Report into the circumstances surrounding the death of 'Dave'

Safeguarding Adult Review

Executive Summary

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September 2025

Introduction

This executive summary provides an overview of the work undertaken to complete a Safeguarding Adults Review (SAR) commissioned in January 2025 by the North Somerset Safeguarding Adults Board (NSSAB). It is an abridged version of the full SAR report which provides more detailed information.

S44 of the Care Act 2014 places a duty on Safeguarding Adults Boards to arrange a Safeguarding Adult Review (SAR) when an adult dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.
A SAR promotes learning and identifies improvements to prevent future death or serious harm occurring again. A SAR does not seek to lay blame; it is an opportunity to consider together what happened and what could have been done differently.[1]

Dave was 73 when he died by suicide. The review has Dave at its heart, his experiences and challenges, the concerns raised by people who cared about him, the missed opportunities to protect and support him and the reflection and learning together to improve. Dave is a pseudonym chosen by his family; his ethnicity was White British.

The SAR identifies the progression of Dave's increasingly concerning mental state and acute distress about his separation from and ultimate loss of his wife when she no longer recognised him because of Alzheimer's disease. Dave sought solace through an excess of alcohol and drugs, his loneliness made him vulnerable to exploitative 'friendships' and cuckooing [2]

Many concerns were raised about Dave and he came into contact with professionals from different agencies. Critical analysis of operational and systemic factors that impacted on effective practice is detailed in full in the SAR report and summarised in the Areas of Focus section of this executive summary.

Information for the SAR was drawn from a wide range of sources including family and partner agency discussion, partner chronologies, agency records and correspondence. The following areas of focus and questions to be addressed were identified for the SAR by the SAR panel:

Safeguarding and Risk Assessment.

- *How effective was the multi-agency safeguarding response for Dave?*
- *Were the needs of Dave supported in a way that made 'safeguarding personal' for him?*

Cuckooing/Home Takeover and Exploitation.

- *How was Dave supported and protected at a multi-agency level from being harmed from cuckooing and other forms of adult exploitation?*

[1] *Care and support statutory guidance - GOV.UK (www.gov.uk)* s14.162

[2] Cuckooing | Adult Safeguarding Board *NSSAB Cuckooing is a practice where people take over a person's home and use the property to facilitate exploitation.*

- *How can the NSSAB assure itself that practice is informed by systems, policies, and practice frameworks, specifically in relation to people who are being harmed from adult exploitation?*

***Suicide Prevention*.**

- *How well did the multi-agency integrated care pathway for suicide prevention support Dave and those that worked with him?*
- *Have lessons been learnt and practice improvements been made since the previous NSSAB SAR 'Colin'?*

***Information Sharing, Partnerships and Collaborative Working*.**

- *What are the lessons to be learned about the way in which professionals worked in partnership to support and to safeguard Dave?*

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Dave

Dave's family and people who knew him well described him to the reviewer as friendly, gregarious and sociable. He was devoted to his wife and they had a very happy marriage. Dave had been a butler and his wife a housekeeper and accounts manager working together in what was described by Dave's nephew as 'grand surroundings' in London and the Home Counties. When they retired they bought property and moved to Weston-Super-Mare where they lived a comfortable and contented life. However, their life changed significantly when Dave's wife was diagnosed with Alzheimer's disease and, as this progressed, she increasingly needed a lot of care and support from Dave.

In December 2020 it is recorded in a letter from a psychiatrist to the GP that Dave's wife's Alzheimer's disease had 'significantly progressed'. Dave was not coping and had disclosed ' suicidal ideation' and that he and his wife had previously come up with a plan to, 'check out together'. The trigger for enacting the plan' was when his wife could no longer recognise him. Following health assessment, Dave's wife moved into a residential care placement.

Dave struggled with the separation from his wife. He was referred by his GP to the Primary Care Liaison Service[3] as he was very anxious, voicing suicidal thoughts and researching suicide methods. With support it is recorded that Dave said he was feeling much better and found it easier to not see his wife, there were Covid restrictions at the time, but to receive regular updates from the Care Home where she was settling well.

***Hospital Admission and Multi-Disciplinary Team Assessments*.**
In May 2022, Dave was admitted to hospital in an agitated and confused state after having seizures which he had not experienced before. It is recorded that Dave 'had been using 30 units of vodka a week and 20mg diazepam a day for some years to help him sleep'. Other records highlight that Dave also used tramadol and cannabis.

