

# **Manchester North Standard Operating Procedure**

**To establish effective notification and information sharing procedures between:**

**HM Coroner's Office for Manchester North, Rochdale, Bury, and Oldham Safeguarding Adults Boards and Safeguarding Children Partnerships, Community Safety Partnerships and the Rochdale, Bury and Oldham Child Death Overview Panel**

## 1.0 Purpose of the Protocol

The purpose of this protocol is to establish effective and consistent notification and information sharing between those involved in Adults and Children's Safeguarding Procedures, Child Death Overview Panels, Domestic Homicide Reviews and Her Majesty's Coroner Office for North Manchester to ensure that in practice:

- The Coroner is informed by the relevant Local Safeguarding Adults Board (LSAB), Local Safeguarding Children Partnership (LSCP) and/or local Community Safety Partnership of all deaths which are to be subject of a multi-agency review e.g. Safeguarding Adult Review, Child Safeguarding Practice Review, Domestic Homicide Review, Learning Lessons or other Reviews. The notification should be completed as soon as possible in case the death is not already known to the Coroner's Office
- The Coroner notifies the relevant LSAB, LSCP or CSP if it is felt by the Coroner's Office that a multi-agency review should be considered
- If the LSCP/Coroner becomes aware of a child death, the relevant CDOP Manager is notified on a timely basis

This will therefore result in:

- Improvements in the experience of those who are bereaved, in obtaining explanations surrounding the death.
- That there are clear lines of communication between safeguarding arrangements and the Coroner's Office
- There is a reciprocal process is established for raising concerns or sharing relevant information.

This document should be read in conjunction with the Children Safeguarding Policies, available at:

<https://greatermanchesterscb.proceduresonline.com/>

Safeguarding Adult Policies and Procedures can be accessed via the local LSAB website.

Consideration must also be given to the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews.

## **2.0 Information Sharing**

The Coroner is required to disclose relevant information obtained during the course of their investigation with anyone deemed to be an interested person<sup>1</sup>.

There is a duty on all agencies involved with the case to assist the Coroner's Court, and the Coroner must see all material which they consider relevant unless there is an application for public interest immunity e.g. concerns re national security.

The LSAB, LSCP or CSP may have concerns relating to disclosure due to the purpose of a review being for agencies involved to learn lessons and improve practice. As part of this process agencies are encouraged to look openly and critically at their practice. However, in promoting candor it may be necessary for the LSAB, LSCP or CSP to assure agencies that some contributions, for example records of practitioner/reviewer conversations, would, under normal circumstances not be made public. This is on the understanding that the Overview Report will almost always be publicly available. For clarity, see Appendix 7.7 below.

The LSAB/LSCP or CSP will contact all agencies to seek consent or inform them when information is shared with the Coroner and any concerns should be addressed directly with the Senior Coroner. Where consent is being sought, this should explicitly detail what information will be shared. The sharing of information relating to adults and children specifically are referenced in the following sections.

Where consent to share is not given, the Coroner will request the information directly from the organisation within the appropriate legal framework.

The Coroners' process should both be supported by and inform actions from agencies who sit on the LSAB, LSCP and/or CSP. Therefore, parallel investigations should take place where possible to minimise delays. Any copies of reviews or investigations should be forwarded to the North Manchester Coroner, subject to the provisions above.

### **2.1 Safeguarding Adults Information Sharing**

The relevant local Safeguarding Adult Board (LSAB) will notify the North Manchester Coroner Office when the screening process for a Safeguarding Adult Review is initiated. Within North Manchester the precedent is that the screening process for a Safeguarding Adult Review should be completed and signed off by the respective Independent Chair within 30 working days from the point of referral.

Clarity should be sought as to which Coroner's Office is dealing with the investigation, if the adult did not die in that LSAB's area for example a Rochdale resident died in Salford Royal Hospital, it may be Manchester West Coroner's Office dealing with the investigation and the Local Safeguarding Adults Board in Salford managing the Safeguarding Adult Review process.

