# Safeguarding Adults Review makes four recommendations

Bolton Safeguarding Adults Board has published a Safeguarding Adult Review following the tragic death of an 18-year-old.

Nevaeh Owen died in March 2024 on Oak Ward at Royal Bolton Hospital.

She was being treated by Greater Manchester Mental Health NHS Foundation Trust.

Nevaeh had been detained for treatment under the Mental Health Act and was an inpatient in a number of settings between December 2021 and her death.

The review was commissioned by Bolton Safeguarding Adults Board, to consider whether agencies could have worked better together to safeguard Nevaeh.

The BSAB will now ensure that the recommendations from the report are implemented, and progress will be formally reported back to the board and Nevaeh's family.

Neil Smith, Independent Chair of the Bolton Safeguarding Adults Board said:

"This was an incredibly tragic situation, and our thoughts remain with the family of Nevaeh at this difficult time.

"The purpose of a Safeguarding Adults Review is to identify what agencies could have done differently and what lessons can be learned to prevent similar situations happening in the future.

"While this review does highlight examples of good practice, it also identified missed opportunities to use the safeguarding process to bring partners together and review the suitability and effectiveness of Nevaeh's care.

"It also identified improvements that that should be made when young people are transitioning from children to adult services.

"Agencies do not wait for a SAR to be published to put changes in place, and work has already begun to implement improvements.

"Each Safeguarding Adult Review has an action plan associated with it which is monitored by the board to embed learning and reduce the risk of repeat incidents or causes of harm."

**END**

**Notes to editors:**

*Safeguarding Adults Boards are a statutory requirement under The Care Act 2014.*

*The board reviews local safeguarding arrangements to ensure measures are effective, person-centred, and outcome focused.*

*Safeguarding Adult Reviews (SARs) were established on a statutory basis under Section 44 of the Care Act 2014.*

*The purpose of a SAR is to review multi-agency practice and promote effective learning and improvements to prevent future deaths or serious harm occurring again.*

*A SAR is not an inquiry into how an adult at risk has died or was seriously harmed. These are matters for coroners and criminal courts, respectively, to determine as appropriate. It is not to apportion blame to any individual or organisation.*