[3] *The North Somerset Primary Care Liaison Service (PCLS) team is the main integrated referral points into adult secondary mental health services based within North Somerset. The team provides Non-emergency Support, brief interventions, advice and signposting.* North Somerset Primary Care Liaison Service (PCLS)

Whilst in hospital Dave had a seizure and a fall sustaining a frontal lobe haemorrhagic contusion. He was assessed by the psychiatric, medical , alcohol specialist and neurology teams and he also had occupational and physiotherapy assessments. The cause of the seizures was inconclusive; Safeguarding concerns were raised as Dave was saying that he was giving away his money and was in possession of guns at home. The concerns were not referred to the safeguarding team and there was no record of multi-agency safety planning for Dave. He was discharged home rather than, according to mental health records, to a local hospital with follow up from the mental health liaison team. Dave's memory was of concern and he did not attend follow up neurology appointments.

Police Risk Assessments.
In the months following Dave's discharge from hospital, police officers completed multiple risk assessments and raised safeguarding concerns about Dave. They felt that he was being targeted and was potentially a victim of 'cuckooing'. The risk assessments were not thought to meet the threshold for referral to Adult Social Care. The Police conducted numerous welfare checks in their visits to Dave but did not detect overt criminal activity, such as the storing of drugs or weapons in the flat, as can be often seen in cuckooing[4]

Family Concerns.
Dave's granddaughter called the Police to raise concerns about an unknown female answering Dave's phone. When police officers visited Dave said he was in a relationship with a female, there were some concerns as she was known to the Police as drug user. Dave's nephew said to the reviewer that when he visited, Dave was surrounded by youths in the street and seemed 'vulnerable' and had 'let himself go'. Family members were increasingly concerned that Dave was acting out of character and that his behaviour, lifestyle and moral judgement was out of keeping with the Dave they knew and cared for.

Bank Concerns.
The local Bank had raised concerns to the Police that Dave was withdrawing large sums of money which was not the norm for him. Dave told police officers that he was giving away money to friends and family and was helping people.

Dave wanted to sell his flat but as this was owned jointly with his wife, he needed to open a bank account in his wife's name, Dave had power of attorney for his wife. The Bank refused to open the account as they felt that Dave was acting out of character and questioned his capability of managing his wife's affairs. They were also concerned that Dave may be a victim of financial exploitation, he was accompanied in the Bank by an unknown male. The Bank wrote to the Office of the Public Guardian (OPG) raising their concerns and this triggered an OPG investigation.

Residents' Concerns: Increase in Anti-Social Behaviour.
Residents of the flats where Dave lived, reported anti-social behaviour and raised concerns about frequent visitors to Dave's flat, late night noise, altercations and suspected drug dealing from Dave's camper van in the car park. Alliance Housing Support referred the residents' concerns to the Anti-Social Behaviour Steering Group [5] *Actions were agreed for the police and Alliance to mitigate risks to Dave and other residents.*

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[4] *Understanding, Preventing and Disrupting 'Cuckooing' Victimisation*

[5] *The ASB Multi-Agency Steering Group enables information sharing and supports agencies with problem solving around problematic ASB issues. The membership includes representatives from the Pollice, Community Safety, Adult Social Care, Hate Crime Victim Support amongst others. ASB Steering Group | North Somerset Council*

Adult Social Care Assessment.
In October 2022, the manager of the Care Home where Dave's wife resided, raised her concerns about Dave to Adult Social Care (ASC). She was concerned that he had memory problems and that he was having falls and seemed unkempt. She also raised concern that she had found previous psychiatric notes in his wife's care plan about Dave and his wife's intention to take their own lives together. ASC practitioners made follow up phone calls to Dave though no contact was made with him. This was a missed opportunity to visit Dave in person and gather and accumulate the numerous concerns being raised about his wellbeing.

Care Home Tenancy.
In February 2023, Dave moved into the Care Home where his wife was being cared for. He was not a resident and had a private rental agreement with the home. Dave's nephew's wife raised concerns to Adult Social Care about Dave's living arrangements in the Care Home and his wellbeing. A social worker visited Dave and reported to the Care Home manager that he was using a camp stove in his room, posing risks to himself and other residents. Dave was also being charged a high weekly rate for renting the room which was thought to be unsustainable and a financial risk to him. There was no evidence of joined up working between the Care Home and Adult Social Care to address and manage the risks.

