and that he believed it was beneficial. This issue was also raised as a safeguarding concern to adult social care. The research on gender and carer roles confirmed Alan's strategy.

4.3.5 The perceptions of Brian and Alan's relationship were contradictory. The carer and the GP raised safeguarding concerns. However, they also stated that Alan's bond with his father was loyal. He was cooperative and assisted the carers with his father's care.

4.3.6 The most prevalent kind of domestic violence is controlling or coercive behaviour, which victims may suffer with or without physical assault. The perpetrator may appear charming and kind on the surface.[25] For example, Brian relied on his son for all his care needs; Alan was listed as Brian's carer and frequently spoke on his behalf. Despite concerns voiced to adult social care since 2017 regarding the relationship, the panel did not find evidence that coercion or control had been considered.

4.3.7 The 2015 Serious Crime Act added Section 76, which criminalises controlling or coercive behaviour in an intimate or familial connection. However, proving this is difficult because the victim must fear that the perpetrator would use violence against them, or this has caused them significant harm or distress and has a significant negative impact on their daily activities.[26] Therefore, it is not unexpected that the number of offences is low.

4.3.8 Although the number of police-recorded Coercive Controlling behaviour offences has increased from 4,246 in 2016/17 to 24,856 in 2019/20, it is recognised that identifying and understanding coercion and controlling behaviour can be improved.[27]

4.3.9 Carers need a great deal of emotional and physical energy. The Carer's Trust[28] has emphasised the pressure this can place on the relationship and the necessity for carers to seek assistance and for agencies to support them in their duty.

4.3.10 Alan had previously declined a carer assessment; however, the panel concluded that this decision should have been reconsidered in January 2021, considering concerns about the home environment, Alan's frustration, and his father's claim that Alan has mobility issues.

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[25] https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/coercive-control/

[26] https://www.cps.gov.uk/legal-guidance/controlling-or-coercive-behaviour-intimate-or-family-relationship

[27] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/982825/review-of-the-controlling-or-coercive-behaviour-offence.pdf

[28] https://carers.org/health-and-wellbeing/health-and-wellbeing

4.3.11 The Home Office published the statutory guidance framework Controlling or Coercive Behaviour in an Intimate or Family Relationship. The guidance states that controlling or coercive behaviour should be dealt with as part of adult and/or child safeguarding and public protection procedures.[29] Consequently, the agencies that raise issues regarding adult social care are suitable. However, these enquiries were closed due to Brian's request not to pursue this and because he did not view himself as a victim.

4.3.12 Safeguarding and coercion and control will be further discussed in practice episode five.

4.3.13 The practitioners spoke of the challenges of seeing Brian alone, as Alan was always present.

4.3.14 Moreover, it was stated that Brian may not have recognised that he was in a controlling and coercive relationship. There was also the discussion surrounding influence and control and where the line was drawn. Brian had declined the Flu Vaccine, and it was uncertain whether his views on medicine were his own. However, he claimed to feel better, and his post-mortem revealed no complications related to discontinuing the medication.

4.4 Practice Episode Four: Making safeguarding personal

4.4.1 Making Safeguarding Personal (MSP) is a sector-led strategy that seeks to promote a focus on outcomes for safeguarding work and various approaches to assist individuals in improving or resolving their circumstances.[30]

4.4.2 Adult social care spoke with Brian in response to a safeguarding concern raised by the ambulance service. He did not consider himself a victim of abuse and requested that no protective measures be required.

4.5 Practice Episode Five: Safeguarding

4.5.1 Adult Social Care received a safeguarding adult concern raised by the GP in August 2017; the concern was that Brian had stopped taking his medication at the recommendation of his son. In addition, Brian had not seen his GP for one year. This

[29] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/482528/Controlling_or_coercive_behaviour_-_statutory_guidance.pdf

[30] https://www.local.gov.uk/our-support/sector-support-offer/care-and-health-improvement/making-safeguarding-personal#:~:text=Making%20Safeguarding%20Personal%20(MSP)%20is,improve%20or%20resolve%20their%20circumstances.

did not fulfil the threshold for a Section 42 enquiry and would be addressed during his hospital stay.

4.5.2 Concerned that Alan was not delivering care by the hospital's discharge plan and receiving one call per day from carers, Bristol Community Health raised a safeguarding adult concern to Adult Social Care in March 2018. Brian was rendered faeces incontinent. It was also stated that Alan affected Brian by speaking over him.

