Southampton Safeguarding Adult Board

Safeguarding Adult Review

Name: Gianbir Date: April 2024

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1. Introduction

1.1 The Care Act 2014 states that Safeguarding Adult Boards (SABs) must arrange a Safeguarding Adult Review (SAR) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked together more effectively to protect the adult. This is a statutory responsibility.

1.2 The overall purpose of a Safeguarding Adult Review is to promote learning and improve practice, not to re-investigate or to apportion blame. 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 issues
- how to improve local inter-agency practice
- service improvement or development needs for one or more service or agency.

2. Reason for Safeguarding Adult Review

2.1 South Central Ambulance Service (SCAS) were called to home address of Gianbir in early December 2021 by their family member/carer, reporting that Gianbir was having difficulty breathing and was very unwell. On SCAS attendance the crew noted significant concerns regarding the environment and Gianbir, was very unwell. There were considerable concerns about the extent of Gianbir’s unkemptness and that there was no internal door handle on the door which would allow Gianbir to leave if he needed to. The family member/carer could not give any information pertaining to Gianbir’s past medical history, allergies etc. although they identified themselves as his primary carer.

2.2 Gianbir was taken to Southampton General Hospital (SGH). Upon arrival noted as COVID positive, with serious chemical burns to his genitals and general groin area, subsequently, he was found to have an occlusion to the aorta.

2.3 The safeguarding team for SGH were notified of the situation and the injuries. A safeguarding alert was submitted to ASC on the same day. The Police were

contacted two days after Gianbir had been admitted, when the safeguarding team came on duty. Gianbir died a few days later. The family member/carer was not able to be see Gianbir due to not completing a COVID-19 lateral flow test as requested, and advice was offered to support completion.

2.4 A criminal investigation has concluded, and no further action has been taken.

3. Scope of the review

3.1 The Southampton Safeguarding Adults Board (SSAB) Case Review Group (CRG) recommended that this case met the criteria for a Statutory Safeguarding Adult Review at its meeting of **28 May 2022**. The case was re-discussed at CRG on **7 December 2022** and confirmed that it met criteria for a Safeguarding Adult Review.

3.2 The time period reviewed was **16 December 2019** to the date of Gianbir's death on **16 December 2021.**

3.3 Key Lines of Enquiry (KLOE)

1. **Lived experience of Gianbir**
   How was the voice of Gianbir, along with his views and wishes, captured by agencies involved in his care? Was consideration given to the pattern of engagement/presentation between Gianbir and his main carer? Were there any language or cultural issues considered by agencies?
2. **Impact of the Covid-19 pandemic on Gianbir's lived experience and care**
   What was the impact of Covid- 19 infection/restrictions on the individual, their family members, and services?
3. **Care co-ordination and oversight for Gianbir's mental health and wellbeing**
   Practice in respect of monitoring by primary care when care coordination is stepped down by secondary health agencies.

The following KLOES will be considered in the context of the learning from previous SARs:

4. **Disparity between MARMs and safeguarding**

   Consideration of the disparity between the use of the 4LSAB Multi Agency Risk Management Framework and when safeguarding enquiries should be started.

5. **Effectiveness of any application of the Mental Capacity Act 2005**

   Did agencies establish whether Gianbir was able to consent to his care arrangements and if unable to do so, was there evidence that the Mental Capacity Act (2005) was utilised? What evidence was there about the use of the Mental Capacity assessments for Gianbir? How does this relate to the learning from other reviews?

6. **Assessment of level of care needed and the support for carers**

   Was there adequate support and input by agencies to Gianbir's brother as his primary carer? Where professionals considered that adequate care was not being provided, was there professional curiosity and tenacity in ensuring that Gianbir was in receipt of the correct level of care? Was a Carers Assessment offered? How does this relate to the learning from other reviews?

3.4 Agencies involved

- Hampshire Constabulary
- Southampton City Council Adult Social Care
- Primary Care/Integrated Care Board
- Solent NHS Trust
- University Hospitals Southampton Foundation Trust
- Southern Health Foundation Trust
- South Central Ambulance Service
- Voiceability

3.5 Methodology

3.5.1 The methodology focused on the practitioner event and a case review panel to work with the independent reviewer to clarify information specific to Gianbir, consider learning from other Southampton reviews and develop recommendations for changes to practice.

