



Derby Safeguarding Adults Board

Learning Brief for Practitioners

Safeguarding Adults Review: Dylan

February 2026

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A Safeguarding Adults Review (SAR) is a legal duty under the Care Act (2014), which states that the Safeguarding Adults Board must arrange for a review of a case involving:

- a) an adult in its area with care and support needs (whether the local authority was meeting any of those needs)
- b) if there is reasonable concern about how the Board, or members of it or other persons with relevant functions worked together to safeguard the adult and
- c) the Safeguarding Adults Board knows or suspects the adult has experienced serious abuse or neglect and there is concern how the partner agencies have worked together to protect the individual.

Derby Safeguarding Adults Board (DSAB) received a SAR referral for Dylan (pseudonym) in December 2023 by Derbyshire Fire and Rescue Service (DFRS) following their internal investigation into the fatal fire. The DSAB agreed that Dylan's case met the criteria for a statutory SAR because he was an adult with care and support needs, and there were concerns that agencies could have worked more effectively to safeguard Dylan.

The time period examined for Dylan's review was between January 2019 to Dylan's death on the 6 March 2023.

A system findings (SAR-SF) methodology was utilised for Dylan's review. A SAR-SF methodology focuses on the 'system findings' relating to any social or organisational factors that influenced the events and circumstances of the case, with the overall objective of identifying higher system learning.

The methodology adopted a flexible and bespoke approach as Dylan's case progressed and included a multiagency meeting where practitioners from all agencies came together to share their collective reflections on Dylan's story.

The objective of SAR-SF methodology was to identify the higher systems learning in Dylan's story at a quicker rate and as a pragmatic approach to the practitioner's and agency's resources and time.

Dylan's family contributed to the review process, and their input was crucial in providing Dylan's human story. The process was understandably difficult for them but without their contributions to Dylan's human story would not have been fully told. The final SAR report was formally approved by DSAB in March 2025.

Background

Dylan was a 65-year-old male who was described by those that knew him as having a good sense of humour, responding well to banter and enjoyed being around people. Dylan was in the army during his working years, and he remained in contact with some colleagues who had become his friends.

Dylan described himself as having a 'stupid sense of humour' and loved playing his guitar which he sadly had to give up when he broke his arm in 2019. Dylan was remembered for busking in Derby, and he loved music with his favourite band being Pink Floyd.

Dylan's daughter was important to him, and he saw her frequently. On a Friday night they would like to go to the pub and would both have a Jack Daniels and coke. Dylan also had a keen interest in motorbikes and particularly liked the old classics.

Dylan suffered with multiple sclerosis and chronic obstructive pulmonary disease. At the time of his death, Dylan was immobile, and he lived on his own in a ground floor flat. Dylan was supported by a care package receiving four visits a day from day care centre. At the latter part of Dylan's life, those who knew him said that he was quickly fatigued, and it was thought this impacted on his level of engagement with services.

Tragically, Dylan was found by DFRS deceased in his lounge and the subsequent fire investigation completed by DFRS concluded that the fire was most likely caused by accidental ignition by careless handling of smoking materials.

Areas of good practice

- 1. Proactive safeguarding action** – East Midlands Ambulance Service promptly alerted DFRS after spotting burn marks on Dylan's carpet and clothing during a call-out.

2. **Persistence in securing support** – The care provider consistently followed up on outstanding referrals, particularly with Speech and Language Therapy, ensuring Dylan’s needs were addressed.
3. **Advocating for appropriate equipment** – The care provider maintained ongoing communication with Occupational Therapy, persistently requesting assessments when concerns were raised about the suitability of Dylan’s mobility equipment.

Areas that require improvements

Four areas were identified that required improvement:

4. Finding one:

There were omissions and failings in the individual and multiagency management of fire risk. Due to:

- Agencies work in a task orientated way.
- Lack of awareness of factors that increase the risk of fatal fires.
- Over optimism that other agencies were managing the fire risk.
- Lack of single ownership of risk.

5. Finding two:

Multiagency engagement and communication were not effective. Due to:

- Agencies working in a task orientated way.
- Services are not commissioned to enable a long-term relationship and monitoring.
- Lack of a collective information sharing systems.
- Agencies worked in silo with poor multiagency engagement.
- Pressure on services due to Covid-19.

