CITY OF YORK
Safeguarding Adults Board

7 Minute Briefing

Safeguarding Adults Review

Catherine SAR

THE ADULT

Catherine was a woman in her late seventies with a rich and independent life history. She enjoyed a happy childhood and a good office career. Catherine enjoyed sport and travel and lived in variety of places. She was widowed and had one daughter, who lived nearby. Diagnosed with Type 1 diabetes Catherine managed her condition independently for many years. She appointed her daughter as her Lasting Power of Attorney (LPA) for health and welfare.

THE BACKGROUND TO THE REVIEW

This Safeguarding Adult Review (SAR) was commissioned by the City of York Safeguarding Adults Board following Catherine's death. The review was initiated under Section 44 of the Care Act 2014, which mandates a SAR when an adult dies or suffers serious abuse or neglect and there are concerns about the effectiveness of multi-agency working. The review aimed to identify lessons and improve safeguarding practices without assigning blame. A multi-agency combined chronology methodology was used, overseen by an Independent Reviewer, and included contributions from health and social care agencies and Catherine's family.

WHAT HAPPENED

Catherine experienced a rapid decline in health over a two-month period. She was referred to mental health services for depression and suicidal thoughts and responded well to support. Her health rapidly declined , leading to hospital admission for confusion, reduced mobility, and incontinence. Diagnosed with probable Lewy Body Dementia and hyperglycemia, she was discharged to a care home with complex diabetes management needs. Inconsistent documentation and medication management at the care home led to dangerously high blood glucose levels. Catherine was re-admitted to hospital with diabetic ketoacidosis (DKA). Despite initial treatment, she refused further care, expressing a wish to die. She died peacefully.

QUESTIONS FOR YOU TO CONSIDER

- Are care plans followed consistently and accurately documented?
- Are there clear systems for managing complex conditions like diabetes?
- Are mental health needs being identified and addressed promptly?
- Is information sharing effective between agencies and professionals?
- Are staff trained to recognize and respond to fluctuating capacity and end-of-life wishes?

KEY LEARNING POINTS

DIABETES MANAGEMENT

Catherine's diabetes care lacked consistency and prioritisation. Staff failed to follow prescribed protocols, and communication breakdowns led to missed medications and inadequate monitoring.

MENTAL HEALTH

Catherine's mental health deteriorated rapidly. Earlier and sustained involvement from psychological services could have provided better support.

CAPACITY AND CONSENT

Catherine was appropriately presumed to have capacity for most decisions. Her refusal of treatment was respected, and her daughter's role as LPA acknowledged.

COMMUNICATION

Poor information flow between agencies contributed to lapses in care. Misfiled discharge letters and inconsistent email practices delayed critical interventions.

COVID- 19 IMPACT

The pandemic added complexity to care delivery, with restrictions affecting Catherine's mental well-being and service coordination.

WHAT YOU CAN DO TO PREVENT A REOCCURRENCE

- Ensure robust training and protocols for managing diabetes are in place in your service
- Promote early referral to mental health services for individuals with new diagnoses and associated with loss of independence and a change of accommodation
- Use the ReSPECT tool to document end-of-life care preferences
- Maintain a high standard of record-keeping in your service and ensure any communication with other agencies is accurate and clear
- Reflect on this case in team meetings and training sessions to reinforce best practices

Click on the link below for the Catherine SAR full report on the CYSAB website

https://www.safeguardingadultsyork.org.uk/safeguarding-adult-reviews?categoryId=32