If a referral is received that is not progressed to SAR screening, the LSAB will notify the Coroner. For cases that are screened for a SAR, the Coroner will be advised

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<sup>1</sup> <http://www.legislation.gov.uk/ukpga/2009/25/section/47>

whether a Safeguarding Adult Review (or equivalent) is commissioned and the expected timescales for completion of this review. Terms of Reference for the review may be shared if this is helpful. The LSAB will inform the Coroner where there are any delays/extensions of timescales.

In cases where the Safeguarding Adult Board Chair informs the Coroner of a Safeguarding Adult Review and the Coroner either is already investigating or chooses to investigate a case, the Chair will nominate a single point of contact for all communication. This is to ensure that there are:

- agreed methods of communication and timings in order that processes are streamlined and to avoid duplication.
- Systems in place to minimise distress to bereaved families and any staff directly involved with the case.
- agreed single points of contact for a multi-agency media strategy (if required)

The final overview report for the Safeguarding Adult Review (or equivalent) will be shared with the Senior Coroner once this has been completed and signed off by the LSAB. It may be helpful to share a draft report with the Coroner before final sign off if the death occurred many months earlier, to inform ongoing coronial investigations.

The Coroner may request additional information, for example single agency submissions or records of practitioner's events which relate to the review and the LSAB should comply with these requests in a timely manner.

Please see Appendix 1 for the SAR information sharing flowchart.

## **2.2 Safeguarding Children Information Sharing**

The relevant local safeguarding Children Partnership (LSCP) will contact the North Manchester Coroner when a Child Safeguarding Practice Review following the death of a child and a Serious Incident Notification (SIN) is received. In line with Working Together to Safeguard Children 2018, agencies are required to submit referrals for Rapid Reviews within 5 days of a death (or serious injury) and the Rapid Review must take place within 15 working days of the referral. When contacting the Coroner, the LSCP will provide details of the child and an expectation of when the review will be completed, taking into account ongoing parallel investigations/reviews.

Once the review is completed, the LSCP will send a copy of the final overview report to the Coroner. As above regarding Safeguarding Adult Reviews, in certain circumstances a draft report may be shared to inform ongoing coronial investigations. Working Together to Safeguard Children 2018 sets out the expectation that such reviews should take no longer than 6 months to complete however in cases where there are criminal investigations, this can sometimes take longer. If the overview report is delayed, regular updates and, where possible, a

draft copy of the overview report will be provided to the Coroner by the allocated single point of contact of the LSCP.

The Coroner may also request additional information pertaining to the review for example chronologies, records of practitioner conversation/events or action plans. The LSCP is not the owner of this information; the LSCP holds information on behalf of partner agencies for the purposes of Child Safeguarding Practice Reviews.

All agencies that have pertinent information regarding a child death are under a duty to disclose such information to the Coroner in an un-redacted format and the Coroner has common law and statutory powers to enforce such disclosure.

The above is set out in the Worcestershire Case 2 which illustrated an important point in that the Coroners should expect greater disclosure to them so that they may properly assess the scope of an inquest. There is a two-stage disclosure process set out in the Worcestershire Case.

**The Chief Coroners Law Sheet No.3 dated 31<sup>st</sup> January 2014 provides a helpful summary.**

In the first stage the Coroner will request all reports or other material which he/she believes to be relevant for the purpose of assessing the scope and content of his/her inquiry. Disclosure at this stage will be to the Coroner alone for the purposes of deciding the scope of the Inquest and the witnesses to be called.

In the second stage the Coroner decides whether there can and should be onward disclosure to interested persons.

Anyone who wishes to make submissions as to the onward submission of disclosure should make the court aware of any concerns. The Coroner will then have to consider the public interest in disclosure and whether the circumstances of the particular case outweigh the public interest in non-disclosure.

The LSCP single point of contact will notify relevant agencies when information is shared with the Coroner. It is then the responsibility of the individual agency to make representations or requests (in extremely rare circumstances) that the information is not disclosed to interested parties (which may include bereaved families). Some agencies may request that the information is anonymised or redacted prior to onward disclosure.

### **2.3 Child Death Overview Panels (CDOP)**

Although CDOPs are no longer the responsibility of the LSCP close links between the two processes will remain. A child's death is not considered by CDOP until all other investigations are finalised and therefore it is essential that the LSCPs establish positive working relationships with their local CDOP's.

