SAFEGUARDING ADULT REVIEW

OVERVIEW REPORT

FOR ADAM

Reviewer – Stuart Douglass

Date of Completion – April 2025

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1. introduction

1.1 Adam was a 40-year-old male from the travelling community who died in the Intensive Care Unit at Southmead Hospital in January 2024. Adam had significant health challenges in the later part of his life because of illicit drug use. Adam was brought to the hospital emergency department by a close friend due to abdominal pain in late 2023. Adam was admitted to the hospital being severely underweight with pressure sores, flu positive and self-neglecting. Adam had a 20-year history of using illicit substances including Ketamine causing significant bladder and organ damage.

1.2 Due to recent agency involvement and concerns relating to neglect a safeguarding enquiry[1] was instigated, sadly however, in the following days Adam died.

1.3 The Keeping Bristol Safe Partnership[2] (KBSP) Board reviewed the circumstances and commissioned a Safeguarding Adult Review (SAR) in line with the Care Act 2014[3].

1.4 The purpose of a SAR is to gain, as far as is possible, a common understanding of the circumstances surrounding the death of Adam and to identify if agencies, individually and collectively, could have worked more effectively, and to promote learning and improvement to prevent future deaths or serious harm from occurring again. The purpose is **not** to apportion blame to any agency or individual.

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

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

1.6 Stuart Douglass was commissioned to write the overview report. He has previously worked in local government for over 30 years as a senior manager of community safety and a children's safeguarding board in a large northeast city. Stuart is an experienced reviewer and has previously led reviews related to travelling communities and substance users.

1.7 This report uses pseudonyms. The subject has been called Adam, and his former partner and friend has been called Sarah. Adam also had support and contact with his brother, sister and adult son who are referred to but have not been named in this report.

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[1] Section 42 (s42) of the Care Act gives Local Authorities the primary duty to make, or cause to be made, whatever enquiries are necessary to enable the Local Authority to decide whether any action should be taken in the adult's case, and if so, what and by whom.

[2] The Board undertakes key statutory and strategic partnership functions relating to keeping children, adults and communities safe. https://bristolsafeguarding.org/about-us/who-we-are

[3] Care Act 2014, sections 44(1), (2) and (3), requires that a Safeguarding Adult Review (SAR) is undertaken where an adult with care and support needs has died or suffered serious harm, and it is suspected or known that the cause was neglect or abuse, including self-neglect, and there is concern that agencies could have worked better to protect the adult from harm.

2. Review Methodology

2.1 A multi-agency panel of the KBSP was established to oversee the SAR. Following panel discussion and assessment of initial information Individual Management Reports were collated together with a chronology of contacts and events.

2.2 The review has focussed upon the 2-year period[4] prior to Adam's death which reflected a period where Adam's health had significantly declined and brought him into contact with agencies.

2.3 The following agencies were involved in the review.
GP Practice/Integrated Care Board
Avon and Somerset Police
North Bristol NHS Trust
University Hospitals Bristol and Western
Developing Health and Independence
Bristol City Council Adult Social Care
Bristol City Council Housing and Landlord Services
Bristol City Council Gypsy, Roma Traveller Service (specialist advisers to the review)
South Western Ambulance Service Trust
Sirona care and health CIC
Department for Work and Pensions

2.4. **Family and friends contact**

2.5 The review attempted to contact Adam's sister, his former partner Sarah, and his adult son via both letter and telephone contact. Adam's sister and adult son did not respond. Sarah initially indicated willingness to be contacted via text and had explained that she had not been in a relationship with Adam for over 20 years (and was the mother of his adult son). She indicated that she had remained a friend and been recorded as Adam's next of kin in the period prior to his death. After several further attempts to make contact there was no further response. It is always understandable that families and friends who have experienced loss may find engagement in reviews difficult, and their participation is voluntary and their decisions to not participate are fully respected. It has been challenging to hear Adam's voice in the review however agencies did reflect this in their records.

2.6 The specialist Gypsy Roma Traveller Service in Bristol were approached to assist in contacting members of the travelling community who may have known Adam and contact details to contact the reviewer anonymously were circulated in the community. No contacts were forthcoming.

2.7 **Parallel processes**

2.8 The conclusion of the coroner (July 2024) was that Adam died from multi organ failure, influenza A, chronic ketamine usage and malnutrition, bilateral hydronephrosis[5].

[4] The panel further considered relevant information concerning Adam before this period where it was available.

[5] Bilateral hydronephrosis occurs when urine is unable to drain from the kidney into the bladder.

He died from complications due to long term use of Ketamine and that the cause of death was drug related.

2.9 The Department for Work and Pensions commissioned an internal review following the request for information in respect of this review.

2.10 North Bristol Trust undertook a mortality review[6] to provide an insight into whether there were any issues or problems with care provided.

The Structured Judgement Review found that Adam was frail and cachectic[7] on admission (21/01/24) and in multi-organ failure with flu and Methicillin Sensitive Staphylococcus Aureus pneumonia (MSSA). He had a high risk of death on that final admission.

2.11 Bristol Adult Social Care received a safeguarding referral for Adam in January 2024 upon his admission to hospital. This referral was triaged with regard to the statutory criteria in S.42[1] Care Act 2014. The grounds were found to be met by the allocated practitioner, and their line manager agreed. This then triggered S.42[2] of the Act which states that the local authority must make, or cause to be made, necessary enquiries in order to decide what action should be taken.

Information was collected by the social work team assigned the S.42[2] enquiry, but by the time work started Adam was deceased and the enquiry was closed soon after this on that basis.

2.12 There were no other parallel investigations.

3. Adam the person - background and personal information

3.1 Adam is recorded as being born in the North West region of England in the 1980s. It is understood from his accounts that he had lived in caravans from a young age, suggesting that he may have lived in the travelling community from childhood. Adam indicated that he had family who lived in caravans abroad and that his mother lived abroad. He was reportedly known in the Bristol van dwelling community. The Department for Work and Pensions had recorded that Adam had dyslexia, had never worked and had no qualifications.

3.2 It is known that Adam has a sister and brother, as they were present and supporting him at various times during his periods of medical treatment. Adam is understood to have had three children who did not live with him, the oldest child being an adult. The mother of the adult child, Sarah, had not been in a relationship with Adam for 20 years but remained supportive and was recorded as his next of kin when his health deteriorated significantly. Sarah and Adam's sister were recorded as living at addresses

[6] These reviews are undertaken by a single clinician using the notes for the patient's last admission. These are quick, subjective reviews and if any problems are identified it may result in a more thorough review such as a PSII (Patient Safety Incident Investigation)

[7] Cachexia, sometimes referred to as wasting syndrome. Symptoms can include severe weight and fat and muscle loss and anaemia – source https://www.cancerresearchuk.org

in the city. Adam may have been staying with his sister in the period just prior to his death though it has not been possible to confirm this.

3.3 It is not known if Adam had previously been employed, though it was recorded by the Department for Work and Pensions that he had claimed benefits and had not previously worked.

3.4 Adam was dyslexic and as such struggled to read and communicate via written communication.

3.5 Adam had used the drug ketamine for over 20 years and this use had caused significant harm to his physical organs.

4. Case chronology and key events

August 2020 – Adam was recorded as being attended to by an ambulance service following transfer of a 999 call from the 111-service due to a possible urinary tract infection, back and bladder pain. Adam was recorded as living on a caravan site but was staying at a hotel to "get away" to feel better. Notes showed Adam had long term bladder and bowel problems due to ketamine use and had recently seen his GP and had been referred to the urology department 10 days earlier. Notes indicated Adam disclosed daily ketamine and weed use. Adam did not want the ambulance, and it had been called by a concerned friend. Adam was assessed, given words of worsening advice and advised to follow up with his GP for a Urology referral and to seek support with drug rehabilitation.

Comment - This incident illustrated that in 2020 Adam was experiencing a high level of physical symptoms associated with ketamine use and that this was an ongoing issue. Adam declined support despite the concern of his friend. The incident occurred in the period between the first and second COVID19 UK wide lockdowns.

Late May 2022 – Adam is assaulted at 930am by unknown "strangers" with a baseball bat whilst he was in his converted van/truck. He had multiple injuries including a deep laceration to the head and injuries to his arm and leg. Ambulance, and police attended, and Adam was subsequently conveyed to hospital. The ambulance crew recorded that when they arrived Adam was with his partner and friends. It was recorded that he had 3 children but that they lived with their mothers. Police had been called by a friend of Adam's however he declined to report the assault to police despite his family asking him to name the offender.

Police recorded the incident as a burglary dwelling and made two follow up visits to the encampment but could not gain entry. A resident had indicated that she had never heard of Adam and that he was not there.

At hospital Adam received treatment for multiple serious injuries. The Doctor had recorded that Adam was from an "alternative" travelling community and that he used ketamine recreationally. The Doctor noted that Adam may need support but that he also had support at home from friends and family. Adam was discharged the following day at his request.

Comment - The University Hospitals IMR author notes A&E records had clearly documented the circumstances of the assault, however the use of more professional curiosity around the circumstances leading up to the assault and the possible risks to Adam once discharged home were not considered in the wider context. It would have been best practice to liaise with the

adult safeguarding team for advice and then a discussion/referral to Adult Social Care should have been considered, given the severity of the injuries and the potential future risks of this happening again. Further, there was no mention of any police involvement or liaison with the police following this presentation in the hospital records.

The Discharge summary to the GP outlines the assault briefly and the injuries sustained but does not mention any community support, just asks GP to arrange for the scalp staples to be removed in 10 days' time. Further it did not reference Adam's living conditions or drug use creating a missed opportunity for further support to Adam.

The police were unable to secure Adam's cooperation at the scene and then were unable to contact him. The travellers that Adam was with at that time were living in a yard that was locked. Due to the inability to recontact Adam the case was closed.

The police (and other agencies such as Children's Social Care and Education) can face challenge, community suspicion and lack of cooperation when working with travelling communities. This can stem from experience of being moved on reinforced by negative attitudes from outsiders to their alternative living arrangements.

It is important to consider the long-term history of policing of travelling communities such as some large-scale evictions[8] of travellers that have taken place, and since the 1980s police and council enforcement and disruption of convoys of new age travellers[9]. These have created a situation that Zoe James in her book, The Harms of Hate for Gypsies and Travellers, summarises as leading to a widespread assumption that, "Travellers have been over-policed as offenders and under-policed as victims"[10].

June 2022 – Adam is recorded as not attending a nurse appointment at his GP practice.

Comment - The IMR author identifies that this could have been an opportunity to make follow up contacts given the vulnerability of Adam and the severity of the assault in line with the Did Not Attend policy which requires follow up to non-attendances.

On **29th of June** Adam attends University Hospitals Bristol and Western fracture clinic to have a cast on his arm removed and replaced. It was noted that he could now wear a trainer on his left foot and an MRI was booked for the following day.

A letter from the hospital indicates that Adam had attended the fracture clinic. It explained the injuries and that Adam lived in a campervan, drinks and takes ketamine occasionally and other than his injuries he is fit and well.