3.6 Evidence used

- Individual Agency summaries of involvement with Gianbir.
- A review of relevant policies, procedures, and processes
- Practitioner reflections on their involvement with Gianbir

4. Family Engagement

4.1 Gianbir's brother was informed of the review and invited to contribute. He returned the letter and asked for the review to be cancelled. Follow up was made by the SSAB team with Gianbir's brother. He confirmed that he did not want to be involved or to talk to anyone about the process.

4.2 The panel agreed that further contact with Gianbir's brother would be made on completion of the review. This has been completed and he remains of the view that the review was not necessary. He did agree to receive the report when ready for publication.

5. Parallel Investigations

5.1 Following Gianbir's death, a police investigation commenced to check if there was any criminal neglect. This was concluded not to be the case and no further police action was taken. There was a police referral to the Community Safety Partnership for a potential Domestic Homicide Review (DHR). The decision was that Gianbir's experience did not meet the criteria for a DHR.

5.2 Following a Home Office Postmortem, the Coroner concluded that the death was due to natural causes and no inquest took place. The Postmortem found no evidence of neglect. The cause of death was linked to him having COVID, which was linked to the blood clots, and this was likely to have taken only 24 hours or less, to get to the stage that it did. At the point of the postmortem, the injuries caused by chemical burns to his groin area were superficial and showed no evidence of prolonged self-neglect. The SAR panel noted that this contrasted with the report by SCAS when they assessed Gianbir at home, prior to the hospital admission, which was provided to the Coroner. The panel considered that, as Gianbir had been in hospital for several days prior to his death, the extent of the external signs of neglect might have been removed due to the care Gianbir received in hospital, e.g., hair and nails trimmed and cleaned.

6. Gianbir

6.1 Gianbir was a 55-year-old man of Asian heritage who lived with his brother in private housing. He was born abroad but came to the UK as a young child, along with his parents and siblings. In the information provided to the SAR, it was noted that his religion was Sikh.

6.2 In his 20s Gianbir was diagnosed with schizophrenia. For approximately 25 years he was, at times, under the care of the Community Mental Health Team. During this time his brother was known to be his main carer, taking him to appointments and assisting with his communication, cooking, paying bills and collecting medication.

6.3 Although not his first language, Gianbir was considered, by the Mental Health services (who knew him well), to be able to understand and communicate in English. However, due to the symptoms arising from schizophrenia, of mutism and catatonia, he was unable to speak many words and tended to use one-word answers. Gianbir's brother was known to routinely answer for him.

6.4 Little is known about how Gianbir spent his life prior to his death in December 2021.

7. Contextual Background

7.1 Over a period of 25 years, Gianbir had been known to Primary Care and the Community Mental Health Team (CMHT), due to the long-standing diagnosis of schizophrenia. He had episodic involvement with the CMHTs. It was noted that Gianbir was offered the necessary periodic health reviews by the GP. However, it was also noted that there was a pattern of difficulties in engaging Gianbir.

7.2 Housing had a record of contact with Gianbir's brother in 2002, when he made a housing application on behalf of himself and Gianbir. He was noted as stating that his house was in disrepair, and he had a carer living with him. He was advised he

did not qualify for SCC accommodation as he was classed as adequately housed and, he didn't qualify due to the level of equity he had in the house. He said he needed to move out whilst work was being completed and advice was given regarding the support he could get for this.

7.3 The police records showed that they had been contacted anonymously in 2012, by an informant who reported that they often heard a male screaming, from the address, and that this had been going on for years. The informant reported that they believed the younger brother was cared for by the older brother in the house, with the younger brother locked up and never let out. The informant reported that they knew someone who had been in the address and that there was a bucket full of urine and the home was in a bad state. It was recorded that Gianbir's brother was spoken to by local police and a safeguarding visit completed.

7.4 Adult Social Care knew Gianbir mainly through their joint working with the integrated mental health teams. A Care act assessment was undertaken in 2014. At that time Gianbir lived with his brother who was his main carer when he was assessed as needing support with prompting for personal care, nutrition, community access and support to manage his finances. Essentially, he was unable to meet most of the aspects of daily living without prompting and support from his brother. A direct payment was set up to provide a paid carer to supplement the care from his brother and the extended family, who lived locally. It was noted Gianbir was suffering from Schizophrenia, did not speak English (only Punjabi), although it was believed that he understood spoken English.