Escalating Concerns
In November 2023 and the months preceding Dave's death, the Care Home staff raised multiple concerns to the Care Home manager that Dave was expressing suicidal thoughts. There is no record that the GP was aware that Dave was experiencing suicidal thoughts. Dave spoke to a mental health social worker who was visiting his wife about his low mood. He said, "I just want it all to end for me and x (his wife)". and that she's 'not the person I remember any more'. He also said that he owed money to the care home and was trying to sell his flat. Dave's increasing distress was evident and there was a recognised potential risk to his wife.

In January 2024, the OPG contacted Adult Social Care as part of their investigation and assessment of Dave's mental capacity and capability to act as an attorney for his wife. They raised safeguarding concerns about Dave potentially being a victim of financial exploitation. The safeguarding referral was not progressed.

In early February 2024, the Care Home manager met with Dave to express concern about his mental health and well-being. It is recorded that the Care Home management gave Dave 28 days' notice and that he 'was happy' with the decision. The GP noted that he had met with Dave who said that he wished to return to his flat as 'his wife shows little recognition of him'. Although not recognised at the time, this resonated with Dave's earlier stated intention to a psychiatrist in December 2020 that the 'the trigger for enacting' the plan for he and his wife to take their lives was 'when his wife could no longer recognise him'.

On 13th February 2024, Dave took his own life by suicide. He was found by Care Home staff in his room with his head covered with a plastic bin liner, and a helium gas cylinder tube attached. He left two notes and Dave's nephew said that in the second suicide note which was found torn up, Dave talked about the pressure he was under regarding the debt he was in. Dave's nephew believed that the date so close to Valentine's day was significant in that it highlighted Dave's feelings of loneliness, love for and loss of his wife.

Areas of Focus for the Safeguarding Adult Review and Questions to be addressed.

The full SAR report gives a detailed account of the identified areas of focus and, for each area, outlines the legal context and discussion of evidence based effective practice as compared and contrasted with the SAR findings and analysis.

This overview report addresses the questions for the SAR and summarises the learning in each area of focus and the associated recommendations.

1. Safeguarding and Risk Assessment.

1.1 How effective was the multi-agency safeguarding response for Dave?

1.1.1 A lack of cohesive information sharing and multi-agency forums for discussion impacted upon communication between partners about increasing risk and safeguarding concerns for Dave.

1.1.2 There is no evidence of safeguarding or multi-disciplinary team (MDT) post discharge safety planning for Dave when he was in hospital. This is reflected in the differing accounts in records related to his hospital admission. Mental health records document a plan to discharge Dave to his local general hospital for mental health liaison team follow up and hospital records document a plan for Dave to return home with follow up neurological appointments.

There were operational pressures and organisational conditions that impacted on the effectiveness of the multi-agency safeguarding response for Dave. The continuing disruption of services arising from the Covid-19 pandemic was a significant factor when Dave was admitted to hospital.

There were sufficient accumulated concerns about Dave, his substance misuse, his memory loss, his cognitive injury and potential safeguarding concerns, to initiate coordinated MDT planning and this was a missed opportunity to mitigate future risk to Dave

Recommendation 1: Multi-Disciplinary Team Meetings

In the light of learning from this SAR, the University Hospitals Bristol and Weston NHS Foundation Trust should review its protocol for multi-disciplinary meetings (MDTs), standardising procedures to streamline MDTs, improving communications and inclusivity of different professional groups and promoting discussion of concerns, and risks with a route to safeguarding if necessary.

1.1.3 There were issues with Police process to recognise and query accumulating concerns and risk assessments and to discuss with/refer to Adult Social Care for further action.

Police recorded that there were three direct concerns raised, one from Dave's granddaughter and two from his bank, regarding Dave being 'taken advantage of' by potential cuckooing and financial abuse. Police spoke to Dave and /or attended his home on eleven occasions. Risk assessments were completed on six occasions following the concerns and attendances and they were referred onwards internally to the Lighthouse Support Unit (LSU) for safeguarding consideration and decision.