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<sup>2</sup> <https://www.judiciary.uk/wp-content/uploads/2016/02/law-sheets-no-3-the-worcestershire-case.pdf>

The LSCP will notify the local CDOP Officer when a Child Safeguarding Practice review is commissioned. The LSCP will ensure that completed reviews are shared with the relevant CDOP in a timely manner to ensure that the CDOP review is not delayed.

CDOPs will complete an annual report, looking at the themes and lessons learned from child deaths that year. The LSCP and the Coroner should be sighted on this report and act upon any recommendations relating to safeguarding children. This report will be publically available.

If the CDOP panel consider that a case may meet criteria to undertake a Rapid Review, the CDOP can refer the case to the LSCP using the relevant referral form.

The CDOP cannot consider a case until all investigations/reviews are completed e.g. coronial, criminal, child safeguarding practice review. It is therefore essential that the CDOP and Coroner's Office establish positive working relationships.

The Coroner's Office will provide CDOP with a Notification of death, Post Mortem reports and Reports on the outcome of Investigations and Inquests. Dependent on where the child dies, the Corners Office for that area provides the information to the relevant CDOP officer via e-mail (see section 5.0) for all reportable deaths. The allocated Coroner's Officer will be the named contact thereafter for the CDOP officer.

The CDOP officer and Coroner's Officer may be in regular communication regarding a case to ensure that updates are shared and the CDOP officer is fully informed as to the progression on the case through the coronial process. This will be considered on a case by case basis.

The Coroner's Officer will send a copy of the final record of inquest to the CDOP officer once the inquest is finalised. This will provide the CDOP officer with the registered cause of death along with confirmation that the coronial process is concluded.

#### **2.4 Out of Borough Process/Communications**

It is the responsibility of the host authority to instigate safeguarding investigations and manage communications when an incident occurs outside of Borough. Where a provider service is involved the host authority should also notify other authorities that may be using the provider both of the incident and of all communications with the Coroner, in accordance with the relevant data sharing protocol.

Where an incident occurs out of Borough, it is the responsibility of the host authority to instigate safeguarding investigations and manage communication with the relevant Coroner.

A Coroner will investigate a death abroad if the body is brought back into his or her area and the apparent circumstances of the death would have led him or her to investigate it if it had occurred in England or Wales.

In the event of a child death out of Borough, there is an agreement across Greater Manchester that the Child Death Overview Panel for the area where the child is normally resident will consider the death (the corporate parent authority).

## **3.0 Roles and Responsibilities**

### **3.1 The Role of the Coroner<sup>3</sup>**

A Coroner is an independent judicial office holder, appointed by a local authority (council) within the Coroner area. Some Coroners cover more than one local authority. Coroners work within a framework of law passed by Parliament. The Chief Coroner heads the Coroner service and gives guidance on standards and practice.

The Notification of Deaths Regulations 2019 (NDR) came into force on 1 October 2019, imposing a duty on medical practitioners to report deaths where:

- they are unable to ascertain the cause of death;
- the cause of death is unnatural, or;
- the death occurred in custody or state detention.

The regulations also place a duty on medical practitioners to report deaths to the Coroner where:

- no attending practitioner is required to sign a Medical Certificate of Cause of Death (MCCD);
- an attending practitioner is required to sign a MCCD but they are unavailable;
- or the identity of the deceased is unknown.

The Coroner may ask a pathologist to examine the body. If so, the examination must be done as soon as possible. If the examination shows the death to have been a natural one, there may be no need for an inquest and the Coroner will send a form to the registrar of deaths so that the death can be registered. If the death is found not to be due to a natural cause then there will be an inquest. The inquest system is described in further detail later in this protocol.

### **3.2 The Role of Local Safeguarding Adults Boards**

Each local authority is required to have an operating Safeguarding Adults Board (SAB) in place as set out in the Care Act 2014<sup>4</sup>. Each SAB has responsibility for overseeing and holding agencies to account in respect of safeguarding activity in its area. SABs may differ in membership and arrangements in each local authority

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<sup>3</sup> [Ministry of Justice – Guide to Coroner Services](#)

<sup>4</sup> <https://www.gov.uk/government/publications/notification-of-deaths-regulations-2019-guidance>

<sup>5</sup> [Care Act Statutory Guidance](#)

area, but must as a minimum, have senior representation from the Local Authority, the Police and the Clinical Commissioning Group.