Over the following 3 months Adam does not attend 3 appointments to 2 respective hospitals for scheduled appointments with Trauma and Orthopaedic and Urology Clinic. Having missed 3 appointments at the Trauma and Orthopaedic Clinic he is discharged to his GP in line with hospital outpatient policy. In addition, following Adam raising a query by phone to his GP

[8] Dale Farm in Essex was an unauthorised camp established in the 1970's and 80 families were forcibly evicted in 2011 following court action in a large-scale police, council and bailiff operation. The issue had been ongoing over 10 years and reportedly has had a significant impact of police and traveller relations since.

[9] In 1985 the newly created English Heritage banned the month-long free festival at Stonehenge usually attended by 40,000 people. An exclusion zone was placed around the area leading to a violent confrontation between travellers and police in what became known as the "Battle of the Beanfield".

[10] Zoe James, The Harms of Hate for Gypsies and Travellers. A Critical Hate Studies Perspective. 2020.

practice in relation to a lump on his back he was asked to send a photo but did not respond *(A further incident where the GP DNA policy should have been triggered).*

30th December 2022 – Adam was admitted to North Bristol NHS Trust after presenting to Southmead Hospital Emergency Department the previous day. Adam had indicated that he been unwell since returning from abroad where he had been staying in a friend's caravan. Adam had indicated that he normally looked after himself.

Adam had been using ketamine and cocaine and was recorded as having chronic renal failure. Adam refused observations and bloods and the insertion of a PICC (intravenous line) and insertion of a bladder catheter (despite the nurse explaining the importance of these). Adam was deemed to be capacitated to make decisions and subsequently gave consent to the full medical treatment and care but not to the catheter. It was noted that Adam had ketamine induced liver and renal failure, and that he may not improve. It was further noted that if Adam survived in intensive care that he would be a candidate for Renal Replacement Therapy as this was his first presentation, and he was of a young age. Notes recorded that a liver and renal transplant may need to be considered but that he may not be a good candidate for either depending upon his compliance and drug taking.

Adam had been recently staying in a caravan abroad and until this incident had no recorded contact with UK agencies since his hospitalisation for the assault 6 months earlier. His ketamine induced health issues had considerably worsened since August 2020 when the ambulance attended to him at the hotel. Adam chooses not to have a catheter fitted and his choice was respected. His capacity[11] to make decisions in relation to his medical treatment was recorded.

January 2023 - The Discharge Case Manager spoke with Adam who confirmed that he would stay with his brother on discharge but also agreed to an offer to refer to Bristol Housing. It was agreed that Adam would fill in the form with the manager but declined to fill it in that day so it was noted that it would be done later.

On the **10th of January** the Doctors had a long discussion and update with partner Sarah who was concerned how Adam is going to have ongoing care post discharge. His reading and writing skills are very poor so things like understanding clinic letters and forms will be difficult. She is worried about him going to stay with his brother as they have lodgers. Sarah was concerned that Adam doesn't understand the seriousness of his condition and the importance of stopping ketamine. Going back to his caravan would not be ideal. Sarah was happy to be contacted by phone or email and for letters to be sent to her address and asked to be told of any advice from dieticians.

It is of note Adam does not raise his challenge with literacy himself however Sarah provides confirmation of Adam's dyslexia and offers a solution to communication regarding appointment contacts and letters.

Throughout the remainder of January Adam remains an inpatient. Medically his recovery is hampered by his low nutritional intake and his weight is recorded as falling from 80kg at admission to 64kg. In mid-January Adam is recorded as having capacity and a Respect document indicating his wishes to be fully resuscitated if required is recorded.

[11] If an adult has the capacity to make a voluntary and informed decision to consent to or refuse a particular treatment, their decision must be respected. https://www.nhs.uk/conditions/consent-to-treatment/

The GP received a copy of the Respect Document, and it is noted by the GP IMR author that this was good practice; that the form was signed by Adam and that he was aware of his condition of renal failure and chronic ketamine use. He had capacity and wanted full escalation to resuscitation to prioritise saving his life.

During this period staff learn more about Adam's life circumstances and his wishes. Initially Adam discusses going to stay with friends abroad who have caravans where he could stay though later indicates that this would not be possible as he would be unable to swim and cycle or have sex. Adam wants to move from Bristol to get away from "drugs and dealers" and explains that his position on not wishing to have a supra pubic catheter[12] because of the psychosocial/sexual impact but also, he later further indicates that it is because he would be unable to heal with herbal remedies from travellers (this is the first time travellers is recorded in notes).

Adam also discusses his discharge options with the physiotherapist. Adam describes that returning to his caravan is not ideal as it is small, has limited heating, untidy with limited washing options and uses electricity extracted from a building without permission. The option to stay with his ex-partner is inappropriate as she has children and a partner. Staying with his brother or friends would be inappropriate as he would be around drugs and alcohol. Adam said his final option was get a friend to drive him abroad to a relative's land where friends live in caravans who do not use drugs. He indicates he would pull his nephrostomies[13] out and was strongly advised against this.

Comment - the hospital staff build a relationship with Adam, show professional curiosity around his life and demonstrate principles of keeping safeguarding personal. This is valuable as once out of a hospital setting it can be more difficult to do this for professionals who have a more limited contact. Adam is also considering his options post discharge carefully.

The Hospital discharge staff liaise with housing due to Adam having a nephrostomy bag and the need to access cleaning to avoid infection and indicate that he is weak and unable to manage stairs. The Housing Advisor interviews Adam in relation to his health and address history, and records that he is from the Traveller community. Adam is deemed as vulnerable, and priority need due to his physical health. Accommodation is secured in a level access studio flat. Adam is referred to the drug and alcohol service, Developing Health and Independence (DHI) who are commissioned to carry out assessments for people entering the Bristol Recovery Orientated Alcohol and Drug Service. After several failed contacts an assessment appointment is made for 13th February.

February 2023 - Adam is discharged from hospital just over a month from his admission. Discharge care planning includes arranging Community Nurse intervention from care and health CIC[14]. This was arranged as the temporary accommodation was some miles away from Adam's GP practice so care could presumably not be easily accessed by Adam from there. The hospital care handover to his GP indicates that upon discharge Adam will require further

[12] A Supra Pubic Catheter is a urinary catheter that is inserted into the bladder from a small cut in the abdomen.

[13] A nephrostomy is a tube that lets urine drain from the kidney through an opening in the skin on the back.
A thin, flexible tube goes through the opening and into the kidney. This is called a nephrostomy tube or catheter. Urine drains through the tube into a bag outside the body. Source Macmillan Cancer Care
https://www.macmillan.org.uk/cancer-information-and-support/treatments-and-drugs/nephrostomy

[14] Sirona care and health are a not-for-profit social enterprise, funded by the NHS and local authorities providing care and health services for adults and children across Bristol, South Gloucestershire and North Somerset.

support. Adam has lost 25% of his bodyweight whilst in ICU and will need lifelong catheter or nephrostomies due to ketamine overuse which has reduced the size of his bladder. The handover letter indicated the support set up in terms of temporary housing and referral to substance use services and that Adam is motivated to address his ketamine use. The letter includes details of Adam's literacy difficulties and details of his friend Sarah and her support to receive appointments and letters on Adam's behalf.

Comment - The hospital has demonstrated a robust awareness of Adam's medical and social needs. In addition to his medical care and recovery, the hospital has ensured effective multi agency working with housing who are responsive in assessment involving Adam directly and securing post discharge accommodation and referral to drug services.

Adam moves into his temporary accommodation and is visited by Sirona care and health for his weekly injection. Adam requested future visits in mornings and to call in advance.

On 13th February, Developing Health and Independence complete a telephone triage assessment. It is recorded that as Adam is 9 weeks abstinent the agency considered him to be no longer requiring treatment. Adam is signposted to SMART meetings, education and training resources, and his details were passed to the Peer Mentoring Team to make contact to arrange to train Adam as a peer mentor.

Comment – The DHI substance use service at this time would only offer structured treatment groups to individuals who were either actively using substances or had been abstinent for less than four weeks. As a result, Adam was deemed ineligible for these treatment groups. Adam had been in hospital for over a month and seriously ill prior to admission which may have reduced or temporarily stopped his use of Ketamine. Was this a missed opportunity to maximise Adam's willingness to engage in services and reduce his drug use and to build upon the engagement whilst he was in hospital? Further, could consideration of drug assessment whilst in hospital have been possible/beneficial? Of note the service has now removed the 4-week abstinence threshold.

Over the next few days Adam does not respond to telephone contacts and appointment from the hospital dietician, and he also arranges to self-administer his injection when he informs Sirona care and health he is not at his property. The dietician letter is copied to the GP and indicates Adam should get in touch or he will be discharged. The letter is considered good practice by the IMR author from the ICB as it contains QR codes which can be scanned allowing access to information to support his diet.

Adam cancels a face-to-face appointment with the DHI peer coordinator as he was in Birmingham and states he will rearrange.

On **February 20th** Sirona care and health carry out a full nursing assessment noting Adam was an ex-drug user who had mobility, but his GP was too far for him to travel. Nephrostomy tubes were redressed, and Adam was left with dressings to allow him to redress areas after showering. The community nurse would continue to do a weekly dressing.

On **February 23rd** Adam requests a sick note from his GP which is issued on 28th.

Adam is recorded by Department for Work and Pensions (DWP) as making a claim for Universal Credit (UC). Adam declared health conditions *'kidney failure and liver failure'* (sic) and self-

certified sickness from 23/02/2023 to 27/02/2023 and provided a fit note from 28/02/2023 to 30/03/2023.

March 2023 - On the 1st the GP records indicate Adam attending his GP practice and having his dressings changed though it is unclear how the appointment was arranged or what was being dressed.

On the **3rd of March** the GP receive a letter detailing the outcome of a telephone consultation between Adam and the Gastroenterologist and Hepatologist. The letter indicates that Adam is prescribed medication for a liver condition which causes pruritus (itching) and to attend his GP for a blood test.

Nurses from Sirona care and health continue weekly visits to administer Adam's darbepoetin injection and to address his nephrostomies. On the 2nd week Adam had no medication to administer but did have a text informing there was a prescription to collect. On the 3rd week his dressings were not in place and Adam stated they had fallen off in bed and that one of his nephrostomies was not draining. The nurse advised him to contact his GP which he agreed to do.

Two days later Adam is recorded as attending A&E at Southmead Hospital where he has a urology review as his nephrostomies were not working and they are clamped. He is asked to attend again for checking again the following day which he does and asked to reattend as a day case in 2 weeks.

Adam answers an appointment by telephone with his dietician and he advises he is eating takeaways as he is no longer with his partner and is advised to consider salt content of this and to check labels on ready meals. Nephrology had recorded that Adam's discharge weight was 60kg but now 75kg showing good weight gain.

On 15th March 2023 Adam was referred by the Department for Work and Pensions (DWP) for a Work Capability Assessment (WCA)[15].