7.5 At the end of 2017 Gianbir attended a mental health review follow-up, where it was noted that there were some concerns that the level of help that his family were providing was insufficient. It was also noted that Gianbir was uncommunicative, and his brother spoke for him at appointments. In 2018, an allocated worker from West CMHT requested support from ASC to review Gianbir's care needs and to review the use of the direct payment and compliance with the regulations. The review took place and the meeting with Gianbir and his brother concluded the direct payment was not needed and had not been used for its original purpose

since first being set up. Gianbir was still being cared for by his brother and wider family. Financially they were able to support him using his benefit payments and carer's allowance. He still needed prompts to manage to self- care and was able to go out accompanied by his brother.

7.6 During those 25 years, no agency seemed to be able to fully understand the nature of the relationship between the brothers, any cultural aspects to Gianbir's care and support needs, or the long-term plans for his care by his family. By 2019, it is not clear whether any of Gianbir's other family members were still alive, or in a position to support him. From the information gained in this review, by this time, the two brothers were alone.

8. Key Timeline 2019-2021

8.1 In the summer of 2020, there was a report to the environmental health department of Southampton City Council regarding a noise concern relating to the home of the family. It was reported that there were *"loud, screaming noises*" and that the person had only once been seen outside of the house in 14 years. The windows were reported to be boarded up and the informant was concerned about the safety of the individual. This was passed to Adult Social Care. It was not shared with the police. There seemed to be no alignment with the 2012 reports from the local community.

8.2 In August 2020, following contact from Adult Social Care highlighting behaviours indicating an apparent deterioration in Gianbir's mental health, the GP contacted Gianbir's brother who reported that "*everything's fine*".

8.3 Subsequently, the GP referred Gianbir to the Central CMHT requesting a mental health assessment. The referral indicated that the neighbours had contacted social services and reported that they could hear "*loud strange screaming noises*" coming from the house during the day and night, with someone who does not usually leave the house having climbed over the wall "*looking for god*". The GP reported that the last prescription for the anti-psychotic medication was issued in February 2019 and so Gianbir had not taken medication since that date.

8.4 In September 2020, the CMHT sent a letter offering an assessment and wrote to the GP asking for the medication to be restarted. The assessment was completed although Gianbir did not fully engage. He was reported to repeatedly say he was fine and planned to see his GP for the medication, as he had misunderstood that he was required to continue the medication once he was discharged from the team. He denied any bizarre behaviour that was described in the GP's letter at the point of referral to the CMHT. A home visit was then offered for later in September 2020. This visit by the shared care team went ahead and there were concerns about Gianbir's well-being, the conditions of the property and possible safeguarding concerns. A social worker was allocated and a request for Consultant Psychiatrist input and a safeguarding concern was raised.

8.5 At the end of September 2020, a home visit was undertaken, and the CMHT reported Gianbir had a strong body odour and they could smell faeces. The staff assessing managed to speak to Gianbir alone, but his brother returned and spoke for him. The CMHT noted that the care of Gianbir by his brother was poor, and it was recorded that this could be due to carer stress and intentional, or unintentional neglect. It was agreed with the allocated social worker, that a Care Act assessment would be offered, along with enquiries about the brother's needs; risk assessment about finances and neglect, and an appointment of an independent advocate.

8.6 At the start of October 2020 the shared care team called at the property but there was no response, the brother was aware that this appointment had been offered. It was planned that shared care would go out again in a few days. A letter was sent out with the next appointment that had been planned. Following this Gianbir was closed to shared care, and it was requested that a social worker was allocated, to follow up on care and treatment.

8.7 At this point the social worker and case worker visited Gianbir at home, to carry out the Care Act assessment. Gianbir was dressed smartly, clean and made good eye contact and was now taking his prescribed medication. When support was offered, his brother said this was not required, as they supported each other and

always had. The social worker linked in with the GP on aspects of care and treatment. A few days later, Gianbir's brother spoke with the social worker, who informed him that the service was involved in Gianbir's care and treatment and Gianbir's brother confirmed that he had collected Gianbir's medication. A referral to the fire service was offered to fit smoke alarms, which was to proceed to referral. Gianbir's brother requested a previous psychiatrist who knew his brother well, to become involved.

8.8 In October 2020, Gianbir was seen for health review by the GP. Gianbir was noted to be non-verbal and was accompanied by his brother, who acted as chaperone/communicator. The GP observed Gianbir to appear well and was '*well kempt*'. The GP also noted that Gianbir's brother was '*adamant*' that home visits were not necessary and stated that '*it is a waste of time to attend an appointment to try and talk*'.