6. Finding three:

A safeguarding framework was not considered or utilised. Due to:

- Cumulative and increasing risks that were not effectively managed were not seen within the context of safeguarding.

- Single agencies did not initiate a 'stop' moment and engage at a multiagency level.
- Ambiguity around when a fall/s become a safeguarding concern.

7. Finding four:

The Mental Capacity Act (2005) is not fully embedded in practice, with a specific lack of awareness around executive dysfunction and how that can impact decision making. Due to:

- Lack of awareness of what executive dysfunction is and how that can impact on decision making.
- Was viewed as 'difficult to engage' but services did not offer alternative, flexible and assertive ways to providing support.
- Practitioners were navigating the tension between the promotion of autonomy and protection.

Recommendations

1. **Fire Risk Training Module** – Derbyshire Fire and Rescue Service to develop and roll out a podcast for professionals on identifying and responding to fire risks in safeguarding contexts.
2. **Fire Safety Awareness Video and Webinars** – Derbyshire Fire and Rescue Service to develop awareness through fire safety awareness video and webinars.
3. **Fire Risk Flagging System** – All partners to explore a fire risk flagging process in partner agency recording systems to allow professionals to clearly see if an adult is identified as at heightened fire risk, with information such as last fire assessment date and relevant contact details. Agencies to develop and utilise practice guidance around the fire flagging system and how to approach cases with it.
4. **Fire Risk Home Sticker Scheme** - Derbyshire Fire and Rescue Service to place visible fire risk stickers in the homes of adults identified as at high fire risk. Stickers include key contact details and the date of the last fire risk assessment.

5. **Risk Assessment Guidance** – Derby Safeguarding Adults Board Risk Guidance to be updated including considerations for those with deteriorating and advanced conditions, multiple risk factors, accumulative risk and when these factors amount to safeguarding.
6. **Fire Risk Guidance for Professionals** - Derbyshire Fire and Rescue Service to create guidance, to be included in the Derby and Derbyshire SAB Practice Guidance, on professional understanding of what constitutes a fire risk, how to identify one, the steps professionals should consider and when to consider Multi-Disciplinary Meetings.
7. **Escalation of commissioning of Services** - DSAB to review and escalate how services are commissioned in the Derby area and whether longer term and coordinated roles are required to support people with progressive conditions?
8. **Information Sharing** – Derby Safeguarding Adults Board to promote the Information Sharing Agreement and emphasise the importance of effective information sharing between partner agencies.
9. **Addressing Cumulative Falls Risk** – Derby Safeguarding Adults Board to review and update its decision-making guidance to explicitly include cumulative falls risk for adults, ensuring that repeated minor incidents are recognised as contributing to overall vulnerability. And that there is a clear understanding on what Long Lies are and what the multiagency response should be.
10. **Re-launching Decision-Making Guidance and Falls Guidance** - Derby Safeguarding Adults Board to re-launch the Decision-Making Guidance and Falls Guidance to ensure all practitioners are aware of the updates and understand how to apply them in practice.
11. **Supporting Adults** - To create a toolkit to support inclusive engagement.
12. **Clarifying Executive Dysfunction** – Derby Safeguarding Adults Board to review the Derby and Derbyshire SABs Practice Guidance to ensure that references to executive dysfunction in practice guidance and associated materials are explained in plain English, avoiding medical jargon.
13. **Partner Assurance on Mental Capacity Act (MCA)** - Using the Assurance Framework, Derby Safeguarding Adults Board to seek formal assurance from

all partner agencies that the Mental Capacity Act (MCA) is consistently embedded in practice.

14. **Escalation of Complex Decision-Making Issues** - Derby Safeguarding Adults Board to review the repeatedly identified national issue regarding the tension between adult autonomy and protection to determine whether it requires escalation through the National SAR Escalation Protocol.

Next steps

All agencies and professionals are encouraged to reflect on the findings and identified recommendations to improve future practice.

These recommendations will be monitored by the SAR Operational Group who will seek assurances from the agencies named in the above report that these recommendations are being acted upon and will inform and improve practice for the future.