April 2023 – Throughout April Adam is supported by Sirona care and health for his dressings and no longer requires the weekly injections. He attends the nephrology clinic and has a telephone consultation with his Gastroenterologist and Hepatologist. Towards the end of the month, he is discharged from the Community Nursing service as Adam states his nephrostomies have been removed. It was noted that the renal team update that his blood tests show significant improvement from January, that Adam is abstaining from ketamine use and therefore should continue to see some improvement. Notes from the liver clinic give a similar picture of improvement.

On 18th of April Adam informed Universal Credit that he has misplaced his WCA health questionnaire. A duplicate questionnaire was posted to him.

May 2023
On the 4th of May Adam informed Universal Credit he was going to obtain a fit note back dated to 31/03/2023, but he failed to provide any further fit notes.

[15](A WCA looks at the customers capability to work, this is completed by an independent healthcare professional, and the outcome determines the customers eligibility to the benefit).

On 16th May DWP record that Adam failed to attend a mandatory work search review. He was sent a journal message asking for reasons but as he failed to reply within the required 7-day period, he was referred to a Decision Maker.

In **late May** Adam is sent a letter via e mail confirming he is owed the main homeless duty under the homeless legislation[16].

June 2023
On 5th of June the DWP Decision Maker placed a sanction on Adam's UC payments from16/05/2023 with an indefinite end date (the sanction would end when he rebooked and attended the missed appointment).

On **8th of June** Adam is recorded as presenting at North Bristol Trust (Southmead Hospital) Emergency Department with Sarah, his former partner and mother of his child. It records Adam as having bilateral nephrostomies, asking for spare caps, and for them to be removed. There is an electronic NBT letter from Urology in March for a follow up nephrostogram. Adam says he has had no correspondence about this. Notes record him at a Staple Hill address until mid-April and Sarah's address following this.
It is unclear from records as to whether the nephrostomies were removed.

On **12th of June** a letter copied to the GP from gastroenterology notes that Adam has stopped his liver medication and needs to resume it. The letter indicates that his nephrostomies are still in place and that Southmead hospital has been requested to remove them and that it is not known why they were not removed in April.

July 2023
On **3rd of July** WCA action was halted as Adam had failed to submit any further fit notes since 30/03/2023. Therefore, he was deemed to be fit for work- and work-related activities.

On **6th of July** the GP practice receive a letter from the Renal Clinic informing them that following removal of bilateral nephrostomies the GP should monitor Adam's renal function via a blood test. A letter to Adam from the renal team asks him to arrange the blood test at the GP. It is not known if he did this or if the GP followed this up.

On **15th of July** Adam did not attend a scheduled appointment with the Trauma and Orthopaedic Team. The GP practice are informed but are not recorded as undertaking any follow up actions.

On **25th of July** records on Adam's DWP account state Universal Credit needed to re-engage with Adam following his sanction. (Adam's attendance to an appointment would ensure the sanction was ended). No further appointments were booked for Adam to engage with UC, and as a result his sanction was ongoing. The last contact Adam had with UC was on 4th May 2023. Between 3rd July 2023 and his date of death in January 2024, Adam received a total amount of £17.22 in Universal Credit payments.

Comment – It has not been possible to identify what Adam's access to resources for food and basic living costs were during this review.

September 2023

[16] A person is owed the main homelessness duty if they remain homeless after the relief duty comes to an end if they are in priority need and have not made themselves intentionally homeless – adapted from Policy Fact Sheet: Relief, Department for Communities and Local Government

On the **1st of September** the GP is notified of Adam having been treated at A&E following a ketamine overdose. He was collected by his son. A further record (which does not appear to be shared with the GP) the same day indicated that a friend had found Adam unconscious behind a wheel of a car. The friend dragged Adam out of the car and called 999.

Comments on this entry to the chronology - ICB IMR author and the GP practice "- No follow up - despite Adam stating he was Ketamine free - no referral to ROADS mentioned. No Vulnerable adult coding added following overdose.
Comments by GP - It is unclear from this entry whether any safeguarding risk assessment or referral was completed by hospital staff during admission, and shared/reported to GP surgery. It is also unclear whether any referral to drug support service was offered / actioned. It is unclear what actions were taken by the GP surgery following receipt of this letter.

This is a significant incident and evidence of Adam taking ketamine. Following this he increasingly does not attend medical appointments and is discharged for non-attendance.

November 2023 – The temporary accommodation placement is terminated on 6th November due to abandonment and non-occupation. Notes record that Adam has advised that as a Traveller he cannot stay in one place and has stayed away from the property. He was advised that to do so would mean he would lose the housing main duty and the accommodation.

On **November 24th** Adam is discharged from Urology for non-attendance at appointments.

On **November 30th** Adam does attend a Gastroenterology clinic appointment with his brother. It is recorded that there is a likely diagnosis of ketamine-induced cholangiopathy (a category of chronic liver diseases), that he has significantly reduced his ketamine use, had rehab in the past and does not drink alcohol to excess.

Comments by GP IMR author - It is unclear whether any safeguarding risk assessment or referral was completed and shared/reported to the GP surgery. It is also unclear whether any referral to drug support services was offered / actioned. It is unclear what actions were taken by the GP surgery following receipt of this letter.

The clinic recorded a weight of 53.8kg however did not record this as significant from 73.5kg on 8th June 2023.

December 2023 – The GP practice sends reminders for COVID and flu vaccinations.

On **December 12th** a 999 call for an ambulance is made to carry out a welfare check on Adam who is temporarily staying with his sister. He is recorded as no fixed abode and residing in caravans or hotels if not with his sister. It is stated he uses ketamine for pain. Adam was described as on the settee and frail however alert when spoken to. Adam explains he is weak and has difficulty mobilising. Record state, "appears emaciated on assessment". The ambulance crew are aware of Adam's complex medical history and his bladder, kidney and liver. Adam says he has ongoing urinary tract infection. Adam is advised to attend the Emergency Department but declines this. The crew speak with the on-call GP to seek advice on antibiotics, but the GP declines that option as it cannot be ruled out that Adam's kidney/liver is failing so tests are required first. The GP strongly advised Adam to go to hospital for urgent care as he may have acute kidney/liver failure, hypovolemia or sepsis. The Crew reiterated advice

given by GP however Adam remained adamant he will not go to hospital. Multiple family members are described as upset and shouting at Adam for not going to hospital.

The situation eventually resolved, and Adam agreed to go to hospital with the crew. Adam is admitted to Bristol Royal Infirmary with abdominal pain and a urinary tract infection.

Comment – IMR submissions from the ICB comment that there is no recorded evidence of an Adult Safeguarding referral or Care Act assessment considered. In addition, there is no recorded evidence of capacity assessment or safeguarding considerations.

Adam is reviewed by the mental health liaison team in hospital on **15th December**. Assessment suggested that it was personal choice to use ketamine, and that he does this to block out the days when he has feelings of low mood. Adam explained that he has a history of depression and uses Ketamine more when he is with friends. Adam explained that he has never spoken directly with his GP or any Mental Health Professionals about his Ketamine use though was assessed to have good insight into the use of Ketamine and how this was detrimental to his health. Adam is advised to contact the community drugs team when he leaves hospital. The drug team see Adam daily and recorded on one day Adam was becoming "snappy" possibly due to ketamine withdrawal, having low mood but not suicidal.

Comment – We should consider carefully the use of language intimating "personal choice" and a "chosen lifestyle" in respect of drug addiction. This can cause unconscious bias of professionals working with drug addicts. The "choice" of lifestyle would likely have been impossible for Adam given the length of his ketamine addiction.

Housing receives a referral on **15th of December** from the hospital advising Adam is an inpatient. He is described as presenting with severe neglect and extremely malnourished, weak and unable to care for himself with urosepsis. The referral gives further detail on medical history since February 2023. It further describes Adam as extremely malnourished with anorexia and has had recent extreme weight loss and is cachexic.

A discharge letter to the GP indicates that Adam was a hospital inpatient from 13th December and discharged himself on 20th December, 9 days into a 10-day course of antibiotics. The GP sends a text to Adam on 27th December inviting him to make contact.

Comment - The GP report does not indicate a phone call or follow up to the text.

January 2024

On **9th of January** the GP is informed by the Renal Clinic/Urology that Adam has been discharged from the service after missing 2 appointments.

Comment – The GP does not evidence that this information is considered in light of the recent self-discharge from hospital and non-response to the GP text on 27th December.

Later in **January** Adam is brought to Southmead Hospital by a friend who was concerned he did not look well and had chronic and worsening abdominal pain. He is noted as cachectic, has ketamine bladder, and using ketamine daily. Adam had a large pressure sore to his sacral and anal area. He had been sofa surfing and it was also noted that he had been recently discharged from Bristol Royal infirmary. Nephrostomies were discussed and it is noted that Adam clearly does not want them and is aware of the risk of death. Adam declined a catheter and is deemed

to have capacity. It is also noted that there is no family or Next of Kin (initially). Adam is admitted to the Intensive Care Unit.

The same day in January a safeguarding referral sent to Bristol for serious self-neglect.

Comment - This is the first safeguarding referral.

Ward notes document Adam stating to urology his wish to die rather than have nephrostomies. He is deemed to have capacity in respect of this decision. The dietician notes that Adam weighed 53.8kg in mid-December and now weighed 40kg. It is also noted that Sarah, Adam's ex-previous partner, has been in touch but feels unable to become involved in Adam's care due to having a new partner and children, and that Adam's son, aged 21, does not want to be involved. Sarah agreed to safeguarding and an Independent Mental Capacity Advocate (IMCA)[17].

The following day – Bristol City Council Adult Social Care (ASC) document the safeguarding referral received from the safeguarding specialist at Southmead hospital. It is noted that Adam was sedated and therefore unable to consent therefore the referral was being made as a best interest decision[18].

A duty senior practitioner reviews the information submitted and requires review of further information in relation to whether S.42[1] safeguarding criteria are met.

The following day - the IMCA reviewed and saw Next of Kin. Sarah provided further background in relation to Adam's background and his family. Adam came from a Travelling background and probably started using ketamine at 17, went to rehabilitation 3 years ago but relapsed. He occasionally uses cocaine and cannabis when not using ketamine. Sarah has seen Adam deteriorate in the previous 5 months and has concerns for his mental health and that he had been purchasing coffee machines and push bikes and has been "manic". She indicated that Adam has taken steps to go to rehab again in Thailand and was due to fly there shortly. She believes he would want to live for his son who recently had a child. Sarah said he has been expressing ongoing issues around his bum for some time. Adam has his mother, who lives abroad.

The following day – Adam is referred to the Drug Team in relation to his chronic ketamine use. The IMCA indicates that Adam hasn't had any ketamine for 7 days and during a recent presentation to Bristol Royal Infirmary did not experience any acute ketamine withdrawal. Discussion with family via IMCA also indicates that he is planning to access support in the future which indicates motivation to longer term behaviour change. IMCA noted that Adam has had support in the past from Developing Health and Independence but may have been too complex for their service; Adam may benefit from a Bristol Drugs Project engagement referral if he wants support around his ketamine use for discharge. IMCA will plan to engage on step down to assess his plans/motivations for discharge support.