4.5.3 The ambulance service reported to adult social care in March 2018 that Brian's care needs were not fulfilled because his bed collapsed, and carers could not provide care safely. The social worker spoke with the ambulance service, who believed Alan was impeding treatment for Brian; he was not maintaining the property and was unkempt.

4.5.4 According to reports, Brian consumed a vegan diet and did not take any medications; he obtained information from the internet and believed that taking medication would shorten his life. Brian was assessed to have the capacity to stop medications.

4.5.5 The social worker visited Brian in the hospital in response to the ambulance's concerns. Brian claimed he was dissatisfied with receiving additional care because he feared he would have to sell his house to pay for it. He was informed that a financial assessment would be required to ascertain this. Concerns regarding Alan's impact on Brian's decision-making were posed to Brian. Brian added that Alan disliked having carers in his home because "they boss him around and tell him to do this and that." Additionally, Alan had mobility issues, which hindered him. Brian did not want the safeguarding to be continued and reported that his son had not committed any wrongdoing or acted maliciously. He indicated he would be unwilling to pay for additional care because "they've already taken my savings away."

4.5.6 The social worker discussed the concerns with the doctor who had spoken with Brian's son and daughter and described them as "new age", and they had advised Brian to use alternative medications. However, according to the doctor, this was not a safeguarding issue.

4.5.7 In June 2018, the care agency reported a safeguarding concern that Alan had dressed Brian in a slightly damp T-shirt, and the carers could not locate a dry T-shirt. As a result, Brian was scheduled for an adult social care review, and it was decided that a laundry service would be addressed. As a result, the concern was closed.

4.5.8 In August 2018, the care agency filed a safeguarding concern; Brian had suffered a burn from coffee, and Alan became aggressive when they attempted to involve the community nurse; he refused input from the community nurse and GP. Adult social care assessed the situation and determined that Brian received twice-daily care visits and had accepted treatment for the now-healing burn. However, social care did not

contact Brian since the agency did not inform him of the concern and did not intend to damage their relationship with Brian.

4.5.9 The police raised a safeguarding concern in January 2021; Alan had been verbally hostile against Brian and "frustrated with his behaviour." Brian declined the referral and advised adult social care that he is satisfied with the care he receives from his son and the carers. According to the care agency, Alan assisted staff daily in caring for Brian and was regarded as a devoted son. Therefore, the safeguarding was closed.

4.5.10 Alan was allegedly withholding water and making Brian lift heavy weights when hungry, fatigued, and thirsty; the care agency claimed he was "disciplining him like a child" in August 2021. In addition, Alan had requested that Brian be dressed in damp clothing. According to his carers, Brian was withdrawn and silent. He also had bruises on his face and hands, resulting from a fall. This appears unlikely to be a plausible explanation for Brian's bruises, given that he was cared for in bed. There were concerns that he was dehydrated and passing a "jelly-like substance" when he opened his bowels. A section 42 Care Act 2014 enquiry was initiated. Adult social care contacted the community nurses, who stated the case was inactive after a phone call to confirm that the pressure ulcer had healed. Adult social care contacted the GP, who consented to see Brian; he described Alan as cooperative, attentive, and resistant to medical interventions.

4.5.11 When adult social care receives a safeguarding concern, an adult's capacity to make decisions regarding their safety and desired support must be considered. The presumption of capacity is the first principle of the Mental Capacity Act of 2005. Adult social care had no cause to suspect Brian lacked the capacity, and agencies backed a declaration that he had the capacity.

4.5.12 However, there are complex situations where a person may have impaired capacity due to the impact of abuse or being coerced.

4.5.13 In a Court of Protection ruling (A Local Authority v DL, RL, and ML [2010] EWHC 2675) and a subsequent Court of Appeal ruling, it was determined that "inherent jurisdiction" could be utilised in such a situation. The elderly parents of DL, a 50-year-old man, were prevented from exercising their decision-making competence due to coercive and controlling behaviour towards them.[31]

4.5.14 Local authorities can apply to the Court of Protection for applicable orders to safeguard individuals who cannot make decisions due to the level of coercion and control exercised over them. Therefore, the social worker must be informed of civil and criminal justice possibilities, collaborate with organisations such as the police to

[31] https://www.39essex.com/information-hub/case/local-authority-v-dl-rl-ml

obtain evidence, and ensure the health and welfare requirements of the adult are satisfied.

