Statement from the Oxfordshire Safeguarding Adults Board

Today (24th November 2020) the Oxfordshire Safeguarding Adults Board has published its review into nine deaths that occurred between December 2018 and July 2019 amongst people who are identified as homeless. The purpose of the review is to promote learning and improve the practice of organisations. The report was written by two independent authors, Dr Adi Cooper and Professor Michael Preston-Shoot involved a number of different organisations and some members of the safeguarding board.

Dr Sue Ross, Independent Chair of the Oxfordshire Safeguarding Adults Board, said *"today we are publishing the report into the deaths of people who were street homeless or in homeless accommodation at the time of their deaths.*

"On behalf of the Oxfordshire Safeguarding Adults Board and its partner agencies I would like to express our deepest condolences to the family and friends of those who died and our thanks to those family members who contributed to developing our understanding of the issues facing their loved ones. I would also like to express our thanks to the authors for their thoroughness and commitment in conducting this independent review on behalf of the Board."

"the Board would also like to acknowledge the work of agencies working directly with homeless people to support them with what are often complex challenges in their lives. This review has highlighted a number of areas of learning for organisations in Oxfordshire, which Board members have recognised and are using to improve their services."

"The Board is committed to working alongside partners in order to ensure that the recommendations are implemented and understood by professionals, improving how we interact and better serve those who are at risk of becoming homeless in Oxfordshire."

Organisations have been very engaged with the recommendations and learning coming out of the report, with the action plan well underway, championed by senior managers in those organisations.

Work is already underway to set up a homeless mortality review process, ensuring that the lives of all those who die whilst homeless or have died after recently leaving homeless services are reviewed by a multi-agency group of specialists working in the field of homelessness to establish if more could've been done by organisations in Oxfordshire.

The Board has shared the report and its findings with various national networks and the Department of Health and Social Care so that the learning can be shared nationally and to promote the "whole system" conversation recommended by the authors.