Gloucestershire
Safeguarding Adults
Board

Safeguarding Adults Rapid Review

Dorothy

Date of Completion: August 2025

Reviewer: Paul Yeatman

Contents

Purpose of the review

This review is designed to learn from the below case, the following principles were applied:

- A culture of continuous learning and improvement across the organisations that work together to safeguard and promote the welfare of adults.
- Aims to identify opportunities to draw on what worked well and promote good practice and what could have gone better and learn from them.
- Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight.
- Makes use of any relevant research and case evidence to inform the findings.

Methodology of the review

This review will be conducted using a 'signs of safety' learning model and will ask the following questions:-

- What went well?
- What were we worried about?
- What is the learning for future cases? **(Recommendations)**

Case Summary

Dorothy was an 89-year-old white woman living in her own home in Gloucestershire with her son, who was her main carer. She was diagnosed with dementia in September 2024, was frail, and had complex care needs. She was resistant to care and support, often refusing medical treatment, personal care, and medication. Dorothy also refused to attend healthcare appointments, including sight and hearing tests.

Dorothy had a history of established behaviours in relation to her personal care and well being, and the way she interacted with health care professionals, that long preceded her dementia diagnosis.

A Community Frailty Matron that was a former District Nurse, had known her for over fifteen years and described her as a strong-willed and "spicy" character who knew her own mind, was resistant to care and protective of her family. She had always slept on her sofa, had dirty clothes and leg wounds, that she dressed herself. She had not showered or bathed for many years and preferred to use wet wipes, despite the bathroom being on the ground floor of the property, with no access issues.

Dorothy was referred to the Complex Care at Home Team, and they visited from October to November 2024, looking at pressure areas and sleep position, but Dorothy did not want continued support from them.

District Nurses had been involved in Dorothy's care since March 2024, primarily for wound care. They attended twice weekly. Dorothy would often not let them in, and she would not let them undertake wound care on her lower legs.

They would check Dorothy's pressure areas when she allowed this. There were no issues with pressure areas in January 2025.

Despite Dorothy's frequent refusal of care, District Nurses consistently documented their attempts to engage her and provided detailed records of her condition. They worked closely with other professionals, including the Community Frailty Matron and social care, to ensure Dorothy's needs were addressed.

Dorothy was assessed as having care and support needs and was in receipt of a package of care, that initially involved two visits daily, Monday to Friday, of 30 minutes each in the morning and evening, but the evening visits had been cancelled as her family were there after work; they also provided care at weekends. Dorothy started to refuse the morning call, so carers tried to accommodate by offering a lunchtime visit.

Dorothy was found at home on Monday 24th March 2025 in a severely neglected state, with dehydration, malnutrition, and multiple pressure areas. An ambulance was called, and she was admitted to hospital; she was said to be very frail on admission.

Dorothy passed away whilst an inpatient in hospital on Wednesday 16th April 2025. Dorothy's cause of death was recorded as dementia and frailty.

What Worked Well

Multi-Agency Collaboration

- Agencies worked together effectively, sharing information and coordinating care.
- Regular communication between health, social care, emergency services, and safeguarding teams.

Persistent Professional Involvement

- Despite Dorothy's resistance, professionals continued to engage and monitor her wellbeing.
- District Nurses and the Frailty Matron maintained consistent involvement and documentation.
- Adult Social Care maintained regular involvement, building rapport over an eight-month period.

Proactive Safeguarding

- Multiple safeguarding referrals were made by various agencies (e.g. Ambulance Crews, Frailty Matron).
- Concerns were raised about neglect, self-neglect, and financial abuse.

Advocacy and Coordination

- The Frailty Matron played a key role in advocating for Dorothy, supporting her family, and coordinating care.
- The Frailty Matron supported Dorothy's daughter in applying for a Court of Protection COP3 for a finance deputyship.

Timely Assessments and Planning

- Although delayed, the Memory Assessment was expedited once the referral was received; the usual wait time is 28 weeks.
- Fast Track Continuing Health Care (CHC) funding was secured ahead of discharge.

- A Best Interest meeting was held to plan for Dorothy's move to a nursing home, which included the wishes of Dorothy and her family.

Efforts to Respect Autonomy

- Professionals respected Dorothy's wishes while balancing safeguarding concerns.
- Capacity assessments were conducted, and a Deprivation of Liberty Safeguards (DoLS) was applied for when necessary.

Fire Safety and Environmental Checks

- Gloucestershire Fire and Rescue Service conducted several Safe and Well Checks.
- Safety equipment was installed, and risks were identified and addressed.

What are we still concerned about

Dorothy's Resistance to care and treatment

- Persistent refusal of medical treatment, personal care, and medication.
- Declined support from professionals and services, including wound care and dementia medication.

Family Dynamics and Understanding

- Family had limited understanding of dementia and Dorothy's cognitive decline.
- There were mixed views within the family about Dorothy's care needs and discharge planning.

Environmental Concerns

- Dorothy lived in poor conditions, including sleeping on a sofa, unsanitary environment, and signs of fire risk.
- Despite interventions, Dorothy's living situation remained unsafe.

Carer Support Gaps

- No carers assessment was completed for Dorothy's son, despite his role as primary carer.
- Lack of formal support may have contributed to care challenges.

What could have been done better

Areas for Improvement

Earlier and More Robust Safeguarding Interventions

- Earlier escalation and stronger safeguarding actions may have helped mitigate risks sooner.
- Consideration of legal options (e.g. Court of Protection) could have been explored.

Consistency in Engagement Strategies

- Whilst rapport-building was attempted, more consistent and creative approaches to engaging resistant individuals could have been explored.

Learning Points

- Consideration of holding a multi-agency meeting to bring professionals involved together.
- Consideration of earlier escalation of safeguarding concerns to mitigate the risks.

Recommendations

- This Report is to be taken to the GSAB Policy and Procedures Sub Group and the GSAB Workforce Development Sub Group to enable the findings to be incorporated into the Self-Neglect Best Practice Guidance and Adult Safeguarding Training.
- This Report is to be included in the Workshop for health and care professionals on the theme of people who are very independent.
- Consideration of conducting a thematic review in the future if there are a number of other similar themed reviews.

Conclusion

The review highlights the complexities and challenges of safeguarding adults who resist care and support, particularly those living with dementia and experiencing significant frailty. Despite persistent efforts from multiple agencies, Dorothy's autonomy, strong personality, and resistance to intervention created substantial barriers to effective care.

Dorothy's situation highlights the importance of person-centred care, multi-agency collaboration, and continued intervention in addressing complex cases.

It also highlights the need for ongoing training and support for professionals working with individuals who have dementia and exhibit challenging behaviours.

Despite the challenges, the collaborative efforts of all agencies involved demonstrated a commitment to supporting Dorothy and respecting her autonomy while addressing her care needs.

This serves as a reminder of the need for vigilance, empathy, and coordinated action in safeguarding vulnerable adults, especially those whose choices may place them at risk.