A Police representative at the SAR Partner Learning Even expressed that LSU Safeguarding Officers were not confident about what constitutes a safeguarding concern and knowing when to refer to Adult Social Care. There was a seemingly fixed definition of what constitutes Adult Safeguarding and it was recorded that Dave did not meet criteria for onward referral to Adult Social Care because he did not have overtly recognisable care and support needs

Recommendation 2: Regional Safeguarding Workshops.

To progress as a priority the proposed Police/Adult Social Care regional safeguarding workshops. The sessions could be usefully informed by practice guidance using the 'Understanding What Constitutes a Safeguarding Concern' and 'How to Support Effective Outcomes Framework' as referenced in the SAR report.

1.1.4 There were missed opportunities for professionals to explore underlying issues with Dave. These included his loneliness, memory problems, substance misuse, financial decisions and his noticeably changed character, moral judgement and lifestyle noted by Dave's family.

The Mental Capacity Act Code of Practice highlights the need for further investigation of 'unwise decision making', taking into account any medical condition or cognitive impairment and the person's previous character, past decisions and choices.

Recommendation 3: Mental Capacity Act Learning and Toolkit Development.

The NNSAB should seek assurance that partners have awareness, understanding and a working knowledge of the mental capacity act. Learning opportunities could include this SAR, the legal framework, codes of practice, the impact of cognitive impairment on executive functioning, ethical consideration and duties and powers to intervene when required to mitigate risk and prevent harm.

Mental Capacity Assessment Toolkits, such as the one referenced in the SAR report, provide comprehensive and helpful practice guidance

1.1.5 Adult Social Care Practitioners shared thoughts on the factors that hindered effective Adult Social Care practice. There were thought to be missed opportunities to work more closely with Dave's GP and consult health records to inform the safeguarding response. It was recognised that Dave would have benefited from a face to face discussion which may have been avoided in the aftermath of Covid restrictions.

There were operational work pressures, time constraints and, at that time, a significant amount of unresolved safeguarding concerns and enquiries that had an impact on practice. It was thought that professional judgement and curiosity had not been effectively applied and this could be attributed to time constraints and also a wider system issue related to information sharing and partnership collaboration. The safeguarding aspect of the OPG referral was missed and this could be attributed to either operational error or a lack of system processes to log and check safeguarding concerns.

Recommendation 4: Adult Social Care: Review of Safeguarding Structure.

In the light of this SAR, Adult Social Care should review and quality assure the previous and proposed changes to the revised safeguarding structure. The identified operational and system

barriers to effective and personalised safeguarding practice should be considered and addressed.

1.2 Were the needs of Dave supported in a way that made 'safeguarding personal' for him?

1.2.1 Ultimately, the needs of Dave were not supported through safeguarding. There was a lack of professional curiosity about Dave and identification of the risks he was exposed to. There was an absence of engagement with his family and people who knew him best.

1.2.2 There were no apparent attempts to better understand Dave or his family to work in accordance with the Safeguarding principles of prevention, protection and partnership with other services and the principles of Making Safeguarding Personal. There was little evidence of prolonged contact or engagement by agencies with family members to discuss their accumulating concerns about Dave

1.2.3 Dave was known to be giving away thousands of pounds, including the proceeds of the sale of the other flat that the couple owned. There was little consideration by agencies of Dave's wife's best interests and the potential financial loss she was incurring through his actions. There were no attempts to safeguard her best interests.

Recommendation 5: Making Safeguarding Personal.

The NSSAB should seek assurance that Partners will review Making Safeguarding Personal and Person Centred Practice to ensure that this includes a 'Think Family' approach and recognition of the importance of trusted relationships, professional curiosity, and appreciation of the impact of trauma..

2. Cuckooing/Home Takeover and Adult Exploitation.

2.1 How was Dave supported and protected at a multi-agency level from being harmed from cuckooing and other forms of adult exploitation?

2.1.1There were attempts to support Dave by the visiting Police officers who completed risk assessments however there was limited evidence of partner knowledge of cuckooing/home takeover, exploitation and the victim – perpetrator relationship which can be complex. Avon and Somerset Police give advice on cuckooing and adult exploitation on their website and North Somerset NSSAB have developed a financial abuse toolkit which references adult exploitation and cuckooing. Full details can be found in the SAR report.