[17] The Mental Capacity Act 2005 introduced the role of the independent mental capacity advocate (IMCA).
IMCAs are a legal safeguard for people who lack the capacity to make specific important decisions: including making decisions about where they live and about serious medical treatment options. IMCAs are mainly instructed to represent people where there is no one independent of services, such as a family member or friend, who can represent the person. Source https://www.scie.org.uk/mca/imca/#:~:text=The%20Mental%20Capacity%20Act%202005,about%20serious%20medical%20treatment%20options.

[18] Mental Capacity Act 2005, Best interests' decision - a person can be assessed as not capable of making a particular decision, in which case that decision should be made for him/her, according to his or her best interests.

The following day - An Adult Social Care practitioner, allocated to triage the case, summarises the position in relation to Adam's health and that there was, "concern that this man may not live through this experience he is that significantly ill".

i. Records summarise the position and evidence rationale, but the outcome is that all three parts of the S42 criteria were met and on **25th January** it is recorded that "Adam had needs arising from their physical health and suspected substance dependency;
ii. That the conditions leading to hospital admission would constitute self-neglect, given that these had resulted in significant skin integrity concerns requiring potential surgery, organ failure, significant weight-loss, and starvation and dehydration that the body was 'shutting down'.
iii. That on the basis of his needs Adam would be unable to protect himself against further risk of self-neglect, given that the referrer had reported that Adam was very seriously ill, could potentially die, and would very likely require the provision of extensive hospital treatment and provision of social care services of some sort to facilitate any future discharge."

The day before Adam's death in January 2024 – The IMCA notes a discussion with Sarah. Adam now has new diagnosis of bowel ischaemia and will pass away. The surgeon confirms that Adam would not survive surgery. The IMCA notes Adam's wishes to not have nephrostomies in discussion with Urology on 21st January. Adam is noted as having family in the UK and abroad. A ReSPECT[19] plan is agreed and signed by Adam's son (Adam at this point does not have mental capacity) and Adam's family are called, and the purple butterfly[20] end of life care pathway initiated.

Adam passed away in **January 2024**

In the following days the GP and ASC are informed of Adam's death. ASC discharge the section 42 investigation having identified that no further vulnerable individuals are at risk.

5. Specific areas of enquiry

5.1 Ten agencies who had confirmed contact with Adam in the two years preceding his death, and who also formed the review panel, submitted Individual Management Reviews. This allowed us to establish a detailed overview of the support to Adam in the two years preceding his death. These single agency reports were comprehensive, identify learning and improvement and are summarised in this section. The Agencies were as follows.

South Western Ambulance Service Trust
North Bristol NHS Trust
Developing Health and Independence

[19] The ReSPECT plan is created through conversations between a person and their health professionals and is recorded on a form. It includes their personal priorities for care and agreed clinical recommendations about care and treatment that could help them receive the right care in an emergency. Once the ReSPECT plan has been agreed it then stays with the patient and should be available immediately to healthcare professionals during the emergency. - https://www.nbt.nhs.uk/about-us/news-media/latest-news/nbt-launch-new-respect-process

[20] The purple butterfly in memory giving model of care focuses on the needs of our patients and their loved ones. The purple butterfly symbol indicates that a patient and their loved ones are facing uncertainty, deterioration, or the end of life.
This approach is used to acknowledge when the focus of a person's care is comfort and symptom control and to identify their priorities and needs.
https://www.nbt.nhs.uk/our-services/a-z-services/palliative-end-life-care/end-life-care#:~:text=In%20order%20to%20support%20staff,identify%20their%20priorities%20and%20needs.

Bristol City Council Adult Social Care
Avon and Somerset Police
Sirona care and health CIC
Bristol City Council Housing and Landlord Services
University Hospitals Bristol and Western
GP Practice/Integrated Care Board
Department for Work and Pensions

5.2 The panel agreed key lines of enquiry for the IMR authors to consider. These are listed below. (The full Terms Of Reference are presented at Appendix 1)

All agencies required to submit IMRs are asked to respond to the key lines of enquiry listed below to assist in the following 3 overarching lines of enquiry.

1. To establish the events and to examine the agency interaction and support to Adam in the two years preceding his death.

2. To establish whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard Adam and to identify what should change as a result.

3. To apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.

Specific areas to consider.

4. Was the work in this case consistent with agency policy and procedures for safeguarding adults at risk of abuse and neglect, and wider professional standards?

5. Did action accord with the assessments and the decisions that were made? Were appropriate services offered and provided to Adam in light of those?

6. Was information shared in a timely manner and to all appropriate partners during the period covered by this review?

7. Were practitioners sensitive to the needs of adults at risk in their work, knowledgeable about the potential indicators of abuse or neglect, and about what to do if they had a Safeguarding Concern about an adult with care and support needs in these circumstances?

8. How was the principle of making safeguarding personal achieved? Did agencies consider Adam's wishes and feelings when providing care and treatment. Was Adam's voice recorded in interactions?

9. Were services aware of Adam as being from the Traveller community. Was this formally recorded in interactions?

10. Do agencies adequately understand the needs Traveller communities and challenges of service provision with them? Is this reflected in terms of both cultural competence of staff and organisational policy? How does your agency work with the Traveller communities in Bristol?

11. Did agencies and their staff understand the potential harms of Ketamine use on Adam and to make appropriate intervention in respect of that?

5.3 South Western NHS Ambulance Service Trust

The Ambulance Service had 3 contacts with Adam, the first a call from a friend concerned about his pains whilst staying at a hotel when Adam declined assistance. The crew noted Adam was a Traveller and was a ketamine user and signposted him to drug support. There was nothing to suggest he required care and support needs. The second contact was following his assault in 2022 where he was treated on site and during his transfer to hospital, and attendance at his sister's house in January 2024 when his health had deteriorated. Adam initially declined to be taken to hospital despite the crew, his GP and family advising he go to hospital. A decision specific capacity assessment was recorded however Adam eventually agreed to go to hospital.

5.4 The crew followed procedures and showed good insight in relation to recording that Adam was a Traveller and used Ketamine however on the final attendance had not submitted a safeguarding referral in relation to Adam's condition and possible neglect. This issue is addressed in the single agency action plan. The crew demonstrated persistence in working with Adam and his family, consulting his GP, and obtaining his agreement to travel to hospital

Comment - It is known that some Travellers groups are resistant to external agencies such as the police, council or social services and in some cases unauthorised sites may be locked. Ambulance crews/paramedics do not generally experience this caution, often being called by the community therefore seen as supportive. Despite the intervention tending to be relatively brief and single in nature the importance of recording background on living conditions etc can be of importance to other services who follow up care and support.

5.5 North Bristol NHS Trust

The IMR indicates that most of the medical care delivered was in line with policies though does highlight a missed opportunity to make a safeguarding referral when Adam's weight is reducing from 75kg in April 2023 to 53kg recorded at an appointment he attended in November 2023. The clinician had been reassured by Adam's brother accompanying him and it is identified that electronic recording of weight is not currently available with outpatient notes scanned. In effect this means that a clinician must read back through notes to identify previous weights.

5.6 Similarly, the IMR author had noted that several teams had supported Adam with care and whilst his Traveller status and low level of literacy had been identified and recorded it was not necessarily readily available information to the different teams without them looking back through records. An action to address this is identified and included in the single agency action plan. Whilst an inpatient, in early 2023, the IMR records there is no evidence of seeking advice from Traveller Services. Awareness of such services may be low with some agencies and will be addressed in the multi-agency recommendations.

Comment – The detailed chronology describing Adam's inpatient stay in January 2023 demonstrates a high level of professional curiosity and relationship building with Adam (which importantly can be seen in the records) to a point where he can conclude himself that his options to return to his caravan for example are not appropriate. The joint work between

clinicians, discharge team and housing to secure post discharge accommodation and support are commendable.

5.7 Developing Health and Independence

Developing Health and Independence (DHI) is a charitable organisation commissioned by Bristol City Council to provide comprehensive drug and alcohol services across Bristol. As a key partner within the Bristol Recovery Orientated Alcohol and Drugs Service (ROADS), DHI operates three Community Recovery Hubs across Bristol.

5.8 The IMR identified that Adam was referred by Southmead Hospital for ketamine-induced renal failure and that he was of no fixed abode. The initial telephone assessment was arranged within 2 weeks of the referral and this took place. DHI eligibility policy regarding for structured treatment groups required users to be actively using substances or abstinent for less than 4 weeks. Adam was deemed ineligible as he had stated that he had been abstinent for 9 weeks. Alternative support from peers/mutual aid, recovery groups, and signposting to educational resources was offered. Adam did not engage further.

5.9 DHI, as a result of learning from Adam's review, have revised the abstinent criteria for eligibility to structured treatment to allow those abstinent for extended periods to access that treatment.

5.10 In addition, they have introduced tailored ketamine risks training for staff and that assessments take greater account of physical effects of substance use and has introduced a Dynamic Care Pathway to collaborate more closely with health professionals. It is commented that the lessons from Adam's case have had a significant impact on DHIs service provision. s are reflected in the single agency action plan.

Comment – Adam was an inpatient for just over a month in early 2023 which was an opportunity to begin to address his long-term substance use. An assessment almost 2 weeks post hospital may have "missed" a potential window where the user is more open to change. The assessment by DHI could not offer structured treatment due to the abstinence policy in place at that time, and whilst other options were available, they perhaps did not reflect that Adam's ketamine use had been both high and prolonged (as evidenced in his hospitalisation where upon admission it was noted the physical effects of his ketamine addiction was so advanced that it was considered he may not survive).

It is of note that DHI have implemented learning and have changed their abstinence policy and working practice encouraging closer working with health professionals.

The Bristol Combating Drugs Partnership[21] are recommended to review this report and to consider if services can be commissioned to carry out face to face assessments where individuals such as Adam are inpatients. Further to ensure Ketamine availability and use trends are monitored in any future drug needs assessment work.

5.11 Bristol City Council Adult Social Care

[21] In December 2021 the Government launched its 10-year strategy to tackle the harms associated with drugs[21]. The strategy was followed with guidance for delivery published in June 2022[21] and the creation of new Combatting Drugs Partnerships requiring partnership at local level.

5.12 Adult Social Care had a limited but significant involvement as they triaged a safeguarding referral from the hospital in January 2024 and initiated a S42 enquiry. The decision was timely and appropriate and the detailed IMR describes the initiation of the enquiry as follows.

"The language of the Act is important here: "…where a local authority has reasonable cause to suspect…" that abuse or neglect has occurred (S.42[1]) … "The local authority must make (or cause to be made) whatever enquiries it thinks necessary…" (S.42[2]). It was reasonable to conclude after fairly minimal information gathering that Adam had needs for care and support, given his physical condition; was experiencing or at risk of abuse or neglect, in this case self-neglect given the description of significant physical harm he experienced as a result of being unable to meet his needs prior to being admitted to hospital; and that given his needs for care and support it was reasonable to believe that he was unable to take protective action to mitigate against the risk of that self-neglect. The test for reasonable belief, therefore, was met after only brief corroboration of the facts, leading to an appropriate and timely legal decision to proceed to a statutory enquiry. As Adam died in the short period between a S.42[1] decision being made and a S.42[2] enquiry taking place it was reasonable to close that enquiry quickly on the basis that no further safety planning could take place."

