TO:	**West of Berkshire Safeguarding Adults Partnership Board (SAB)**
DATE:	**28th February 2025**
TITLE:	**Ursula SAR Executive Summary Report**
LEAD OFFICERS:	**Lynne Mason, Business Manager, SAB** **Rebecca Berry, Ursula SAR Author**

1. PURPOSE OF REPORT

To provide an executive summary of the Safeguarding Adult Review in relation to Ursula (pseudonym) that was endorsed by the SAB on the 13th February 2025.

2. Ursula

Ursula lived alone in a privately owned detached property in Wokingham. Ursula was in her early 70s. Her property was heavily hoarded with items preventing her from using or accessing most areas of her home. There were also items including food collected and stored within her car on the driveway. Ursula was reported to be a very private person who had very limited contact with most of her neighbours who said she was rarely seen, more often at night. In August 2022 concerns about Ursula and her property were raised from Anti-Social Behaviour Team to Adult Social Care, there followed an extended period where multiple organisations including police, health, adult social care and fire service made attempts to make contact with and engage with Ursula with limited success. Ursula sometimes answered text messages and sometimes spoke through the door. In December 2023 she was found deceased inside her property.

3. Who had contact with Ursula?

The following organisations/teams were involved with Ursula:

- Police
- Adult Social Care
- GP
- Fire Service
- Wokingham Integrated Care Network
- Anti-Social Behaviour Team
- Environmental Health
- Community Mental Health Team

4. Approach to SAR

The SAR Panel agreed to a new approach to identifying learning in this case. Practitioners from partner agencies attended an in person reflective learning event. This event included a conversation with Ursula's niece and neighbour. This enabled the SAR author to identify what could make a difference in cases where individuals are at risk or are experiencing self-neglect and hoarding, through the lens of people with lived experience and those working in the system.

After the reflective learning event thoughts and feedback was gathered from the attendees to form the recommendations for this SAR.

5. Initial findings

Prior to the reflective learning event, the author, through the chronologies collected from partner agencies, identified the following for further exploration:

- Application of the Mental Capacity Act, indiciators of potential concerns about executive capcacity.
- Repeating behaviours that have been shown not to work, telephone calls and unannounced visits.
- Unannouced visits repeated which allowed people to check Ursula is still alive but did not impact the risk.
- Assessment of Mental Health declined by common point of entry – Hoarding Disorder as a potential diagnosis.
- Lack of consideration of Inherent Jurisdiction of High Court.
- Seek order to allow access to assess capacity – indicators of possible lack of executive capacity.
- Not using appropriate multi-agency meetings.
- Lack of multi-agency risk assessment.
- Safeguarding enquiry could have provided framework for multi-agency working.
- Self-neglect and Hoarding safeguarding pathway tool kit.
- Multi Agency Risk Management Framework (MARM).
- Ursula not informed in writing that she had been assessed as having eligible care and support needs and how the local authority suggested meeting these.

6. What could have made a difference for Ursula's family

Ursula's niece shared her views during the learning event on what would have helped her:

- Knowing where to get support without breaking trust and relationships
- Bereavement support
- Support for family after a loved one's death
- Information and guidance from Environmental Health Navigation more difficult if family are out of borough, e.g. not allowed access to recycling centres

7. Reflections from SAR Panel

Discussion highlighted that the areas raised through Ursula SAR were prevalent across West of Berkshire and that a similar situation could happen again. Themes that arose from the SAR were having time, skills and knowledge when working with people with hoarding behaviour.

8. Training needs identified by practitioners

- Self-Neglect and hoarding behaviour – root and cause and effective interventions.
- Mental Capacity, Executive Capacity and Self Neglect and hoarding behaviour.
- Self-Neglect and Hoarding – Legal Framework.
- Impact of affluence and eloquence on intervention.

9. Recommendations from the SAR

Communication / Awareness

- West of Berkshire SAB to raise public awareness and seek to destigmatise hoarding behaviour and hoarding disorder and provide information about where to get help or advice, including exploration of community support available for people and their family and friends through groups of people with lived experience. Signposting to existing resources.
- West of Berkshire SAB to produce information to provide to people with hoarding behaviour explaining legal duties of Local Authorities and others, including when those organisations have to be involved and how they can work with them.
- West of Berkshire SAB to work with stakeholders to produce information for families about specific bereavement support after someone dies related to self-neglect and hoarding.
- For learning to be shared with key stakeholders to aid consideration of how refuse collection (or lack of) could provide early indication of hoarding behaviour and how families can be signposted to resources

Practice

- Agencies to review their existing hoarding protocol to consider whether any amendments are needed to be made based on reflections in this SAR. Protocols to include guidance on recognising escalating risk or risk not changing and when to seek legal advice and how.
- Health and Social Care to work together to establish hoarding pathways and more in depth understanding of root causes of hoarding behaviour.
- Multiagency review of existing Multiagency risk management forums for hoarding and self-neglect: SG Strategy Meetings, Case Conferences, MARM, Best Interest Meetings - explore why not working in hoarding and self-neglect cases and consider the alternatives.
- Stakeholders to explore commissioning of specialist providers to work with people with hoarding behaviour.
- Agencies to review their training plans against training needs identified by the workforce in this SAR to assure themselves and the board.

END