8.9 Later that same month, the GP contacted Gianbir's named Mental Health worker to share concerns that it was difficult to contact Gianbir via his brother's telephone, as it was apparently not connected. The GP shared concerns about the potential for Gianbir not to engage and questioned his mental capacity to decide on his treatment. The Mental Health worker confirmed there were no plans to discharge Gianbir, and that a best interest meeting may be necessary.

8.10 Towards the end of October an appointment was arranged by the CMHT social worker to discuss fire safety equipment. It was noted that Gianbir was clean; watching a film; made good eye contact and responded to the social worker verbally. Gianbir's brother said that the medication was supporting him to become well, and the social worker asked to see the medication packet. An advocacy referral was made to Voiceability to ensure that Gianbir was able to express an independent view about his care and treatment.

8.11 In mid-November 2020, a CMHT home visit was made during which Gianbir was seen to be watching a film and appeared to be improving in his mental state in relation to communication and eye contact.

8.12 In mid-December 2020 Gianbir was visited at home by the CMHT allocated social worker. Gianbir was noted to be able to remember who the social worker was, and replied to questions, albeit verbal communication was limited. He said he had eaten, been for a walk and was happy to see the social worker again.

8.13 At the beginning of February 2021 there was a home visit made by the SW and case worker. It was recorded that there was ongoing improvement now the medication was established. Both brothers were noted to be in a positive mood. It was noted that they stated that they did not require any additional support at this time, although it was not clear whether this was Gianbir or his brother speaking.

8.14 In March 2021 the social worker and Voiceability visited Gianbir at his home. He was able to respond with yes and no, in reply to the advocate. His brother indicated they hoped to visit their local community group, now that Covid restrictions were lifting. Voiceability felt the brother was a representative for Gianbir and that their service was not required.

8.15 It was agreed after a discussion with a Team Leader at the Central Team that care would be transferred to outpatient care, and that part of the transfer plan was for the GP was to advise the team if medication was not collected. It was agreed that Gianbir would continue to be seen in the Outpatient Department under the review of the consultant psychiatrist.

8.16 In May 2021 the consultant psychiatrist recorded that there was no evidence to suggest Gianbir was being exploited or neglected and the advocate felt Gianbir's brother was a good advocate. Gianbir was well dressed, clean and not malodorous. There were no physical health concerns. He was checked by the GP and the social worker's concerns were resolved. The plan was for the social worker to see if a mobile was accessible and to arrange a review, contingent on phone access. The letter was copied to Gianbir's GP from the Southern Health Community Mental Health Team (CMHT) which indicated that Gianbir had been seen regularly and would now be discharged from the CMHT. The content of the letter indicated that Gianbir was able to verbally communicate at this point, as the letter referenced him accessing a phone to talk with his psychiatrist.

8.17 In October 2021, the social worker emailed the consultant for a request of medication. A care plan was in place for care and treatment and a risk assessment. There was consideration of whether an interpreter was required, but it was felt that communication had improved, over the period when the medication was reinstated, and that there was good rapport between the social worker and Gianbir. It was also highlighted that the social worker had asked for the advocate be involved, to ensure Gianbir's views on his care and treatment and the support from his brother, were represented.

8.18 According to his electronic GP notes, Gianbir last had face-to-face contact with his Solent NHS GP early in November 2021 for a routine appointment, to monitor his blood pressure and pulse. An Electrocardiograph (ECG) was also completed at this appointment. It is documented that Gianbir was brought to this appointment by his brother. There was an attempted home visit, made by a Health Care Assistant, for a follow up blood test three days later. However, there was no reply from the home.

8.19 In December 2021, Gianbir's brother called an ambulance, reporting that Gianbir was having difficulty in breathing and was very unwell.

8.20 When the ambulance crew arrived at the address, they found the home to be in a bad state. They noted that Gianbir was lying in a pool of his own excrement, his clothing was soaked with urine and there was a bucket in the corner of the room that he appeared to have used as a toilet. They also noted that there was no internal door handle on the door which would have allowed Gianbir to leave.

8.21 Gianbir's brother identified himself as Gianbir's primary carer but could not provide any information relating to Gianbir's past medical history, apart from that Gianbir suffered with a mental health condition, but his brother did not know what. It was reported that the brother repeatedly said that he looked after Gianbir as best as he could.