A SAB has three core duties:

- It must publish a strategic plan for each financial year that sets how it will meet its main objective and what the members will do to achieve this. The plan must be developed with local community involvement, and the SAB must consult the local Healthwatch organisation. The plan should be evidence based and make use of all available evidence and intelligence from partners to form and develop its plan.
- It must publish an annual report detailing what the SAB has done during the year to achieve its main objective and implement its strategic plan, and what each member has done to implement the strategy as well as detailing the findings of any Safeguarding Adults Reviews and subsequent action.
- It must conduct any Safeguarding Adults Review in accordance with Section 44 of the Act.

### **3.3 The Role of Multi-Agency Safeguarding Arrangements**

Working Together to Safeguard Children 2018<sup>5</sup> outlines the definition of safeguarding partners, who should agree on ways to co-ordinate their safeguarding services; act as a strategic leadership group in supporting and engaging others; and implement local and national learning including from serious child safeguarding incidents.

The purpose of these local arrangements is to support and enable local organisations and agencies to work together in a system where:

- children are safeguarded and their welfare promoted
- partner organisations and agencies collaborate, share and co-own the vision for how to achieve improved outcomes for vulnerable children
- organisations and agencies challenge appropriately and hold one another to account effectively
- there is early identification and analysis of new safeguarding issues and emerging threats
- learning is promoted and embedded in a way that local services for children and families can become more reflective and implement changes to practice information is shared effectively to facilitate more accurate and timely decision making for children and families

Multi-Agency Safeguarding Arrangements are also responsible for undertaking Child Safeguarding Practice Reviews. The purpose of reviews of serious child safeguarding cases, at both local and national level, is to identify improvements to be made to safeguard and promote the welfare of children. Learning is relevant

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<sup>6</sup> [Working Together to Safeguard Children](#)



locally, but it has a wider importance for all practitioners working with children and families and for the government and policymakers. Understanding whether there are systemic issues, and whether and how policy and practice need to change, is critical to the system being dynamic and self-improving.

### **3.4 The Role of Child Death Overview Panels**

The Child Death Review Operational and Statutory Guidance (England)<sup>6</sup> sets out the key features of what a good Child Death Review (CDR) process should look like. Clinical commissioning groups (CCGs) and local authorities (the child death review partners) are able to make arrangements for child death reviews as they see fit in order to meet the statutory requirements under the Children Act 2004.

These arrangements should result in the establishment of a Child Death Overview Panel (CDOP), or equivalent, to review the deaths of all children normally resident in the relevant local authority area, and if they consider it appropriate the deaths in that area of non-resident children. The review should then be carried out by a CDOP panel, on behalf of CDR partners, and should be conducted in accordance with the Child Death Review Operational and Statutory Guidance (England) and Working Together 2018.

In practice, CDOPs will conduct the independent multi-agency scrutiny on behalf of the local CDR partners responsible for ensuring that the review of deaths of all children normally resident in that area takes place.

The functions of CDOP include:

- to collect and collate information about each child death, seeking relevant information from professionals and, where appropriate, family members;
- to analyse the information obtained, including the report from the CDRM, in order to confirm or clarify the cause of death, to determine any contributory factors, and to identify learning arising from the child death review process that may prevent future child deaths;
- to make recommendations to all relevant organisations where actions have been identified which may prevent future child deaths or promote the health, safety and wellbeing of children;
- to notify the Child Safeguarding Practice Review Panel and local Safeguarding Partners when it suspects that a child may have been abused or neglected;
- to notify the Medical Examiner (once introduced) and the doctor who certified the cause of death, if it identifies any errors or deficiencies in an individual child's registered cause of death. Any correction to the child's cause of death would only be made following an application for a formal correction;

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<sup>7</sup> [Child Death Review Operational and Statutory Guidance \(England\)](#)

- to provide specified data to NHS Digital and then, once established, to the National Child Mortality Database;
- to produce an annual report for CDR partners on local patterns and trends in child deaths, any lessons learnt and actions taken, and the effectiveness of the wider child death review process; and
- to contribute to local, regional and national initiatives to improve learning from child death reviews, including, where appropriate, approved research carried out within the requirements of data protection.