2.1.2 The Anti-Social Behaviour steering group missed an opportunity to refer the safeguarding concerns, referenced in the minutes of the meetings, to Adult Social Care (ASC). This would have ensured that ASC were made aware of the concerns being raised and involve them in the safety planning together with the Police and Alliance Homes. This may have opened the door to advocacy support for Dave and/or engaged his family in discussions.

2.1.3 The lack of operational pathways and siloed practice between partners combined with a lack of relationship building with family members led to a fragmented safeguarding response. There was no attempt to engage a trusted person or advocate to speak with Dave, as

recommended in the Cuckooing Toolkit, resources and practice guidance[6]*. There were few attempts to engage with family members who potentially could have been influential in a risk management and safety plan for Dave.*

2.2 How can the NSSAB assure itself that practice is informed by systems, policies, and practice frameworks, specifically in relation to people who are being harmed from adult exploitation?

2.2.1 As data on cuckooing, is not routinely collected by any of the safeguarding partners, it is hard to quantify the size of the problem. This will change with the introduction of the new legislation making cuckooing a criminal offence.

The proposed government guidance for police and other operational partners, in line with making cuckooing a criminal offence, will help improve identification of cuckooing and support professionals to take effective action against perpetrators and identify the best pathways to support and safeguard victims. This may introduce a national framework and comprehensive resources for all Safeguarding Adult Boards to draw on.

Recommendation 6: Cuckooing and Adult Exploitation.

The NNSAB should consider how best to approach Cuckooing and Adult Exploitation awareness raising and practice guidance across the partnership. An audit of current practice may be a useful starting point. A professionals toolkit and resources to draw on and inform learning, is referenced in the 4.2 best practice section of the SAR report.

3 Suicide Prevention

3.1 How well did the multi-agency integrated care pathway for suicide prevention support Dave and those that worked with him?

Dave would have greatly benefitted from a more collaborative response between partners to risk and suicide prevention which likely would have happened if Dave had been referred for mental health support and/or a safeguarding referral had been actioned. This would have supported the Care Home and brought partners together to work with Dave, and ideally with his family, to develop a shared risk and suicide safety plan. This was a missed opportunity to support Dave through compassionate and person centred care.

At the time of Dave's death, staff training in the Care Home did not include suicide prevention therefore there was an absence of knowledge and skills to support and help Dave. Also, at the time, staff and management recording and documentation was not of consistent quality leading to inconsistencies and fragmented information about residents.

The Care Home have identified numerous areas for learning and improvement including staff training, supervision, consultation with professionals, escalation of risk and risk management and the reviewing of the admissions policy and procedures. All front-line staff currently receive mental health training that includes suicidal ideation and self-harm and depression training as part of the homes mandatory training.

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[6] *Preventing and Disrupting Cuckooing Victimisation: Professional Toolkit | School of Law | University of Leeds*

Recommendation 7: Care Home Learning.

it is recommended that the Care Home establish a plan to capture the areas of learning, the actions and measures being taken and scheduled progress reviews.

Commissioners should review the plan through contract monitoring.

Commissioners should monitor all Care Homes to ensure that they have suicide prevention training in place for all staff and managers as recommended by the previous NSSAB SAR 'Colin' and this SAR 'Dave'.

3.2 Have lessons been learnt and practice improvements been made since the previous NSSAB SAR 'Colin'?

3.2.1 The NSSAB Safeguarding Adults Review, Learning from the Circumstances of Treatment and Support for Colin concluded in 2022. Colin took his own life by suicide whilst residing in a Nursing Home. It made recommendations for system and practice improvement including system-wide understanding of supporting people at risk of suicide and responding to suicide attempts.

In response to the SAR, North Somerset Council Commissioners developed a briefing to be used by Care Providers in supporting people at risk of committing suicide and those who have attempted suicide. New ways of working to prevent suicide that are focused on developing kind, compassionate and caring relationships and agreeing person -centred safety plans are now in place in North Somerset. There is movement away from clinical language and much more proactive involvement of people and families who have lived experience.

3.3.3 There is scope to have a focus for learning on the increasing prevalence of suicide in older people. There are many studies which reference this[7] and the NSSAB together with the suicide prevention leads may wish to consider how best to address this area of learning.

Recommendation 8: Suicide Prevention.