8.22 Gianbir was conveyed to hospital where he was found to be Covid-19 positive and had serious burns in his groin, seemingly caused by significant periods of

time where urine and faeces had been left to seep into the skin. He was found to have an occlusion to the aorta and was given a fatal prognosis. It was not known if the occlusion has been caused by immobility or Covid. Gianbir's brother was reported to reiterate that he looked after Gianbir as best as he could.

8.23 Gianbir was sedated and kept alive by artificial life support. The hospital tried to contact his brother but were unsuccessful for two days. He then attended the hospital but was denied entry as he refused to complete a lateral flow test, which the hospital was insistent on, given Gianbir's positive test.

8.24 The hospital requested an Independent Mental Capacity Advocate (IMCA) be notified in order to support decision making for Gianbir, at the end of his life.

8.25 Gianbir died in December 2021, five days after he had been admitted to hospital.

9. Analysis through the Key Lines of Enquiry

9.1 Lived experience of Gianbir

9.1.1 At the Practitioner Event it was reported that Gianbir could communicate and was able to understand English, although not all the time. When Voiceability visited the home, there was a definite sense that Gianbir understood what was going on and his brother was advocating for him. At that point there was no reason for advocacy services to be involved.

9.1.2 There was good practice undertaken by the CMHT and GP to seek to speak to Gianbir to gain his views. This included the home visits undertaken to speak to Gianbir in his own environment.

9.1.3 However, when the timeline is considered, there could have been a greater focus on how practitioners assessed the ongoing response from Gianbir's brother to professionals. There seemed to be engagement by Gianbir and his brother when they needed to placate professionals, yet the door was unanswered at follow up visits.

9.2 Impact of the Covid-19 pandemic on Gianbir's lived experience and care

9.2.1 When the concerns came through to agencies in the summer of 2020, there was a good response by professionals, to come together to identify what was needed for Gianbir. This included home visits by the CMHT. This was at a point in the Covid-19 pandemic when there was no vaccine programme, and the country was coming out of the first lockdown period. There were concerns about vulnerable individuals; risks to the population's health and care workers, and home visits were limited.

9.2.2 For individuals with care and support needs, and their families, this was a time of intense isolation and fear of the coronavirus, particularly for those within some minority ethnic groups, due to job types ,economic vulnerability, and underlying health conditions.[1]

9.2.3 During 2021, Gianbir was in the initial cohort to be offered the vaccine, but he had declined, as he had done previously, when offered flu vaccine. When Gianbir was admitted to hospital in the days before his death, his brother refused to complete a lateral flow test. It is not clear, how Gianbir contracted the virus. It is also not clear whether the brothers had access to testing, prior to the admission to hospital.

9.2.4 The lateral flow tests were not simple to use. There were instructions to follow, and it is not clear whether Gianbir's brother was able to follow these instructions.

9.2.5 Gianbir had been reported in 2020, and previously in 2012, to never go outside. It is not known how much his brother went out into the community. At the practitioner event, there was a sense that both brothers only ever went out, when necessary, e.g., for Gianbir to attend the GP.

9.3 Care coordination and oversight for Gianbir's mental health and wellbeing

9.3.1 At the practitioner event, there was a discussion about how individuals are stepped down from secondary mental health care. It was agreed that this process

[1] Platt, L. Warwick, R. (2020) Are some ethnic groups more vulnerable to Covid19 than others? The Institute for Fiscal Studies. Are some ethnic groups more vulnerable to COVID-19 than others? | Institute for Fiscal Studies (ifs.org.uk)

needs to be clearer. For Gianbir, there was a 'step down' to the GP. This would have meant that the GP would issue repeat prescriptions, However, for Gianbir, there was no evidence of medication monitoring, given he had not taken the medication for a considerable time, which was only picked up when there was a concern raised by a member of the community.

9.3.2 Once the CMHT stepped Gianbir down again in 2021, there was more clarity for the GP to raise an alert with the CMHT if there was evidence that the medication was not routinely being administered.

9.3.3 The SAR panel was informed that there is extensive work in progress to improve the primary care systems for monitoring of long-term medication for individuals.

9.4 Disparity between MARMs (Multi Agency Risk Management) and safeguarding

9.4.1 The reviewer of the GP records concluded that there was a potted history of concerns regarding neglect/self-neglect/mental health problems/poor engagement and suggested that there should have been a Section 42 Enquiry into the care of Gianbir. In the absence of the application of the statutory framework, Gianbir may have benefitted if the 4LSAB MARM framework had been utilised (although it is possible this would also have been declined/refused).