### **3.5 The role of Community Safety Partnerships**

Community Safety Partnerships were introduced through the Crime and Disorder Act 1998 as amended.

The CSP has a statutory duty under s6 of the Crime and Disorder Act 1998 to produce:

- a strategy for the reduction of crime and disorder in the area (including anti- social and other behaviour adversely affecting the local environment); and
- a strategy for combatting the misuse of drugs, alcohol and other substances in the area; and
- a strategy for the reduction of re-offending in the area

When a domestic homicide occurs, the relevant police force should inform the relevant Community Safety Partnership (CSP) in writing of the incident. Overall responsibility for establishing a review rests with the local CSP as they are ideally placed to initiate a DHR and review panel due to their multi-agency design and locations across England and Wales. CSPs are made up of representatives from the 'responsible authorities' (police, local authorities, fire and rescue authorities, probation service and health) who work together to protect their local communities from crime and help people feel safer.

Where partner agencies of more than one local authority area have known about or had contact with the victim, the CSP of the local authority area in which the victim was normally resident should take lead responsibility for conducting any review. If there was no established address prior to the incident, lead responsibility will relate to the area where the victim was last known to have frequented as a first option and then considered on a case by case basis. There may be circumstances in which lead responsibility for conducting a review may not be easily determined due to the complex nature of the case. It is for local areas to come to an appropriate arrangement in such circumstances.

Any professional or agency may refer such a homicide to the CSP in writing if it is believed that there are important lessons for inter-agency working to be learned.

## **4.0 Criteria for Undertaking Reviews**

### **4.1 Coroner's Investigations**

There are statutory provisions<sup>7</sup> to outline when an Inquest must be opened to allow the Coroner to finish his or her investigation.

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<sup>8</sup> <http://www.legislation.gov.uk/uksi/2013/1616/made>

The purpose of the inquest is to discover the facts of the death. This means that the Coroner (or jury) cannot find a person or organisation criminally responsible for the death. A Coroner does not apportion blame and would halt an inquest if at any stage the evidence gave rise to criminal consideration.

Sometimes an inquest will show that something could be done to prevent other deaths. If so, the Coroner must write a report drawing this to the attention of an organisation (or person) that may have the power to take action. This is called a 'report to prevent future deaths'. The organisation must send the Coroner a written response to the report. If it does not respond within 56 days, stating what action it has taken, the Coroner will follow up the matter with the organisation, and may inform the Chief Coroner of the failure to respond.

#### **4.2 Safeguarding Adult Reviews**

A Safeguarding Adult Review is a multi-agency review undertaken by the Safeguarding Adults Board (SAB) under Section 44 of the Care Act 2014.

A review will take place if there is a case of an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) where:

(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

(b) condition 1 or 2 is met.

##### **Condition 1 is met if—**

(a) the adult has died, and

(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

##### **Condition 2 is met if—**

(a) the adult is still alive, and

(b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

(3) An SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

(4) Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to—

- (a) identifying the lessons to be learnt from the adult's case, and
- (b) applying those lessons to future cases.

#### 4.3 Child Safeguarding Practice Reviews

The responsibility for how the system learns the lessons from serious child safeguarding incidents lies at a national level with the Child Safeguarding Practice Review Panel (the Panel) and at local level with the safeguarding partners.

Serious child safeguarding incidents are those in which:

- abuse or neglect of a child is known or suspected and
- the child has died or been seriously harmed

*Serious harm includes (but is not limited to) serious and/or long-term impairment of a child's mental health or intellectual, emotional, social or behavioural development. It should also cover impairment of physical health<sup>75</sup>. This is not an exhaustive list. When making decisions, judgment should be exercised in cases where impairment is likely to be long-term, even if this is not immediately certain. Even if a child recovers, including from a one-off incident, serious harm may still have occurred.*

Locally, safeguarding partners must make arrangements to identify and review serious child safeguarding cases which, in their view, raise issues of importance in relation to their area. They must commission and oversee the review of those cases, where they consider it appropriate for a review to be undertaken.