4.5.15 Adult social care collaborated with the hospital doctor and community nurses. The doctor informed the social worker that the case did not need safeguarding, and the community nurses had ceased working with Brian. The social worker called the police to ask them for a strategy meeting in August 2021; regrettably, this was to occur after Brian's death.

4.5.16 In this scenario, gathering evidence to bring before the Court of Protection would be challenging. The available evidence consisted of the eyewitness testimony of the carers. The pharmacist had portrayed Alan as aggressive; nevertheless, this hostility was directed at their conflicting beliefs on medicine. The community nurses reported that Alan would not grant them access; however, the additional investigation revealed that the visits had to occur before 1100hrs and that Brian had agreed. A photograph of the facial bruise was not requested, and the doctor's report regarding the son was positive. Therefore, the panel concluded that this case did not meet the criteria for referral to the Court of Protection.

4.5.17 Brian was seen by carers four times daily, which functioned as a protective measure.

4.5.18 In addition to the themes, the practitioners identified the following as learning opportunities they wished to pursue as part of the review:

- Information sharing – to support decision making
- Escalation and challenge concerning outcomes of safeguarding adult concerns
- To consider multi-agency meetings to discuss complex cases

4.5.19 The panel has approved the practice episodes, which have been accepted following a practitioner event. The events have highlighted and demonstrated the challenges Brian, Alan, and the agencies faced. Agencies have shown good practice by persevering and ensuring all partner agencies participated in Brian’s care. In addition, individual agencies have endeavoured to improve their practices, as seen by the recommendations included under Individual Agency Recommendations.

5. Conclusions

5.1. This review aims to establish the circumstances surrounding Brian's death in August 2021 and to describe life through his eyes.

5.2. Brian's death was attributed to natural causes, and there was no indication of negligence or grounds for concern in the post-mortem report. However, numerous referrals to Safeguarding citing possible neglect by Alan toward his father prompted the review.

5.3. The only source of Brian's voice is agency communications with him. The carers who visited Brian at home reported having developed an excellent rapport with him, and their relationship was described as trusting. Unfortunately, the carers left the organisation before this review began, preventing access to Brian's voice.

5.4. Five themes have emerged from the review findings captured in the practice episodes. The themes were derived from the material shared with the author, including the practitioner event.

5.5. The review concluded that Brian's death was not preventable, and its themes aim to support and improve safeguarding practice.

5.6. According to the review's findings, seven safeguarding concerns were made to adult social care. One part of learning is triangulating these to ensure that agencies work together to protect the adult. However, it was clear that not all agencies shared the same concerns since Alan was described as a loyal son and cooperative. This division ought to have convened a conference of professionals to discuss their concerns and professional opinions regarding Brian and the care he received.

5.7. The review uncovered the use of alternative therapy; however, there was no evidence that healthcare professionals had explored this option with Brian or Alan, nor were they assisted in making informed decisions. As maggot therapy is a recognised form of treatment, giving Brian this option or informing him of when and how it is used may have helped healthcare professionals work with him and, if necessary, supplement the medication he was prescribed.

5.8. Brian reportedly had diabetes but had not taken medicine in seven years and was following a vegan diet. According to him, this benefited his health, and he did not experience any negative consequences for not adhering to his treatment. Additionally, healthcare professionals did not report any detrimental effects.

5.9. Brian had expressed financial concerns, hence his reluctance to increase the number of carers. He owned his home but feared selling it to pay for carers because his savings had been depleted. Brian was advised that he would have a financial assessment, but it should have been made clear that he would only need to sell his home if he moved into a care home.[32]

5.10. The safeguarding concerns associated with coercion and control. The panel has agreed to additional work in this area to ensure that all practitioners are aware of the indicators and have a greater understanding of the procedure for supporting adults experiencing this. The recommendations of the single agency support these.

[32] https://www.nhs.uk/conditions/social-care-and-support-guide/money-work-and-benefits/paying-for-your-own-care-self-funding/

6. Recommendations to the Board

6.1. Individual Agency Recommendations

Adult Social Care

6.1.1 An allocated worker should have undertaken 6.1.1 A Care Act review/reassessment and potentially undertaken a face-to-face visit and noticed the state of the property. Later, the frustration, issues with the damp T-shirt, etc., may have been more opportunities to examine in context clearly, enabling a relationship built with Brian (and Alan in his caring role).