9.4.2 The description of the home situation for Gianbir in 2012, and in 2020, by members of the community, should have warranted joined-up consideration by agencies, beyond the CMHT and GP. This could have enabled a clear plan of needs identification and associated actions. CMHT made planned interactions allowing the brothers to present the home in a favourable way. This could also have been considered through the MARM process.

9.4.3 The report from the ambulance service regarding Gianbir's inability to leave his room and the state of the home, should have initiated safeguarding referrals being made to Adult Social Care, for consideration of a s42 Enquiry.

9.4.3 This has been reviewed within other local SARs and has led to a programme of work to strengthen the interface between MARM and s42 enquiries. (The local four Safeguarding Adult Boards (4LSAB) in the region have completed a MARM review, informed by findings of several SARs, in relation to disparity between s42 Enquiries and the use of MARMs. The review has led to revised guidance which is being implemented with a clear message to practitioners about the primacy of S42 over MARM. This was recently launched in June 2023).

9.5 Effectiveness of the application of the Mental Capacity Act 2005

9.5.1 There were clear points where practitioners sought Gianbir's consent. This was recorded as being achieved, at times, without his brother present.

9.5.2 At the practitioner event, it was discussed how the Mental Capacity Act (MCA) could have been explicitly considered in the context of Gianbir not taking his medication, given he was reliant on his brother to request medication. It is not clear what Gianbir's views were as to why he had not been taking it for so long, or about his understanding about the impact of the 'step down' from the CMHT.

9.5.3 Other Southampton SARs[2] have recently questioned the effectiveness of the application of the MCA across health and social care services. This has led to a programme of work to raise awareness of the Mental Capacity Act 2005. The focus of this programme is to give practitioners clear guidance on the legislative duties and responsibilities placed upon them.

9.6 Assessment of level of care needed and the support for carers

9.6.1 The GP records review showed that Gianbir's brother may have struggled at various points over the years. Gianbir had never lived independently, and his brother had informed professionals that the two had supported each other throughout their lives.

9.6.2 A carer's assessment had been offered to Gianbir's brother, but he had declined. Prior to the timeline for this review, it was evident that there had been a review

[2] SSAB 2020 Brenda SAR; 2022 Louise SAR

of the care being provided to Gianbir and direct payments were discontinued. However, there should have been more in-depth assessment as to how Gianbir would receive care, and how his brother could be supported to do so. At the time, there seemed to be other family members providing support, but this was not so clear during the timeline of 2019-2021.

9.6.3 At the practitioner event, it was discussed that there should have been more consideration of Gianbir's brother's needs as a carer. This was particularly in relation to how he understood the implications of the care that Gianbir needed. For example, when Gianbir's brother was told he needed to complete a lateral flow test before entering the hospital, there was no consideration of whether he understood how to do the test, or whether he knew where to get help.

9.6.4 Since Gianbir's death, there has been considerable changes made. It was reported that there is a new policy for health providers to identify carers and to offer support. An adult carer support service is being set up in Southampton, commissioned by the Integrated Care Board. There is also a group which has representation from Adult Social Care and all local health providers in the city, reporting to the Carers Partnership Board, who oversee the delivery of the Carers' Strategy.

9.6.5 There were indicators of self-neglect by Gianbir. However, the impact of this on his health and wellbeing, and that of his brother, was not considered. Since this case, there has been considerable development by the Southampton Safeguarding Adults Board (SSAB) in relation to self-neglect, with the creation of guidance specific to:

- Overview of self-neglect
- Hoarding
- Substance misuse
- Trauma
- Homelessness

10. Findings

10.1 There was some good practice by agencies to support Gianbir during his final years. Environmental Health, Adult Social Care, the GP and CMHT all responded well, when concerns were raised about Gianbir. This was at a critical period during the Covid-19 pandemic, when services were stretched and home visiting limited. The fact that home visits took place and agencies persevered when the brothers did not answer the door, was good practice. When his brother called an ambulance in the days before Gianbir's death, there was prompt action taken by SCAS to make a safeguarding referral.

10.2 However, no agency knew Gianbir well enough to be able to understand how he was living in a home that was in such a poor state, and in a room with no door handle. There was a disparity in how the CMHT and Voiceability saw the home when they visited during 2021, to how SCAS viewed it when they attended the home in December 2021.

10.3 Gianbir's brother has declined to contribute to the review, which means that it is difficult to fully comprehend the lived experience of this family. There has been consideration as to the extent to which the lived experience of this family is representative of other households across Southampton. The conclusion, in consultation with those at the practitioner event, is that Gianbir's situation can draw the SSAB to three wider themes for greater learning.