The criteria which the local safeguarding partners must take into account include whether the case:

- highlights or may highlight improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified
- highlights or may highlight recurrent themes in the safeguarding and promotion of the welfare of children
- highlights or may highlight concerns regarding two or more organisations or agencies working together effectively to safeguard and promote the welfare of children
- is one which the Child Safeguarding Practice Review Panel have considered and concluded a local review may be more appropriate

Safeguarding partners should also have regard to the following circumstances:

- where the safeguarding partners have cause for concern about the actions of a single agency

- where there has been no agency involvement and this gives the safeguarding partners cause for concern
- where more than one local authority, police area or clinical commissioning group is involved, including in cases where families have moved around
- where the case may raise issues relating to safeguarding or promoting the welfare of children in institutional settings

#### **4.4 CDOP Reviews<sup>8</sup>**

The Children and Social Work Act (2017) and Working Together set out expectations for Child Death Review Partners (Local Authorities and Clinical Commissioning Groups) to make arrangements for the review by a Child Death Overview Panel (CDOP) of the deaths of all children normally resident in the relevant local authority area, and if they consider it appropriate the deaths in that area of non-resident children.

This review includes the death of any new-born baby of any gestation who shows signs of life following birth, or where the birth was unattended; but does not include those (of any gestation) who are stillborn where there was medical attendance, or planned terminations of pregnancy carried out within the law.

CDR partner footprints should be locally defined based on patient flows across existing networks of NHS care. CDR partner arrangements should typically cover a child population such that they review 80-120 child deaths each year.

#### **4.5 Domestic Homicide Reviews**

The chair of the CSP holds responsibility for establishing whether a homicide is to be the subject of a DHR by giving consideration to the definition set out in the Domestic Violence, Crime and Victims Act 2004. This decision should be taken in consultation with local partners with an understanding of the dynamics of domestic violence and abuse. CSPs should contact relevant bodies to establish the existence of any other ongoing reviews, which will need to be considered as part of the decision to undertake a DHR.

The purpose of a DHR is to:

- a) establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- b) identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- c) apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;

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<sup>9</sup> [Child Death Review Statutory Guidance](#)

- d) prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;
- e) contribute to a better understanding of the nature of domestic violence and abuse; and
- f) highlight good practice.

A Domestic Homicide Review should take place where the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by

(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or

(b) a member of the same household as himself

or

where it appears that a victim took their own life (suicide) and the circumstances give rise to concern, for example it emerges that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable.

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<b>5.0</b>	<b>Publication of Overview Reports</b>
<b>5.1</b>	<b>Report Publication</b>
	<p>According to Working Together 2018, Chapter 4, Section 41 a Local Child Safeguarding Practice Review should be, "completed and published as soon as possible and no later than six months from the date of the decision to initiate a review". Where other proceedings may have an impact on or delay publication, for example an ongoing criminal investigation, inquest or future prosecution, the safeguarding partners should inform the Child Safeguarding Practice Review Panel and the Secretary of State for the reasons for the delay. Since the publication of Working Together 2018, all safeguarding partnerships have received further guidance from the National Panel that all reports should be published, unless there are very exceptional circumstances not to do so.</p> <p>The fact that an inquest is due to take place should not on itself delay publication of the review report, it very much depends on the particulars of each case. Safeguarding partners will always endeavour to meet the deadlines set out in Working Together 2018 but remain willing to discuss cases which the Coroner</p>

