Richmond and Wandsworth Safeguarding Adults Board Safeguarding Adults Review – Robert recording script

Robert was 86-years-old at the time of his death in September 2020. He had a career in the arts and hospitality industries. Following a fall in July 2020, which resulted in a hospital admission, his family arranged for Robert to move into a residential care home. Shortly after he moved in, there was an unwitnessed incident between Robert and James, a fellow resident and there was a further unwitnessed incident between them in early August 2020. Robert sustained a minor injury but did not need medical attention. On the same day as the second incident, Robert had a fall and was admitted to hospital. He was described as having increased confusion or delirium, which was attributed to a subdural bleed on his brain (possibly due to a fall), an infection and low sodium. He was treated for the infection and low sodium and returned to the care home with a plan for further intervention from the GP and the memory clinic. Robert was moved to a different unit in the care home to create distance between him and James. Within hours, James attacked Robert, who was subsequently admitted to hospital with an intercranial haemorrhage where he died. The coroner determined that Robert’s death was caused by pneumonia with an antecedent cause of a head injury.

What did the review find?

1. There are no agreed mechanisms for collaborative working and decision-making across the range of professionals who provide support to older people with dementia. As a result, the understanding of escalating risk was hindered by imprecise or incomplete communication about the situation.

2. All staff across health and social care need to have a shared understanding of the nature of dementia and skills required to manage behaviours that challenge and of the level of expertise available in a residential care home to do this.

What can we learn?

1. To support people living with dementia, it is important to have access to a range of skills and a shared understanding of the changes in the person and in risks. Regular multidisciplinary case discussions can help to achieve a more holistic understanding of care needs and risk management. A formal mechanism to embed regular multidisciplinary and multiagency case discussions is a significant asset.

2. When structural changes happen within an organisation it is important that all stakeholders affected by the changes are aware of what to expect from new organisational delivery systems.

3. Providing care and support to people with dementia is complex because of the variation in individual symptoms and the growing number of physically strong and

able people living with dementia. It is important for providers to have access to a range of skills and strategies for managing the behaviours of people with dementia as well as access to specialist input such as that provided by Community Mental Health Teams.

4. Formally documented best interest decisions should be undertaken for all people permanently moving into a care home, who lack capacity to make decisions on where they live.

5. And when the person alleged to have caused harm is also vulnerable, consideration should be given to instructing an Independent Mental Capacity Advocate.

6. Finally, mechanisms for multiagency reviews of the needs of care home residents who have dementia to identify the need for early interventions would ensure that changes are planned and crises avoided. Risk management and care planning to support the person and their family to understand changing needs is vital.