The IMR notes that staff effectively understood the process and procedure, and documented it thoroughly.

5.14 A minor improvement was identified in that an automatic notifying to liquid logic (social care recording system) from the NHS system that Adam was deceased would have been beneficial as it was only apparent when the hospital contacted ASC and would avoid unnecessary communication if automatic.

5.15 The case was reviewed with line management and professional development. Reflective learning following Adam's death showed that some practitioners were not informed about the Traveller Support Service within the Council or the significant harms of ketamine. It was also further identified that the issue of assumptions in relation to Travellers require a greater understanding to assist in the Equalities Diversity and inclusion supervision template.

5.16 Learning and improvement is reflected in the single agency recommendations.

5.17 Avon and Somerset Police

5.18 Police recorded only one interaction with Adam which was following his assault in May 2022. Police attended the scene and travelled with Adam to Bristol Royal Infirmary. Adam declined to give a statement or give his clothes to officers for forensic analysis.

5.19 The Officer in Charge attended hospital the following day to discuss safeguarding with Adam who indicates that the suspect may return, but that he felt that residents on the encampment would look out for him. Adam is recorded as stating his family were pressuring him to name the offender. In the following days Adam does not respond to calls or visits to the site where officers cannot gain access. There were no postal facilities at the encampment, so confidential letters could not be left. This meant that Adam was not in receipt of his crime number and no safeguarding advice or support from the Lighthouse Safeguarding Unit (LSU) was able to be given despite numerous

attempts to contact Adam via the phone numbers he had given to officers. As the only witness to the incident, it prevented any further investigation and the case was filed, after review by an Inspector.

5.20 The IMR indicated that Adam was not formally identified in records as a Traveller, however further exploration of the incident at panel indicated that police had recorded that Adam was identified as living within a locked compound with what appeared to be other travellers, as he was found by officers. Officers attending initially had been met with a lot of hostility from other residents and had to calm the situation down so were aware of potential co-operation issues. The force has no specific identifier for 'Travellers' on their systems though Adam's living lifestyle and circumstances were clearly considered within the decision making and risk assessment of the investigation. Police indicated that Adam did not self-identify as a traveller which is the only place such a protected characteristic would be recorded.

5.21 The crime was incorrectly recorded in 2022 as Aggravated Burglary[22] and due to the IMR review has now been changed to Wounding with Intent to do Grievous Bodily Harm[23]. It should be noted that both offences are serious and as such the crime data integrity issue would have had no impact on the level of resource or investigation.

5.22 The IMR concludes that without Adam's co-operation as a witness, and the fact he could not be contacted, there were no options open but to file the offence. Options did exist to discuss the case at a local problem-solving multi-agency forum, but this was not done though no learning is identified by the Police reviewer as they consider it individual oversight rather than a system issue.

5.23 Police had correctly identified Adam as "vulnerable", however their assessment deemed him medium risk therefore he did not meet the thresholds for a multi-agency safeguarding referral.

5.24 Police did recognise consideration of bespoke input to staff regarding the challenges faced by the GRT community and potential impact on policing. This is reflected in the single agency action plan.

5.25 Sirona care & health CIC

5.26 Sirona care and health provide community nursing support to Adam following his hospitalisation in early 2023 primarily to change dressings and administer a weekly injection. This was because his temporary accommodation was some distance from his registered GP so although he was not housebound it was appropriate to receive care at his home.

Comment - This is a good example of demonstrating flexibility to support Adam and linking to the coordinated discharge from hospital in February 2023.

[22] Aggravated burglary is defined at section 10 of the Theft Act 1968 as follows: "A person is guilty of aggravated burglary if he commits any burglary and at the time has with him any firearm or imitation firearm, any weapon of offence, or any explosive".

[23] Grievous Bodily Harm with intent Wounding/causing grievous bodily harm with intent
Section 18 Offences Against the Person Act 1861 and is a serious criminal offence in England and Wales. It's also known as grievous bodily harm with intent, meaning that the attack was premeditated and malicious. GBH with intent is one of the most serious assault charges in the UK and can carry a life sentence for those who are convicted.

5.27 The IMR author highlights that contact was limited however Adam's voice was heard and his wishes around pre communication, time of visits, and on occasion choice to self-administer his medication was supported. Staff were aware that Adam had been previously homeless and had a history of previous ketamine use but were not aware of him being a Traveller.

5.28 Bristol City Council Housing and Landlord Services

5.29 Housing and Landlord Services completed a thorough assessment of Adam's homelessness status and vulnerability in accordance with homeless legislation and actioned the relevant statutory duties that were owed to him.

5.30 Sharing of information between Housing and Landlord Services and the NHS took place effectively relating to the initial hospital discharge and sourcing of suitable temporary accommodation.

5.31 Adam was provided with self-contained temporary accommodation in a timely manner upon notification that he was medically fit for hospital discharge.

5.32 Housing and Landlord Services referred Adam to supported housing providers offering low level support to address his longer-term housing situation and he was kept informed throughout the homeless process with the progress of his homeless application and the duties owed to him. Adam was notified that the duty may be discharged if he voluntarily ceased to occupy the temporary accommodation provided to him.

Comment - The IMR does not identify if Adam's inability to read written communication was known. Housing did later indicate that it was thought that Adam could read and write however had difficulty with complex forms.

5.33 The IMR does identify potential learning regarding professional curiosity, possible floating support, and consideration of referral to substance use services.

5.34 Single agency recommendations are reflected in the single agency action plan and usefully include exploration of ways that housing could provide enhanced support for those clients from traveller communities in the ability to occupy temporary accommodation, not to leave and therefore result in the potential discharge of their homelessness duty.

5.35 University Hospitals Bristol and Weston NHS Foundation Trust (Bristol Royal Infirmary)

5.36 The IMR author noted that Adam had previously attended the A&E department in 2010 after a car accident, 2015 following an assault, and in 2018 following a dog bite.

5.37 During the review period, Adam was hospitalized following an assault in May 2022. Although his injuries were treated and documented, the IMR author notes that there was limited exploration of the broader context or potential contributing factors. The author mentions that the severity of Adam's injuries and his precarious situation should have led to a referral to the hospital's adult safeguarding team. Involving

safeguarding professionals could have enabled more comprehensive information sharing and assessment of his needs, including follow-up support from Adult Social Care to address risks related to his living conditions, substance use, or safety.

5.38 After discharge Adam went on to attend fracture clinic appointments and the hospital gave a detailed update to Adam's GP including information that he lived in a camper van, consumes alcohol and ketamine occasionally and does not smoke and was in good health apart from his injuries.

5.39 By July, Adam has not attended 3 clinic appointments and is discharged to his GP.

5.40 The IMR author regards this as a missed opportunity from a safeguarding perspective. "Adam's repeated non-attendance at outpatient appointments in July and August 2022 should have raised concerns, given his history of serious assault, living in a van and ketamine use. When an individual with complex needs and recent trauma fails to attend appointments, this could suggest potential barriers to accessing care. Considering Adam's history of injuries, non-fixed abode and recreational drug use, the trust could have highlighted this to the GP when referring him back. This was also an opportunity to discuss the missed appointments as possible safeguarding concerns with the UHBW safeguarding team."

5.41 The next contact was the 12th December 2023 when he arrived via ambulance from his sister's home. Family reported that he had lost significant weight in the previous two weeks and has ketamine bladder syndrome. It is recorded that he has not been compliant with medications since March 2023.

5.42 The IMR highlights some shortfall in respect of addressing concerns at this admission that were not further explored including his access to nutrition, recent decline in physical health and access to a suitable safe living environment. The ability of his sister and friend to look after him was not documented.

5.43 Adam was admitted and his immediate health concerns treated, and there was a referral to the homeless team (which was identified as good practice) and next steps including a referral to the dietician and substance use services. The staff did not however contact the hospital safeguarding team for advice potentially missing an opportunity to ensure a more coordinated and holistic approach to Adam's complex needs.

5.44 The Mental Health Liaison Team see Adam on the ward (good practice), and he disclosed that he uses ketamine to tackle depression. "In his own words, he stated that he used it "to block out the days when he has feelings of low mood." He also explained that he had never discussed his ketamine use openly with his GP or any other mental health professional." The IMR indicates that a more coordinated plan involving mental health services and substance use specialists to support Adam in addressing both his depression and long-term ketamine use could have been a consideration.

5.45 In respect of weight loss, Adam stated that this was due to his recent ketamine use and whilst his nutritional needs were addressed the underlying causes of substance use and self-neglect were not.

The specialist Drugs Team at the hospital saw Adam on 21st December and they noted that Adam was irritable possibly due to ketamine withdrawal symptoms. The Team planned to see Adam daily which was good practice however Adam self-discharged from hospital the same day further compounding the concerns from a safeguarding perspective.

5.46 The IMR author could not find a copy of the discharge letter to the GP however the ICB provided a copy.

5.47 In summary in respect of the later hospitalisation there is a mixed picture of positive health care, involvement of mental health, dietician and hospital Drugs Team and referral to the Homelessness Team but there were no documented discussions with the Trust Safeguarding Team or Adult Social Care.

5.48 The IMR suggests several areas for learning and improvement that are addressed in the single agency action plan.

5.49 GP practice

5.50 The GP IMR was authored by the Named GP for Safeguarding at the Integrated Care Board.

5.51 The IMR notes that Adam did not see a GP in the 2 years prior to his death and only had face to face contact with a nurse appointment on one occasion. There were 29 contacts/entries in the review period with the majority of these being events and letters from various hospital departments. Adam frequently missed appointments and there was little evidence of follow up by the surgery or that the means of text and letter was suitable communication.

5.52 The only recorded GP direct conversation between professionals was the contact by the paramedic on 12th December 2023 when Adam had initially declined to go to hospital and the GP advised he needed to be assessed at hospital.

5.53 The surgery made limited attempts to contact Adam, but these were often via text without confirmation that these were received or could be read. It was not clear that Adam's literacy and digital literacy was known.

5.54 The GP was aware of previous ketamine use and had in fact referred Adam to ROADS in 2020.

5.55 The care offered to Adam was not affected by the COVID pandemic, however, the author states that the pandemic led to a period of

"enforced transformation of primary care services, with digital appointments and communications becoming the default mode of engagement with health services. Whilst the new technology now embedded in primary care is highly efficient and convenient to both staff and patients the majority of the time, there are cases such as this where the 'digital first' approach may have been unsuccessful, and its continued use may represent a failure of the service to make reasonable adjustments to the individual patient's communication needs".

5.56 In summary the IMR highlights that Adam's Traveller heritage was not recorded as known to the GP surgery and as such could not be considered in raising additional professional curiosity in dealings with him. Finally, there were many hospital letters received by the GP surgery outlining significant medical illness and the impact of chronic, ongoing drug use, but it is not clear from the chronology what action was taken by the GP on receipt of information, and what attempts were made to initiate contact or offer follow up when Adam struggled to engage in health improvement. It was not clear whether Adam had a named GP, or whether the practice has implemented any strategies for promoting continuity of care for vulnerable patients.