Personal Care Provider

6.1.2 Therefore, we will be giving all our staff further training on the following:

- Safeguarding
- Further training on reporting concerns
- Recognising Abuse
- Handling abusive and aggressive behaviour
- "What is intimidation" and why it needs reporting

6.2. Multi-agency Recommendations

6.2.1 Recommendation one: Balancing the choice between alternative and conventional treatments

6.2.1.1 To ensure that patient's treatment preferences are not disregarded, the prescriber should discuss their preferences with them to assist patients in making informed decisions. In addition, the prescriber should document all findings, including Mental Capacity and the principle of making unwise decisions.

6.2.1.2 To ensure that all agencies are working together, a care plan should be in place to identify individual choices that consider their opinions and requests for treatment, as well as a contingency agreement of what should happen if the individual's choice is ineffective.

6.2.1.3 The plan should also include the agreed-upon response to future emergencies, such as death or cardiac arrest: ReSPECT plan.[33]

6.2.2 Recommendation Two: Engaging with carers

6.2.2.1 All carers must be offered a carer's assessment per the Care Act 2014.[34]

[33] https://www.resus.org.uk/respect/respect-healthcare-professionals
[34] https://www.legislation.gov.uk/ukpga/2014/23/section/10/enacted

6.2.2.2 Practitioners should be aware of the study identifying carer stereotypes and how this may influence their perceptions. To offer practitioners awareness sessions so they can respond to the requirements of informal carers and determine how they complete the activities, they have agreed to. For example, identifying how informal carers do their tasks and providing resources to increase this and decrease carer burnout.

6.2.2.3 A carers campaign will be created and launched during Carers Week. Work with statutory and non-statutory organisations to reach informal caregivers who do not regularly use statutory services.

6.2.3 Recommendation Three: Coercion and Control

6.2.3.1 To consider the statutory guidance[35]: Controlling or Coercive behaviour and ensure the partnership complies with the published guidance.

6.2.3.2 Agencies must ensure their staff can recognise and respond to coercion and control. Staff should have easy access to documentation to record and refer concerns and prompts to consider all aspects of domestic abuse.

6.2.4 Recommendation Four: Making Safeguarding Personal

6.2.4.1 The review found that agencies did hear Brian's voice but that it was difficult to speak to him alone at times owing to the setting (he lived in a one-bedroom flat with his son).

6.2.4.2 To ensure that the partnership's approach for making safeguarding personal includes the concepts outlined in SCIE[36] and is disseminated and available to all staff.

6.2.5 Recommendation Five: Safeguarding

6.2.5.1 The SAB will ensure the escalation procedure is streamlined and easily accessible to all staff.

6.2.5.2 Strategic managers should encourage and empower staff to contest decisions and escalate as needed.

6.2.6 The Keeping Bristol Safe Partnership will develop and monitor the recommendations.

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35 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/482528/Controlling_or_coercive_behaviour_-_statutory_guidance.pdf

36 https://www.scie.org.uk/care-act-2014/safeguarding-adults/safeguarding-adults-boards-checklist-and-resources/making-safeguarding-personal.asp

Appendix 1: Safeguarding Adult Review 'Brian': Terms of Reference

1. Introduction

A Safeguarding Adults Review (SAR) is a multi-agency review process that seeks to determine what agencies could have done differently that could have prevented harm or death. A Safeguarding Adults Board (SAB) has a statutory duty to arrange a SAR when:
a) An adult with care and support needs have died, and the SAB knows or suspects that the death resulted from abuse or neglect, or an adult is still alive, and the SAB knows or suspects that they have experienced serious abuse or neglect,

b) And when there is reasonable cause for concern about how the Board, its members or others worked together to safeguard the adult.

Board members must co-operate with and contribute to the SAR to identify lessons learnt and ensure that learning is shared and applied in the future.
(The Care Act 2014: Section 44)

This Safeguarding Adult Review is commissioned with due regard to the Care Act 2014, in response to the death of Brian in August 2021.

The coroner requested a review of the sudden death. The police concluded Brian had care and support needs, and it is suspected that neglect may have contributed to his death at the least.

Parminder Sahota has been appointed as the Independent Chair and Author of the review panel and agreed to commence these duties on 8th June 2022.

2. Purpose and Aim of the Safeguarding Adult Review

The purpose of a SAR is not to apportion blame. It promotes effective learning and improvement to prevent future deaths or serious harm from occurring again.

The objectives include establishing:

- lessons that can be learnt from how professionals and their agencies work together
- how effective the safeguarding procedures are
- learning and good practice
- how to improve local inter-agency practice
- service improvement or development needs for one or more services or agencies.