10.4 Culture and Language

10.4.1 The conclusion of those at the practitioner event was that the most crucial learning from Gianbir's case was in relation to culture and language.

10.4.2 Gianbir had never lived independently, yet there was little understanding as to the reason why, i.e., possibly due to a stigma relating to his schizophrenia diagnosis, culture, or the family's lack of knowledge about what support they could have to care for him. Although it was reported that Gianbir was a Sikh by religion, this was not widely recorded by agencies and there was no information regarding any professional asking further questions of Gianbir's religious beliefs and how that might impact on the care and treatment he wanted. This indicates

that there was not sufficient consideration of how ethnicity, culture or religion impacted on the support that Gianbir received. This has been highlighted nationally as crucial when undertaking SARs.[3]

10.4.3 There are national SARs[4], as well as other reviews[5], that indicate how agencies can misinterpret an individual's understanding when English is not their first language. This needs to be particularly considered when dealing with complex information, such as when there is medical treatment to discuss.

10.4.4 Another issue that is shown within Gianbir's experience, and in national SARs, is how services continue to use family members as interpreters. This means that the individual is not always spoken with, alone and assumptions can be made as to the views of that individual. It also places family members in a difficult position as they might not have the language capability to fully understand medical explanations.

10.4.5 Culture is a focus of another SAR (Anna) currently underway at SSAB, posing further opportunity to attest competence demonstrated by practitioners and how the approach can be strengthened, in relation to cultural impact on both service user and worker.

10.4.6 In Gianbir's situation, it is not clear why professionals did not record his cultural needs, e.g., religion, community networks. For the mental health teams, it would appear that he had been known for 25 years - prior to a time when possibly there would have been less expectations on workers of being culturally aware, however assessments are updated and opportunities to update this information existed. Additionally, most workers, from all agencies, appeared to treat Gianbir and his brother as a unit, and not as separate individuals. This could indicate a lack of professional enquiry and curiosity to consider Gianbir's lived experience;

[3] Preston-Shoot, M. et al. (2020) Analysis of Safeguarding Adult Reviews. LGA
[4] Rochdale SAB (2023) SAR H; Lincolnshire SAB (2019) Learning from the experience of Large-scale Modern Slavery; Slough Safeguarding Partnership (2020) SAR Mr A.
[5] Merton SCP (2021) Child H: Ananthi

his mental capacity in decision making and or what may have been in his best interests.

Recommendations

- The SSAB should develop guidance on culturally competent practice, in partnership with cultural community groups, supported by briefings and shared learning events (this is aligned to the learning from SAR Anna).
- There must be a shared expectation by all SSAB members that they will commit to ensure that staff have access to professional interpreter services for individuals, for whom English is not their first language, with care and support needs in relation to assessment and decision-making requirements.

10.5 Lived Experience: Think Family

10.5.1 There was limited understanding of the lived experience of the two individuals living in the home. Gianbir had never lived independently, his brother advising they had both always looked after each other. There seemed to be no discussion with them about how they would manage as they aged. When Gianbir was admitted to hospital, he was Covid positive and was in a poor state of health. However, it was not established whether his brother had been unwell and the impact of the deterioration of Gianbir's health on the brother's capacity to provide care for him.

10.5.2 At the practitioner event, there was an ambition for all agencies to adopt a think family approach to adult services. For example, had any practitioner been able to develop a trusting relationship with Gianbir's brother to establish what help he would accept (if he was struggling at any point), then he might have sought help at an earlier stage. Additionally, more could have been done to find out Gianbir's views about his circumstances and how he wanted to be supported, if anything happened to his brother.

10.5.3 What is striking in Gianbir's experience is that, although several agencies were aware of the family for several years, there was no understanding of what Gianbir, or his brother wanted, in order to enable them to live fulfilling lives. Gianbir was cared for by his brother, but there was no formal caring role. Given the length of time that Gianbir needed someone to provide his care and support,

there seem to have been assumptions that his brother was happy to do this. From a cultural perspective, this might have been due to expectations that family care for their own, and that it would not be appropriate to ask for help and Gianbir had been cared for by his brother for at least 20 years. There was no evidence of how agencies considered a changing experience for the brothers, as they aged, and in the wake of the deaths of the other siblings who had previously offered some support. Greenwood and Smith (2019) describe the motivation for informal carers as being mainly due to long standing family relationships, such as siblings, or some due to duty and obligation.[6]