5.57 The IMR makes several learning and improvement actions that are reflected in the single agency action plan.

5.58 Department for Work and Pensions (DWP)

5.59 The DWP have provided an interim report as they are undertaking an investigation in relation to their contact with Adam.

5.60 From the interim report it is apparent that Adam made a claim for Universal Credit for the first time in February 2023 when he entered the temporary accommodation after his period in hospital in January. He was noted on claiming not to have any previous employment or benefit history. His initial claim was by phone due to low mobility, low digital skills and dyslexia. Despite this, in the following month Adam is contacted for a work capability assessment and does not return the form. He is issued a further form and ultimately is sanctioned after not submitting this and not attending an appointment and there is no further contact from DWP after May 2023. Between 03/07/2023 and Adam's date of death in January 2024, Adam received a total amount of £17.22 in Universal Credit payments.

5.61 The interim report highlights that DWP policy had not been followed in respect of contact with Adam and his literacy disability and this is being investigated. All long-term sanction cases are being reviewed to identify if any vulnerable individuals require support.

6. Thematic analysis

This section considers themes identified by the review panel as follows.
Equalities
Ketamine
Travellers
Self-neglect
Literacy

6.1 **Equalities considerations** –
Adam was a 40-Year-old white male who was from a traveller background and community, was dyslexic, and his substance use was inevitably leading towards long term physical disability.

6.2 The review panel identified that it is important to consider these protected and non-protected characteristics of Adam within the concept of what is termed "intersectionality".

6.3 This describes the ways in which systems of inequality based on gender, race, ethnicity, sexual orientation, gender identity, disability, class, and other forms of discrimination "intersect" to create unique dynamics and effects. All forms of inequality are mutually reinforcing and must therefore be analysed and addressed simultaneously to prevent one form of inequality from reinforcing another[24].

6.4 It has not been possible to ascertain whether Adam was for example an Irish Traveller which would have been regarded as a protected ethnic characteristic under the 2010 Equalities Act. Gypsies and Travellers are a racial group as defined in s9 Equality Act 2010[25]. They are therefore protected, from direct discrimination (s13), indirect discrimination (s15) and harassment (s26).

6.5 Without further confirmation it is probable that Adam was a "new" or "new age" traveller, and as such is not recognised by the 2010 legislation as a protected ethnicity (despite often facing similar challenges and discrimination). This is because what are often described as cultural rather than ethnic Traveller groups do not meet the legal test as a recognised ethnic minority as its history only goes back to the 1960s, and therefore it does not meet the Mandla test[26].

6.6 Addiction to drugs is generally not considered a disability under the Equalities Act, despite section 1 of that Act defining that a person has a disability if they have a mental or physical impairment which has a substantial and long-term adverse impact on their ability to carry out normal day-to-day activities. This is because the Act carried through the Disability Discrimination (Meaning of Disability) Regulations 1996[27] which state that addiction to alcohol, nicotine or any other substance must not be considered an impairment for the purposes of the 2010 Act.

6.7 This is important, as the omission of substance use from the definition potentially has implications in relation to matters such as housing, education and employment for substance users such as Adam. However, in some cases disease or other conditions associated with long term drug use, for example depression and physical damage caused to organs, may lead to qualification under the definition of disability under the Equality Act. In that regard Adam may have fulfilled the definition if he had survived or if the DWP work capability assessment in 2023 had been completed. The test as to whether effects of a drug addiction is considered by the Department for Work and

[24] The Center for Intersectional Justice - Berlin
https://www.intersectionaljustice.org/what-is-intersectionality

[25] In *Moore & Anor v Secretary of State for Communities and Local Government* [2015] EWHC 44, the High Court noted that: by virtue of section 9(4) of Equality Act 2010, Romany Gypsies, and Irish Travellers, each a distinct racial group, form a racial group for the purposes of section 9 of the Act.
http://researchbriefings.files.parliament.uk/documents/CBP-8083/CBP-8083.pdf

[26] In Mandla v. Dowell Lee [1983] 2 A.C. 548, H.L.(E), the House of Lords set down the test for determining the meaning of the terms "ethnic origins" and "ethnic group" under the Race Relations Act 1976 (now replaced by the Equality Act 2010). It was held that there are two essential criteria: "(1) a long shared history, of which the group is conscious as distinguishing it from other groups, and the memory of which it keeps alive; (2) a cultural tradition of its own, including family and social customs and manners, often but not necessarily associated with religious observance".
https://www.google.com/url?sa=t&source=web&rct=j&opi=89978449&url=https://pattinsonbrewer.co.uk/case-reporting-definition-of-travellers/&ved=2ahUKEwiR3MbCrfeKAxUKVEEAHcEINkEQFnoECBUQAQ&usg=AOvVaw1ZBmgnq0uJ3mGJZiExR6V7

[27] https://www.legislation.gov.uk/uksi/1996/1455/made/data.xht?view=snippet&wrap=true

Pensions as a health condition therefore centres on whether the circumstances restrict the individual's ability to take up or look for work.

6.8 Adam is described, and evidenced in some agency's records, as not being literate/dyslexic. There is no recorded formal diagnosis of this or routine recording of this in records as an area where routine adjustments in communication are required. Dyslexia is a recognised disability under the 2010 Equalities Act.

6.9 The review considers there was no evidence of any intentional discrimination to Adam in respect of these matters (DWP have identified and are investigating a recording issue). However, agencies may consider whether being a male Traveller with a drug addiction might have had led to unconscious bias? Whilst Adam's long-term addiction may not have been recognised as a disability in law, was there any impact of underlying assumptions of a "*chosen lifestyle*" and the risks associated with that? It should not be assumed by agencies as the "*choice*" of lifestyle as it is often impossible for those with long term substance use addiction to make changes. The NHS "Stigma Kills" campaign that ran in 2024[28] has key messages to reduce the stigma faced by individuals with addictions, particularly in terms of health services, and to correct the harmful myths that addictions are not an illness, addicts are not unwell and, in some way, deserve their experience.

6.10 **Ketamine**

Ketamine is widely used in both human and animal medicine as an anaesthetic, sedative and pain reliever. Discovered in the 1950's it was widely used by the US army as a field emergency wound pain relief during the Vietnam war. In the UK It is increasingly used as a "party drug" due to hallucinogenic effects and noted to be used increasingly by students in large University cities such as Newcastle, Manchester and Bristol. The drug comes as a crystalline powder or liquid and is classed by the government as a Class-B drug carrying up to 5-year prison sentence for possession and 14 years for supply with unlimited fines. Of note the drug had previously been classified as a category C substance.

6.11 The official statistics of the numbers of ketamine users entering drug treatment indicates that ketamine users are relatively low, though increased in 2022 to 2023 by 42% (from 1,551 in 2021 to 2022 to 2,211 2022 to 2023)[29]. The Home Office report that in the year ending March 2023, an estimated 299,000 people aged 16-59 had reported ketamine use in the last year[30].

6.12 Tolerance is known to build quickly, so users can increasingly need more and more to feel an effect. Chronic usage affects the lining of the bladder leading to frequency in needing to urinate, infections, bleeding, blockages and incontinence. These conditions can be very painful and can cause damage so serious that the bladder needs surgical repair or even removal. The urinary tract, from the kidneys down to the bladder, can also be affected and abdominal pain can occur in long term users and evidence of liver

[28] https://www.stigmakills.org.uk/

[29] https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2022-to-2023/adult-substance-misuse-treatment-statistics-2022-to-2023-report#peoplestarting-treatment-substances-age-and-referral-source

[30] https://www.gov.uk/government/news/home-office-requests-review-of-ketamine-classification

damage due to regular, heavy ketamine use is emerging.[31] There was evidence that Adam was affected by all these physical effects.

6.13 In a BBC West Investigation in April 2024, it was reported that Southmead Hospital in Bristol was currently treating 60 patients from across the West and that the use of ketamine was becoming more prevalent[32].

6.14 There are no physical withdrawal symptoms with ketamine, so ketamine addiction is sometimes called a psychological dependence. It is believed that much illegal ketamine is manufactured in China and India and the drug can for example be bought by users in the UK via mail order on the dark web (readily accessed by downloading appropriate software). Street costs can be as little as £10 per gram (cheaper in larger quantities) compared to average cocaine costs of £80 to £100 per gram[33].

6.15 In December 2024 the senior coroner for Manchester South submitted a regulation 28 report to prevent future deaths to the Home Secretary calling for consideration of the reclassification of Ketamine from a class B to class A drug. This followed the inquest of James Boland who had died because of complications caused by ketamine use. The coroner highlighted in the report that Mr Boland had been a class A Cocaine user but had changed to use ketamine perceiving a class B drug to be less harmful. The Government is seeking expert opinion on a potential change of classification[34].

Comment – The review IMRs indicate varying levels of Agency and practitioner knowledge of ketamine and its harms. The current classification may lead users to consider it less harmful than class A drugs and for example it can be legally prescribed as an anti-depressant and recently, for example, Elon Musk has discussed his weekly use of the drug to control his moods[35]. Therapeutic prescribed Ketamine doses are however significantly lower than doses for recreational use, however, high-profile users may create an unintended influence of acceptability on recreational users.

Recommendation – Bristol drug and alcohol partnership to ensure practitioner briefing in relation to ketamine and its harms are made available as part of the dissemination of learning from this review and to include key messages from the Stigma Kills NHS campaign

Recommendation – that KBSP submit a copy of this review to the Advisory Council on the Misuse of Drugs who are responsible for the classification and scheduling under the Misuse of Drugs Act 1971 (currently reviewing Ketamine classification).

6.16 Travellers

[31] Adapted from https://www.talktofrank.com/drug/ketamine#the-risks

[32] Ketamine bladder: Special clinics as youth addiction 'explodes' https://www.bbc.co.uk/news/uk-england-bristol-68826392

[33] source Rehabs Uk May 2024 - https://rehabsuk.com/blog/the-rise-of-ketamine-use-in-the-uk/

[34] https://www.judiciary.uk/wp-content/uploads/2024/11/James-Boland-Prevention-of-Future-Deaths-Report-2024-0599.pdf

[35] https://www.google.com/url?sa=t&source=web&rct=j&opi=89978449&url=https://www.cnn.com/2024/03/18/tech/elon-musk-ketamine-use-don-lemon-interview/index.html&ved=2ahUKEwi914XBoZ2LAxUZdUEAHWN3MsUQFnoECBwQAQ&usg=AOvVaw2BgeCL0SrO5A-o4YHhAQn_

6.17 Adam identified as a Traveller and had lived in caravans/vans on unauthorised sites in the Bristol area. The city has a significant number of unauthorised encampments of travellers and in some cases, these can be highly visible with large numbers of caravans and vans parked at the kerb side. Jess Fox, a New Age Traveller commented in his written evidence to the parliamentary enquiry in 2021,

"When we park up, we are often subjected to discrimination, unkind comments and even vigilante attacks by locals driven by prejudices that come from disdainful depictions in the media or stereotypical narratives of problem Travellers. This can mean we seek to find safety in numbers, travelling with friends or stopping for longer periods in small communities of those who we share a life with"[36].

