

Learning On One Page (LOOP)

(Derby Safeguarding Adults Board (DSAB) – Dylan - Derby SAR04)



Content

- 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.
- 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 Fire Service deceased in his lounge and the subsequent fire investigation completed by Fire Service concluded that the fire was most likely caused by accidental ignition by careless handling of smoking materials.

Areas of Good practice

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

What didn't go so well?

Four areas were identified that required improvement:

Finding one:

- There were omissions and failings in the individual and multiagency management of fire risk.

Finding two:

- Multiagency engagement and communication were not effective.

Finding three:

- A safeguarding framework was not considered or utilised.

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.

Recommendations

The Derby SAR04 Recommendations were signed off by the DSAB in February 2026, and actions are being monitored by the Derby SAR Operation Group.

- **Recommendation 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.
- **Recommendation 2: Fire Safety Awareness Video and Webinars** – Derbyshire Fire and Rescue Service to develop awareness through fire safety awareness video and webinars.
- **Recommendation 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.
- **Recommendation 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.
- **Recommendation 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.
- **Recommendation 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.
- **Recommendation 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?
- **Recommendation 8: Information Sharing** – Derby Safeguarding Adults Board to promote the Information Sharing Agreement and emphasise the importance of effective information sharing between partner agencies.
- **Recommendation 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.
- **Recommendation 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.
- **Recommendation 11: Supporting Adults** - To create a toolkit to support inclusive engagement.
- **Recommendation 12: Clarifying Executive Dysfunction** – Derby Safeguarding Adults Board to review the Derby and Derbyshire SAB Practice Guidance to ensure that references to executive dysfunction in practice guidance and associated materials are explained in plain English, avoiding medical jargon.
- **Recommendation 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.
- **Recommendation 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.