	<p>believes may raise significant concerns if publication of the report precedes the inquest.</p> <p>The above also applies to Safeguarding Adult Reviews and SAB's will liaise with the relevant Senior Coroner regarding publication arrangements for reviews.</p>
<b>5.2</b>	<p>The Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews states that publication of Overview Reports and Executive Summaries will take place following agreement from the Home Office Quality Assurance Panel and should be published on the local CSP website.</p> <p>In all cases, the Overview Report and Executive Summary should be suitably anonymised and made publicly available. The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future. The aim in publishing these reviews is to restore public confidence and improve transparency of the processes in place across all agencies to protect victims.</p> <p>All Overview Reports and Executive Summaries should be published unless there are compelling reasons relating to the welfare of any children or other persons directly concerned in the Review for this not to happen. The reasons for not publishing an Overview Report and Executive Summary should be communicated to the Home Office DHR Quality Assurance Panel. The publication of the documents needs to be timed in accordance with the conclusion of any related court proceedings and other review processes. The content of the Overview Report and Executive Summary must be suitably anonymised in order to protect the identity of the victim, perpetrator, relevant family members, staff and others and to comply with the Data Protection Act 1998 as amended. This means preparing reports in a form suitable for publication, or redacting them appropriately before publication.</p>
<b>6.0</b>	<b>Relevant Contact Details</b>
<b>6.1</b>	<p><b>Manchester North Coroner's Office</b>  Monday to Friday 8.30am-12.30pm and 1.30pm-4.30pm.  Office of HM Coroner  Floors 2 and 3  Newgate House  Newgate  Rochdale  OL16 1AT  TEL: 01706 924 815  E-MAIL: <a href="mailto:Coroners.office@rochdale.gov.uk">Coroners.office@rochdale.gov.uk</a></p>
<b>6.2</b>	<b>Rochdale Safeguarding Adult's and Children's Partnership</b>

	<p>Monday – Friday 8:30am-4:45pm  Floor 4, Number One Riverside,  Smith Street,  Rochdale,  OL16 1XU  TEL: 01706 927700  E-MAIL: <a href="mailto:rbsb.admin@rochdale.gov.uk">rbsb.admin@rochdale.gov.uk</a></p>
<b>6.3</b>	<p><b>Bury Integrated Safeguarding Partnership</b>  Monday – Friday 09.00-5.00pm  TEL: 0161 253 6153  E-MAIL: <a href="mailto:BISP@bury.gov.uk">BISP@bury.gov.uk</a></p>
<b>6.4</b>	<p><b>Oldham Safeguarding Adult’s Board</b>  Monday – Friday 8:30am-4:45pm  4<sup>th</sup> Floor, Civic Centre,  Rochdale Road,  Oldham Council  Oldham  OL1 1UT  TEL: 0161 770 1532  E-MAIL: <a href="mailto:OldhamSafeguardingAdultsBoard@oldham.gov.uk">OldhamSafeguardingAdultsBoard@oldham.gov.uk</a></p>
<b>6.5</b>	<p><b>Oldham Safeguarding Children’s Partnership</b>  Monday – Friday 8:30am-4:45pm  Rock Street Resource Centre  Rock Street  Oldham  OL1 3UJ  TEL: 0161 770 8081 / 0161 770 8087  E-MAIL: <a href="mailto:LSCB.group@oldham.gov.uk">LSCB.group@oldham.gov.uk</a></p>
<b>6.6</b>	<p><b>Manchester North/Bury, Rochdale and Oldham Child Death Overview Panel</b>  Monday – Friday 8:30am-4:45pm  Floor 4,  Number One Riverside,  Smith Street,  Rochdale,  OL16 1XU  TEL: 01706 925271  E-MAIL: <a href="mailto:BROCDOP@rochdale.gov.uk">BROCDOP@rochdale.gov.uk</a></p>
<b>6.7</b>	<p><b>Oldham Community Safety Partnership</b>  Monday – Friday 9am to 5pm  Civic Centre,  West Street,  Oldham,  OL1 1UT  Tel: 0161 770 1582/0161 770 3000  Email: <a href="mailto:lorraine.kenny@oldham.gov.uk">lorraine.kenny@oldham.gov.uk</a> / <a href="mailto:css.admin@oldham.gov.uk">css.admin@oldham.gov.uk</a></p>



## 7.0 Appendices

7.2	Rochdale SAR Policy and Procedures	 Rochdale SAR Process Ch13 Octob
7.3	Rochdale Rapid Review Flowchart	 Rochdale SIN-Rapid Review Flowchart 20
7.4	Bury SAR Protocol	 SAR Protocol and Procedure Final Jan
7.5	Oldham SAR Protocol	 OSAB-Safeguarding -Adults-Review-Polic
7.6	Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews	 DHR Statutory Guidance December
7.7	Information Sharing	 Appendix 7.7.docx