6.18 The Council has a Gypsy Roma Traveller Team (GRT Team) which works to provide suitable places to park and where necessary enforce action against unauthorised encampments. The Team counts vehicles and locations every 6 months. In August 2024 the count identified 77 street locations comprising of 411 vans (though numbers are noted to increase at night), and it was estimated that there are around 620 people living in vehicles.

6.19 The Care Act (2014) provides no specific duties around van dwellers though in all other respects (wellbeing and safeguarding) equally applies to van dwellers who are living in the area.

6.20 In 2023 the Councils Public Health Service published a comprehensive Health needs analysis[37] of Travellers in the city. The analysis identified many challenges for the van community, however of note, and relevant to Adam's physical condition post hospitalisation, were the lack of basic sanitation including toilets and places to wash and the exclusion of van dwellers from access to health due to lack of postal addresses. The report further recommended that further research was required in relation to levels of substance use and its associated harms amongst vehicle dwellers in the city.
There are many types of van dwellers though it is probable that Adam was part of a traveller group who live in vans due to their heritage (Adam indicates he was living in vans before he was an adult) or have chosen to live "off grid".
Adam had been last known to reside in the Spring Street area of the city, in an unauthorised encampment of around 70 vehicles.

6.21 There was evidence of agencies recognising and recording Adam as a Traveller. This was often assisted by Adam or Sarah informing agencies of his living arrangements. In some instances, however, the Traveller status was omitted or if recorded not readily recognised by professionals. There was no evidence of Adam indicating any stigma associated with being a van dweller and in fact he stated that he found it difficult to stay full time in his temporary flat after his hospitalisation in 2023 due to his need to live as a Traveller. We should note that this will not always be the case and for example some Travellers such as those from the Irish Traveller community will often disguise that they are Travellers to avoid discrimination[38].

[36] https://committees.parliament.uk/writtenevidence/36394/pdf/
[37] https://www.bristol.gov.uk/files/documents/6665-health-needs-assessment-people-living-in-vehicles-bristol/file

[38] The Traveller Movement In their 2017 report, The Last Acceptable Form of Racism, described that hiding ethnicity was a dominant coping mechanism cited by 77% of participants in their study.
http://travellermovement.org.uk/index.php/news/last-acceptable-form-racism/

Comment – Bristol demonstrates exceptional practice in respect of understanding the non-homogenous nature, number and location of the van dwelling community through the work of the GRT team, Public Health and partners. Providing temporary or "meanwhile" sites on Council owned land awaiting redevelopment is commendable and goes beyond the traditional or more typical Council/Police enforcement and removal of unauthorised encampments. This work provides potential for targeted health awareness and support initiatives for example in relation to substance use treatment and prevention, access to advice and services and understanding of how to report safeguarding concerns.

Recommendation – That the KBSP partners engaged in this review each identify a single point of contact to lead on GRT issues within their organisations to enable multi-agency public health, welfare and safeguarding work with the traveller and van dwelling community.

6.22 Self-Neglect

6.23 The Care Act 2014 include self-neglect as a category of abuse and neglect and the Statutory Guidance (2016) acknowledges that behaviours can neglect hygiene, health or surroundings[39]. For Adam we see his withdrawal and in some cases discharge from treatment for non-attendance in 2023. This is the period prior to his eventual hospitalisation with significant weight loss and a reported non-compliance with medication. His family previously called an ambulance for a welfare check and Adam refused to go to hospital. Whilst this could be considered a failure to meet health and social care needs, we also know that Adam was dyslexic and may have not been aware of some appointments.

6.24 There are many causes of self-neglect and root causes may be difficult to establish but of the many causes it is worth considering traumatic life change in respect of Adam.

6.25 Adam was only 40 years of age. He lived an "off grid" lifestyle with very little contact with agencies and services. He was reportedly well known and indicated he had support of his community including for alternative healing. Of note he was only observed once in 2022 in his normal van living conditions, immediately following the serious assault. Later contacts were all at his temporary flat, hospitals, clinics, or his sister's home. He was physically affected by ketamine use in respect of his bladder and renal health and he had strongly expressed that he did not wish fitment of catheter and nephrostomy tubes.

6.26 Adam may therefore have been fearful about the psychosocial (that is the mental, emotional, and social effects) of his conditions. During his January 2023 hospitalisation he discusses that he cannot go abroad to recuperate as he wouldn't be able to participate in physical activities. In late 2023 he articulates to medical practitioners that he would rather die than have the nephrostomies permanently fitted.

[39] Often the reasons for self-neglect are complex and varied, and it is important that health and social care practitioners pay attention to mental, physical, social and environmental factors that may be affecting the situation (Braye, Orr, Preston-Shoot 2015) source https://bristolsafeguarding.org/media/j2nd32f2/kbsp-self-neglect-guidance-june-21-v2-1.pdf

6.27 The key indicator for identifying Adam's self-neglect was his weight loss. He had been recorded as weighing 75kg in April 2023 (after weight loss before and during his month inpatient treatment in January 2023). However, by mid-December this had fallen to 53kg upon admission to hospital again. Adam discharges himself and then upon his readmission just a few weeks later he is described as cachectic and weighing just 40kg with a significant pressure sore in his sacral and anal area. Agencies had limited contact with Adam in the previous months, so observation was not possible. It has been identified that records of weight are not readily visible in records, and this is addressed in the single agency action plan.

Comment - It is important to note that it has not been possible to identify what Adam's access to resources for food and basic living costs was though we know he was sanctioned from benefits.

Comment – The KBSP website contains clear signposting and practical resources for professionals in relation to self-neglect. The linked Multi Agency Guidance last updated in 2021[40] is comprehensive and directs professionals to consider initiating a Multi-Agency Planning Meeting if there is doubt that a S42 threshold is met. This is clearly written and accessible guidance. In Adam's circumstances loss of weight as an indicator of self-neglect is being addressed in the single agency action plan.
The partnership had a thematic review of self-neglect in 2021 (following the deaths of Charles and Bridget[41]) and have confirmed that actions have been significantly progressed.

6.22 **The presumption of Mental Capacity**

6.23 It is important to note that the Mental Capacity Act 2005 does not only apply to the individual's physical, emotional or mental welfare, it is based on the protection of the individual's autonomy to make decisions for themselves.

6.24 Except for the final hospital admission in January 2024 when Adam became physically incapacitated and was appointed an IMCA to advocate on his behalf with family and healthcare professionals, Adam was always presumed to have mental capacity. The records indicate that capacity assessment considerations were recorded on several occasions and were appropriate in respect of Adam and his expressed wishes.

6.25 Literacy

6.26 Adam had dyslexia though this was only known when Sarah, his former partner, notified hospital staff in early 2023 and asked to be a point of contact for Adam's appointment letters and texts.

6.27 It was recorded that Adam declared he was dyslexic when he made his initial benefit claim in 2023 with DWP though subsequent contacts did not reflect this and are being Investigated.

6.28 The GP practice had been alerted in a discharge letter that Adam could not read written communication. Reasonable adjustments were not recorded or made and the GP and some outpatient clinics continued to contact Adam via text and e mail. There are some

[40] https://bristolsafeguarding.org/media/j2nd32f2/kbsp-self-neglect-guidance-june-21-v2-1.pdf

[41] https://bristolsafeguarding.org/adults/safeguarding-adult-reviews/thematic-review-of-self-neglect

instances of appointments where Adam attends so might be presumed to have "read" or had assistance to read the communication (such as an outpatient appointment where he attends with his brother). Nevertheless, there are a significant number of non-attendances to outpatients or non-responses to messages from the GP and by the later months of 2023 Adam is being discharged from outpatient clinics for non-attendance. The GP practice is informed of this but makes no follow up enquiry.

6.29 In a US based study, researchers explored the impact of low literacy on patients and identified that many patients can feel a deep sense of shame and may not access or be able to access healthcare without support[42]. The study concluded that patients with poor reading ability have important problems accessing the health care system, understanding recommended treatments, and following the instructions of providers. Because of their shame, patients with low literacy may be unwilling to disclose their problem to health care providers.

6.30 The lack of comprehensive recognition of Adam's written communication difficulties and the roll out of online communication and appointment booking via NHS Digital from 2020 created a treatment and potential safeguarding gap. This may have been exacerbated with Adam's reluctance (we do not know if this was through either choice or fear, or both) to receive medical treatment. The position led to an unintended lack of reasonable adjustments as required by the 2010 Equalities Act not being considered.

Comment – Members of the panel reflected that in the importance of wider diversity and inclusion considerations it is possible that we may sometimes unintentionally miss the basic consideration of literacy or that most people can communicate digitally.

Recommendation – *KBSP partner agencies involved in this SAR to review the current reasonable adjustments in relation to client literacy and preferred communication to ensure these remain up to date and appropriate.*

7. Summary and Conclusions

7.1 Adam had little contact with any agencies prior to 2022. Following that he has episodes of contact with agencies linked to a serious assault and injuries sustained. Following his treatment he does not recontact agencies until he is hospitalised in December 2022 due to serious decline in his health due to his prolonged ketamine use. At this point it is considered that Adam may not survive, however, significant medical intervention, recovery, and post discharge planning including temporary accommodation and community nursing support is commendable.

7.2 Adam's traveller status was recognised by some agencies but not consistently recorded. The review recommends improved cultural competence and targeted support for the traveller community. The work of Public Health and GRT team from the City Council in recent years is commendable and provides a foundation for further improvement. Adam's case highlights the intersectionality of his protected and non-protected characteristics, including his traveller background, dyslexia, and substance use, which can lead to unconscious bias in service provision for some individuals in similar circumstances to those of Adam.

[42] **The health care experience of patients with low literacy**
D W Baker[1], R M Parker, M V Williams, K Pitkin, N S Parikh, W Coates, M Imara DOI: 10.1001/archfami.5.6.329

7.3 Substance use support in relation to Adam's ketamine addiction was not available due to his period of abstinence and he does not engage with the alternative options available to him. The review has identified varying levels of knowledge about ketamine and its harms among agencies. Ketamine use led to severe physical health issues for Adam, and there were missed opportunities for intervention.

7.4 Agencies were unaware, despite some recording, of Adam's inability to read written communication. He does not attend several outpatients and GP communications and subsequently is discharged from important areas of care relevant to his ketamine related bladder and renal functions. Adam receives virtually no benefits for his claim covering the last 11 months of his life. He had been sanctioned for not submitting written information (despite DWP being aware of his disability at initial claim). Adam's dyslexia impacted his ability to engage with services. The review highlights the need for reasonable adjustments in communication to support individuals with literacy difficulties. ***KBSP partner agencies involved in this review should each consider whether changes are required to ensure necessary reasonable adjustment in relation to client literacy and preferred communication.***

7.5 Adam withdraws from health support later in 2023 and reattends hospital after a ketamine overdose incident in September.

7.6 There are missed opportunities to refer Adam to safeguarding or services such as ROADS which may have allowed a wider understanding and support to be engaged.

