Cornwall and Isles of Scilly Safeguarding Adults Board

Safeguarding Adult Review
Executive Summary

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As with all cases in which we seek to learn from circumstances concerning the death of a person, it is important that the human cost involved is recognised. The loss of a family member, friend, member of the community or person that we were seeking to help and support can bring much sadness, together with a number of other emotions. As the lead reviewer I offer my sincere condolences to anyone affected by the circumstances that led to this Review.

RAF – An Executive Summary of a Safeguarding Adult Review (SAR).

This Safeguarding Adult Review (SAR) was commissioned by Cornwall and the Isles of Scilly Safeguarding Adults Board in early 2023. RAF was living in a care home for older adults when he died following a tragic event in the home that happened in spring 2022.

RAF had lived in Cornwall for many years following a career in the Royal Air Force. He was a loving husband, step-father and grandfather. In his later years he developed several health problems, this included a diagnosis of dementia. RAF lived at home with his wife until she could not provide the care and support that he needed as his health conditions deteriorated. In the spring of 2020, he moved into a local care home where he lived for almost two years before a tragic incident resulted in his untimely death at the age of 85 years.

RAF had moved into the care home two years before his death after a short spell in hospital as he was becoming increasingly frail, was at increasing risk of falls and his cognition had declined due to vascular dementia. At home, his main care was provided by his wife; this continued during his time living in the residential home as his wife visited daily. RAF maintained very regular contact with his wife and family throughout the Covid-19 pandemic and afterwards, and his needs for 24-hour care were met by the care home. In early March 2022, RAF was involved in an incident with another resident in the care home and was physically assaulted. As a result, he experienced significant injuries and was admitted to hospital. Unfortunately, after just over a week in hospital, he died.

It was later agreed that a Joint Review process would be undertaken, connected to a Mental Health Homicide Review, commissioned by NHS England [NHS(E)] and carried out concerning the other resident involved in the incident. This specific review was carried out as a parallel process to the Safeguarding Adult Review, as the two reviews were conducted separately but were aligned. Through the process of this joint review, system and shared points of learning were identified and developed for robust action planning for relevant organisations.

The Safeguarding Adult Review concerning RAF, established that relevant policies and procedures relating to RAF's care and treatment in the residential home were broadly followed by the organisations involved in his care. It is apparent that appropriate levels and of care and support were provided to him as far as possible, but sadly it was not possible to prevent the incident that led to his death. The Coroner's inquest that was held and completed in early 2025 concluded that RAF was unlawfully killed.

This SAR review covers the one-year period before the incident happened – from March 2021 to March 2022 - and the short period of several weeks after the event, until RAF's death in hospital. The final report was agreed by the Safeguarding Adults Board in July 2025.

A hybrid approach was taken in the SAR review. The review principally relied on documentation and information obtained from agencies involved with RAF during the relevant time covered by the review. This was provided in the form of chronologies and individual/independent management review reports, a practitioner learning event that was held, together with some key discussions with relevant staff about policies and procedures. The review also engaged with RAF's family on a regular basis, and this provided significant and valuable information for the review. RAF's wife contributed a poignant written biography of RAF and their family life to the review; this is also available on this web-page and we are very grateful for their contribution(s).

The review examined key practice episodes and interactions across all agencies involved with RAF and the incident that happened, with a focus on professional practice, multi-agency working, responses to the event and its impact. This meant that the review had the opportunity to maximize reflection and learning for both individual agencies and the wider safeguarding partnership.

Following examination of the key practice episodes four key findings were identified.

- The review ascertained that not all practitioners (from the Ambulance Service – SWAST - and the care home) recognised the interactions between residents that led to potential safeguarding risks and the duty to report concerns, including notification to the care regulator, in a timely manner.

- Care homes can require additional support at times of emergency, and timely and effective responses to urgent requests for assistance and support may be needed.
- Adult Social Care practitioners did not report safeguarding information in routine reviews of RAF's care and placement undertaken during his residence in the home
- People living with dementia have additional needs for care and support that can mean that at times they are at increased risk of harm. Resident-to-Resident abuse can happen in care homes and occasionally results in serious harm to individuals. From a UK context, not enough is known about these types of incidents, and how to prevent them. Additional specialist training for practitioners might be helpful.

Conclusions

The review made four recommendations, linked to the Findings, that aim to help the Safeguarding Adults Board embed learning and improve multi-agency practice. It is important to respect RAF as an individual and to learn lessons from his untimely death. However, it is also incumbent on the Safeguarding Adults Board to recognise that there may be a number of vulnerable adults in quite similar circumstances. Therefore, lessons learned from this Review should be disseminated and specific action plans developed to develop longer term solutions and take relevant learning forward towards the prevention of future harm (or deaths) relating to this type of incident in care settings.

Recommendation 1 – South-West Ambulance Service (SWAST) and the care home should provide assurance to the Safeguarding Adults Board that there has been enough learning to provide reassurance about decreasing missed opportunities to raise relevant concerns in line with statutory duties.
Recommendation 2 – Further work should be undertaken by relevant services, in this instance Adult Social Care, mental health agencies, commissioners, and care home support teams to establish whether additional responses to urgent issues are needed. All agencies should provide assurance to the Safeguarding Adults Board about how they would respond if this type of incident were to happen now.
Recommendation 3 – Adult Social Care should issue a reminder to all appropriate staff that any relevant safeguarding concerns are documented, including when reviews are completed.

Recommendation 4 – All agencies should provide the Safeguarding Adults Board with assurance that they have access to relevant training to appropriately consider and manage risks to individuals living with dementia (and others, in all settings) and whether they have identified a need for any other form of additional or specialised training, including any plans to do so.

Independent Reviewer/Author

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