The NSSAB should seek assurance that:

Public Health and Mental Health partners will incorporate the recently published NHS England practice guidance on Staying Safe from Suicide (April 2025) into existing suicide prevention strategies. Consideration should be given to promoting suicide prevention for older people.

Learning from research studies and previous local and national SARs are considered with attention to be given to suicide prevention in Care Homes

Suicide prevention should be strengthened across the partnership and knowledge and accessible and flexible learning opportunities are readily available.

[7] The Silent Struggle: Understanding Suicide Among Older People in the UK – OPAAL UK Understanding and Preventing Suicide in Older Adults

4 Information Sharing, Partnerships and Collaboration.

4.1 What are the lessons to be learned about the way in which professionals worked in partnership to support and to safeguard Dave?

4.1.1 There were a number of systemic factors that hindered effective safeguarding practice to support Dave including:

- *Partners working and viewing information in isolation.*
- *An absence of identified low level concerns being seen together and cumulatively as a pattern of sustained risk to Dave.*
- *Workload pressures, time constraint and increasing demand which had an impact on response.*
- *There was a lack of confidence and uncertainty about Partners approaching each other to access professional specialist support and expertise. Consequently, there was no shared approach to support and safety planning for Dave.*

4.2.2 Although the Multi-Agency Risk Management (MARM) approach has been introduced, safeguarding partners have expressed concern that if Dave was known today, he may not have been referred because he would still be seen as 'low risk'. The root of the systemic issue has not been resolved, namely that individual agencies continue to view information through a single lens and siloed work continues to prevail.

There have been encouraging improvements supporting a more personalised approach to practice and the introduction of learning together partner forums.

Recommendation 9: Multi-Agency Information Sharing and Collaboration.

It is recommended that NSSAB Partners consider:

- *A review of MARM in the light of this SAR.*
- *A review of sharing information pathways across the partnership including data sharing in accordance with the MARM Tier One Overarching Information Sharing Protocol..*
- *Involving in the review, extended partners such as people with care and support needs, families and carers. housing and care providers.*
- *Ways to facilitate relationship building between partners and appreciation of roles, responsibilities and legal duties.*
- *Working together with the Care Home to embed the safeguarding enquiry recommendations, the learning from this SAR and practice improvement.*

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5. What's Changed and Changing.

Since April 2024, there have been positive changes made including the refreshed AWP Suicide Prevention practice approach, the introduction of the Multi-Agency Risk Management (MARM) approach and the Avon and Somerset Police review of the BRAG risk assessment to embed a more person centred way of working with adults who are at risk. Others are listed in section 5 of the full SAR report.

Building in assurance that the changes being made are not only effective but also coordinated across agencies wherever possible to support further integration will be of value. The recommendations should be translated into a SMART (specific, measurable, achievable, relevant and time bound) action plan which is regularly reviewed.

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6. Recurring Themes

All of the themes that are discussed within this SAR are identified has being highly prominent in the Second National Analysis of Safeguarding Adult Reviews: April 2019 -March. The NSSAB Partnership is therefore not alone in facing significant challenges in safeguarding practice. SARs across the country are highlighting similar themes and also identifying examples of good practice, areas for improvement and useful resources.

A review of the most recent NSSAB SAR 'Learning from the Treatment and Support of Colin highlights that there are findings and recommendations which recur and resonate with this SAR as detailed in the full report. Ensuring that recurring issues are identified and that learning, and improvement plans are regularly reviewed would be beneficial.

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7 Conclusions

The Safeguarding Adults review has focused on the experiences of Dave and has drawn on sources of information and insight from family members, agency chronologies and discussions with practitioners and managers. The SAR Panel established the SAR Terms of Reference and the review methodology is underpinned by the SAR Quality Markers.

The findings and analysis of events highlight areas of good practice as well as areas for improvement. The findings are compared and contrasted with best practice to assist learning and recommendations.

A major and fundamental issue was the missed opportunities for multi-agency partners to come together collaboratively to discuss accumulating concerns about Dave and to support him to manage risks. The absence of a partnership approach, building relationships and working together with Dave and his family led to a fragmented agency response.

There have been some very positive changes including the introduction of the Multi-Agency Risk Management forum, changes to the Adult Social Care structure and pathways and more person centred Police risk assessments. The learning from this SAR has enabled identification of further areas for improvement which have informed the report recommendations.

End