7.7 The issues raised in the previous paragraphs in respect of individual agencies are acknowledged in the chronology and IMR as learning and improvement and reflected in the single agency action plan. This demonstrates a KBSP commitment to the Duty of Candour[43] and has assisted the review. Agencies positively identified 18 improvement actions within their Individual Management Reviews. These are contained in the action plan at appendix 2.

7.8 Concerned friends call an ambulance to Adam in December 2023 though he declines to be taken to hospital against advice of the paramedics, his duty GP and family members. The following day he is brought to hospital again in December 2023 and he has weight loss, severe pain and is in a similar condition to the December 2022 hospitalisation. He is stabilised however discharges himself around a week later just before Christmas. Adam's significant weight loss and non-compliance with medical treatment were key indicators of self-neglect. The review emphasises the importance of recognising and addressing self-neglect in safeguarding practices.

7.9 In January, Adam is brought to hospital again and had deteriorated further though on this occasion it is difficult to stabilise his condition. He has lost considerable weight and is possibly in renal failure. A s42 referral is made to Adult Social Care and initiated.

[43] The Duty of Candour Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20 is to ensure that health and social care providers act in an open and transparent way. In December 2023 the College of policing announced that the Duty of Candour was being introduced for Police following the Hillsborough Families Report.

7.10 Adam is incapacitated due to his condition and an IMCA is appointed who works to support decisions based upon Adam's previous indications, views of family and professionals. This is good practice and allowed Adam's voice in relation to his care to be heard with his family and close friends. There was good evidence of Adam's voice being heard, considered and recorded in a range of the records available to this review.

7.11 Adam passes away approximately one week following his admission to the hospital.

8. Recommendations

8.1 The reviewer had considered whether there was value in a recommendation for a multi-agency panel to consider complex individuals such as Adam. Since his death key services in Bristol have established an Adult Multi Agency Safeguarding Hub[44]. This facilitates effective multi-agency collaboration and timely information sharing to enhance the safeguarding outcomes for the population of Bristol. Adam would have met the threshold for referral due to his ketamine use and self-neglect. Due to the establishment of the MASH no recommendation for establishment of a further forum is made.

8.2 The review makes seven recommendations.

Recommendation 1 – that KBSP submit a copy of this review to the Advisory Council on the Misuse of Drugs who are responsible for the classification and scheduling under the Misuse of Drugs Act 1971 (currently reviewing Ketamine classification).

Recommendation 2 – Bristol drug and alcohol partnership to ensure practitioner briefing in relation to ketamine and its harms are made available as part of the dissemination of learning from this review and to include key messages such as those from the Stigma Kills NHS campaign.

Recommendation 3 - Bristol City Council Public Health are recommended to work with the local provider Horizons, and the acute Trusts, to improve pathways of care into treatment (including face to face assessments) who present with significant drug use issues and are not currently in treatment.

Recommendation 4 – Bristol City Council Public Health to explore the opportunities to capture ketamine use and trends as part of any future drugs needs assessment work.

Recommendation 5 – That the KBSP partners engaged in this review each identify a single point of contact to lead on GRT issues within their organisations to enable multi-agency public health, welfare and safeguarding work with the traveller and van dwelling community.

[44] The MASH provides a secure environment for the collation and analysis of information concerning safeguarding issues related to vulnerable adults or Adults at Risk (AARs). Efficient information sharing is crucial and a statutory requirement in safeguarding vulnerable adults, enabling better decision-making and more appropriate responses to safeguarding concerns. The MASH is supported on a weekly basis by staff from Bristol City Council Adult Social Care, Health System Partners, represented by the ICB Adult MASH Nurse, and Avon and Somerset Police. Additionally, other relevant agencies such as SWAST, Fire & Rescue, and housing may attend MASH meetings to improve outcomes for those adults identified and referred to the MASH for assistance and support. The criteria for entry into the MASH include the presence of safeguarding concerns for an adult and the potential benefit of information sharing with partner agencies to determine the appropriate course of action.

Recommendation 6 – KBSP partner agencies involved in this SAR to review the current reasonable adjustments in relation to client literacy and preferred communication to ensure these remain up to date and appropriate.

Recommendation 7 – That KBSP circulate a key lessons learning briefing to all partners for dissemination with relevant frontline staff.

Acronyms

Abbreviation	Full Form
A&E	Accident and Emergency Department
ASC	Adult Social Care
CIC	Community Interest Company
DHI	Developing Health and Independence
DWP	Department for Work and Pensions
GP	General Practitioner
GRT	Gypsy, Roma, Traveller
ICB	Integrated Care Board
IMCA	Independent Mental Capacity Advocate
IMR	Individual Management Review
KBSP	Keeping Bristol Safe Partnership
KG	kilogram
MRI	Magnetic Resonance Imaging
NBT	North Bristol Trust
NHS	National Health Service
PICC	peripherally inserted central catheter
QR	quick response code
ROADS	Recovery Orientated Alcohol and Drugs Service
SAR	Safeguarding Adult Review
SPOC	Single Point of Contact
UC	Universal Credit
WCA	Work Capability Assessment

Appendix 1

Safeguarding Adult Review (SAR) Terms of Reference

1. Introduction

A Safeguarding Adult Review (SAR) is a multi-agency review required by The Care Act 2014: Section 44 and conducted by a local Safeguarding Adults Board (SAB). In Bristol, the Keeping Bristol Safe Partnership (KBSP) fulfil the function of the local SAB. Local SABs have a statutory duty to arrange 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 SAB, its members or others worked together to safeguard the adult.
A SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).
SAB 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.

2. Subject details

This SAR is commissioned with due regard to the Care Act 2014, in response to the death of Adam.
Date and place of Death: January 2024, Southmead Hospital, Bristol
Home Address:
Other addresses -
Please note Adam was a traveller who was known to have lived in vans in the Bristol area.

Summary of Incident: Adam, aged 40, died in January 2024 at the ICU in Southmead Hospital with extremely low body weight. He was brought to the ED by a close friend due to his long-term abdominal pain and was noted as flu positive, self-neglecting and had a large pressure injury to his anus and sacrum. Adam had a 20-year history of using illicit substances including Ketamine causing bladder and liver damage. Adam was from the travelling community.
The **conclusion of the coroner** (July 2024) was that Adam died from complications due to long term use of Ketamine and that the cause of death was drug related.
Stuart Douglass has been appointed as the Independent Chair and Author of the review panel and agreed to commence these duties on 30/08/2024.

3. Purpose and aim of the SAR

The purpose of a SAR is to promote effective learning and improvement to prevent future deaths or serious harm from occurring again. The purpose is **not** to apportion blame to any agency or individual.
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

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

4. Methodology

The review will use a hybrid methodology including analysis of Individual Management Reviews (including reflective analysis), Information reports, relevant research and a combined chronology. This will be supplemented by a practitioner learning event and where possible the contributions of family and friends. This approach will provide reflection and development and allow opportunity to identify learning and improvement across the partnership.

5. Period under review

The panel agreed that the review should focus on the time period between **01/01/2022 and January 2024.**
The panel agreed that any relevant information concerning Adam before this time that supports the aims of this review be submitted in summary form unless it becomes apparent to the chair that the timescale should be extended.

6. Panel membership

The following agencies and individuals constitute the SAR panel:

Role	**Agency**
Senior Practitioner triage/ immediate response	Adult Social Care, Bristol City Council
Detective Chief Inspector and Head of the Major Crime and Statutory Review Team	Avon and Somerset Police
Deputy Designated Nurse for All Age Safeguarding	BNSSG Integrated Care Board
Service Manager	DHI
CRS Team Lead	DHI
Service coordinator	Gypsy Roma Traveller Team - Bristol City Council
Housing Safeguarding Reviews and Improvement Officer	Housing and Landlord Services, Bristol City Council
Specialist Safeguarding Practitioner	North Bristol NHS Trust
Named Lead for Safeguarding Adults	Sirona care & health CIC
Safeguarding Specialist	SWAST
Specialist Advisor	Housing and Landlord Services, Bristol City Council
Interim Director of Safeguarding	UHBW and NBT

7. Chronologies, Individual management reviews (IMR) and other reports

An Individual management review (IMR) and chronology of contact will be requested from the following organisations:

- Avon and Somerset Police - IMR

- Bristol City Council - Adult Social Care - IMR
- Bristol City Council - Housing and Landlord Services - IMR
- BNSSG/ICB - GP – IMR
- Drugs and Alcohol – Developing Health and Independence – IMR
- North Bristol NHS Trust – IMR
- Sirona care and health CIC – IMR
- University Hospital Bristol and Weston NHS Trust - IMR
- SWAST – IMR
- DWP – summary information report

All chronologies should focus on events from 01/01/2022 until January 2024
All chronologies and IMRs should be completed and returned by **29/11/2024**

8. Key lines of enquiry [or] research questions to consider:

All agencies required to submit IMRs are asked to respond to the key lines of enquiry listed below to assist in the following 3 overarching lines of enquiry.

1. To establish the events and to examine the agency interaction and support to Adam in the two years preceding his death.

2. To establish whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard Adam and to identify what should change as a result.

3. To apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.

Specific areas to consider;

4. Was the work in this case consistent with agency policy and procedures for safeguarding adults at risk of abuse and neglect, and wider professional standards?

5. Did action accord with the assessments and the decisions that were made? Were appropriate services offered and provided to Adam in light of those?

6. Was information shared in a timely manner and to all appropriate partners during the period covered by this review?

7. Were practitioners sensitive to the needs of adults at risk in their work, knowledgeable about the potential indicators of abuse or neglect, and about what to do if they had a Safeguarding Concern about an adult with care and support needs in these circumstances?

8. How was the principle of making safeguarding personal achieved? Did agencies consider Adam's wishes and feelings when providing care and treatment. Was Adam's voice recorded in interactions?
9. Were services aware of Adam as being from the Traveller community. Was this formally recorded in interactions?

10. Do agencies adequately understand the needs Traveller communities and challenges of service provision with them? Is this reflected in terms of both cultural competence of

staff and organisational policy? How does your agency work with the Traveller communities in Bristol?

11. Did agencies and their staff understand the potential harms of Ketamine use on Adam and to make appropriate intervention in respect of that?

9. Family involvement

Adam's partner and family will be contacted by the KBSP at the earliest opportunity. This will be done via letter and the SAR information for families' leaflet. The independent chair will ensure that family have the opportunity to engage in the review, provide Adam's voice to the review and to consider the draft overview report.

10. Media and communications

All media enquiries must be managed by the Communications Advisor to the KBSP in consultation with the KBSP Independent Chair.
Following an information governance review, the final report will be published on the Keeping Bristol Safe Partnership website.

11. Terms of reference agreed

The SAR panel considered these terms of reference at panel and then via correspondence on 9th October 2024.
The terms of reference will be kept under review by the panel throughout the review.

Amendments made	**Agreed by**	**Date**
Amendments made following initial panel by reviewer. Further addresses added. Panel members added. key dates and additional lines of clarification to kloe/research question section.		