Lessons learnt are shared to maximise the opportunity to better safeguard adults with care and support needs who may be at risk of abuse or neglect.

3. Panel members, expert witnesses, and advisors

The following agencies and individuals constitute the SAR panel:

Su Parker	Avon and Somerset Police	SP
Jacqueline Keane/ Carol Sawkins	Operational lead for safeguarding, University Hospitals Bristol and Weston NHSF trust Lead Safeguarding Nurse, University Hospitals Bristol and Weston NHSF trust	JK/ CS
Tracey Judge	Head of Service Safeguarding Adults and Specialist Teams, Bristol City Council	TJ
Jenny Thompson	Interim Designated Professional/Nurse for Safeguarding Adults, BNSSG Clinical Commissioning Group	JT
Christina Turner	Safeguarding Adults Practitioner, Sirona Care and Health	CT
Santosh Chaston	Director, Personal Care Provider	SC

4. Scope of the Review

Period

The panel decided that the review should focus on the period between 6th June 2018 to Brian's death in August 2021. The panel agreed that this period reflected the issues identified through scoping and contact with agencies in respect of these.

The panel requested that any relevant known information before the period outlined be included in summary form unless it became apparent to the independent chair that the timescale should be extended.

Individual management reviews (IMR) and other reports

Individual management review and comprehensive chronology are to be requested from the following organisations:

Agency and Profile	Contribution- Chronology/IMR/Letter/Other
Avon and Somerset Police	Chronology
Bristol City Council Adult Social Care	Chronology and Summary Report
Bristol Community Health ***Bristol Community Health provided community health and care services in Bristol until 31st March 2020 and no longer operates. BNSSG ICB are the data owners and will provide the chronology for this review***	Chronology
Bristol, North Somerset and South Gloucestershire Integrated Care Board	Chronology and Independent Management Review (GP)
Personal Care Provider	Chronology and Independent Management Review
Sirona Care and Health	Chronology and Independent Management Review

All chronologies should be completed and returned by **26th July 2022** (four weeks from 28th June 2022: First Panel Meeting).

All agencies required to submit IMRs are asked to respond to the critical lines of enquiry listed below and reflect the case's complexity. They are asked to consider additional factors which may have camouflaged or hidden abuse. Brian was paralysed from the waist down and depended on his son and carers visiting twice daily. The carers had raised safeguarding concerns about the care Brian received from his son. There was a history of the son not allowing healthcare professionals in the house, and the home's state was described as untidy and unclean.

Key lines of enquiry

This review aims to identify the learning from Brian's case and for action to be taken in response to that learning: to prevent deaths related to safeguarding.

The critical question to be addressed by the review is:

- What can agencies learn from the case about the effectiveness of care and support of adults dependent on others to attend to their needs, and where families/carers decline additional support or refuse entry to health care professionals?

The Safeguarding Panel agreed on the following questions concerning Brian to be addressed in this review:

- How did agencies assess Brian's capacity, were the assessments shared, and how did this impact the care Brian received?
- How was the principle of making safeguarding personal achieved? Did agencies consider Brian's wishes and feelings when providing care and treatment?
- Did agencies consider aspects of coercion and control by Brian's son?
- Did the son's refusal to allow agencies into the home impact professional practice?
- Were the assessments and decisions carried out appropriately and timely way?

5. Family involvement

The SAR will seek to involve Brian's family in the process, considering who the family wishes to be involved as lead members and identifying other people they think are relevant to the SAR process.

We will seek to agree a communication strategy that keeps the family informed, if they so wish, throughout the process. We will be sensitive to their wishes, their need for support and any existing arrangements that are in place to do this.

6. Findings and recommendations

It is intended to consult with the following agencies and individuals to provide a view of the findings and recommendations arising from the report:

- Keeping Bristol Safe Partnership
- Avon and Somerset Police
- Bristol City Council Adult Social Care
- Bristol, North Somerset and South Gloucestershire Integrated Care Board
- Personal Care Provider
- Sirona Care and Health

Other appropriate agencies and people may be identified during the review.

7. Media and communications

All media and communication management will be through the Communications Team of Bristol City Council in consultation with the Independent Chair and the Chair of Keeping Bristol Safe Partnership.

Following an information governance review, it is anticipated that the SAR will be published on the Keeping Bristol Safe Partnership website.

8. Terms of reference agreed

The safeguarding adult review panel agreed upon these terms of reference following their initial Panel meeting on 28th June 2022.

The terms of reference will be kept under review by the panel throughout the review.