10.5.4 ASRA (2021) highlights how some communities face challenges in accessing the resources to meet their needs in caring for family members, highlighting the experiences of migration, poverty and intergenerational trauma that need to be understood by the professionals offering support.[7] ASRA (2021) describes the need for support systems that create spaces for carers based upon who they are caring for, e.g., a space for people caring for their siblings.[8]

Recommendations: Lived Experience

- The SSAB should develop a multi-agency protocol which sets out how agencies commit to facilitate their staff in gaining the views and wishes of individuals with care and support needs directly, rather than with any influence from a third party. The protocol should include how agencies can support staff through supervision to discuss how to access individuals who are viewed as hard to reach, and to explore the role of family members in the individual's life.

10.6 Professional Curiosity in Safeguarding Adults

10.6.1 There was good practice in how agencies worked with Gianbir. Nonetheless, the absence of crucial understanding of the lived experience of the family,

[6] Greenwood, N., Smith, R. Motivations for being informal carers of people living with dementia: a systematic review of qualitative literature. *BMC Geriatr* **19**, 169 (2019). https://doi.org/10.1186/s12877-019-1185-0
[7] ASRA (2021) What does community care look like for Punjabi communities? What does community care look like for Punjabi communities? – Asra: The Punjabi Alcohol Resource (asranow.ca)
[8] ASRA (2021) What does community care look like for Punjabi communities? What does community care look like for Punjabi communities? – Asra: The Punjabi Alcohol Resource (asranow.ca)

suggests that practitioners could have been more curious about how the household functioned. For example, Gianbir's brother told professionals that they would be accessing support groups once the initial Covid restrictions had been lifted. However, there was no indication about what community activity Gianbir took part in prior to the pandemic. The only clear picture is that of a neighbour describing how they had only seen Gianbir once in 14 years and the description of an individual screaming, should have elicited more questioning of when this happened. There seems to have been an assumption that it was down to Gianbir not taking his medication, yet the indication from the neighbour is that this was not a recent issue.

10.6.2 There will be other households that choose to be isolated from their community. However, when a member of the household needs help to meet their care and support needs, practitioners need to be provided with the tools to enable them to be effective in asking the questions to build a true picture of how safe the situation is for the adult at risk.

10.6.3 For Gianbir, there is insufficient understanding of the environment he was living in. Professionals who visited did not raise concerns about the state of the home, until the ambulance crew when Gianbir was conveyed to hospital. It is not clear to what extent Gianbir neglected himself, or whether his brother was unable to provide the level of care Gianbir needed as his health deteriorated. Neither brother asked for help.

10.6.4 Practitioners need to be able to access safeguarding supervision to be able to unpick the risk or need assessments they undertake in the community. This will support them to think safeguarding and reduce the risk of normalising evidence of neglect.

Recommendation: Professional Curiosity The Gianbir SAR has raised questions regarding how professionals recognise and respond to indicators of self-neglect. Other Southampton SARs have made recommendations related to this. It is recommended that the SSAB evaluated the

effectiveness and accessibility of the tools available for assessment of household functioning. This should focus on revisiting the recommendations from the Diana, and Nicola SARs and the Angela Tabletop Review, to assess the impact of the changes made in response to the recommendations in those reviews.

- The SSAB should seek to understand the barriers professionals are faced with when undertaking community assessments where the individual is difficult to engage with services. This is also set out in the Nicola SAR, and the fact that this is a theme within two SARs should make this a priority for the SSAB to explore what support can be provided to practitioners to engage individuals. The SSAB should require partner agencies to have disengagement policies in place.

- How effectively has the SSAB implemented the recommendations from the Angela Tabletop Review?: Agencies should use the Multi-Agency Risk Management Framework to manage cases where a Section 42 safeguarding threshold is determined not to have been met by the Local Authority for statutory safeguarding response but who would still benefit from a multiagency risk management approach.

- In the Diana SAR (2021) it was identified that not all agencies were confident in calling MARMs. The SAR recommended that the SSAB should ask for assurance from the agencies that there is guidance in place for MARMs, that staff have had training and have access to supervision regarding complex cases. Gianbir’s experience would have been prior to the completion of that SAR. Therefore, the SSAB should evaluate what has changed since the recommendations of the Diana SAR and what impact this has had on the professional response to individuals about whom there are safeguarding concerns.

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