Homelessness Mortality Review Procedure

1. Introduction

1.1. Oxfordshire Safeguarding Adults Board (OSAB) is committed to ensuring that the needs of vulnerable adults at risk are appropriately and effectively met by local services and agencies and that mechanisms are in place to protect people from the harms of abuse and neglect (including self-neglect).

1.2. The OSAB is committed to responding compassionately and robustly to the deaths of people who are homeless or with histories of homelessness. We believe that it is crucial that professionals, peers and next of kin have the opportunity to remember, reflect and learn from the lives and deaths of people who have, or should have, received our support.

1.3. **The OSAB will review all deaths of people who are homeless** to identify opportunities for learning and prevention and to ensure that services and agencies in Oxfordshire are responding effectively, to the safeguarding needs of adults who are homeless. This procedure sets out the action we will take, in response to notification of the death of someone who is homeless, or in receipt of housing related support services.

2. Scope

2.1. This policy applies following the death of someone who is street homeless, living in temporary or supported accommodation, or with a history of homelessness, in receipt of housing-related support services, **or within 6 months of exiting housing-related support services.**

2.2. It does not apply to children under the age of 18 years old, who would be subject to Children's safeguarding mechanisms.

3. Statement of Policy

3.1. The Oxfordshire Safeguarding Adults Board will:

- Promptly and accurately record the occurrence, subsequent communication and activity in relation to deaths within the scope of this policy.
- Communicate the death promptly within Oxfordshire Safeguarding Adults Board partnership and externally to relevant stakeholders.
- Communicate with friends, family, or representatives of the bereaved in a sensitive, compassionate and professional manner in line with our GDPR responsibilities.
- Adopt a reflective, systems learning-focused and prevention-centred approach to the deaths of homeless people.
- Review the intervention and involvement of the relevant statutory and voluntary organisations involved in the care and support of the person who died, with the intention to identify and communicate opportunities for learning and prevention.
- Engage collaboratively with other relevant statutory review processes including Safeguarding Adults Reviews, Domestic Homicide Reviews and Fatal Fire review, as appropriate.

- Highlight professional practices which are identified as having had an effect (positively or negatively) on the safety and support of vulnerable homeless people & recommend actions to implement change if considered necessary.
- Monitor the number of deaths, circumstances, trends and learning on an ongoing basis.
- Deliver an annual thematic review of deaths and reviews within scope of the procedure to the Oxfordshire Adult Safeguarding Board and external stakeholder/governance partnerships.

4. Review Process

Notification

Initial Communication

4.1. The Board Officer (Homelessness) should be made aware of any death of a person or persons that fall within the scope of this process, as soon as possible via the current referral form found on the OSAB website.

4.2. The Board Officer (Homelessness) will inform the Chair of (Safeguarding Adults Review) SAR Subgroup, once a referral is received.

4.3. Occasionally information shared with the OSAB may indicate another type of statutory review would be more appropriate e.g., Safeguarding Adults Review (SAR), Domestic Homicide Review, or LeDeR review, and in these instances the Chair will liaise with relevant colleagues to ensure information or intelligence gathered through the Homelessness Mortality Review process is shared with relevant Reviewers elsewhere.

4.4. Although a Full Review might not be recommended, the Chair may still wish to draw attention to a particular issue or example of good practice from the Desktop Review process. This may be communicated by e-mail or could merit a meeting to explore a particular area of practice or partnership working in more detail.

4.5. If the death occurs in a housing-related support service, or if the person who dies is receiving a housing-related support service, commissioned by Oxfordshire County Council, Oxford City Council, Cherwell District Council, West Oxfordshire District Council or South & Vale District Council, **notification should be immediate and accompanied by an incident report**.

4.6. An agreement must be reached as to which agency will facilitate the Multi-Agency Meeting. They should provide a date for the meeting (within 4-6 weeks), to the OSAB Officer.

4.7. A Multi-Agency Meeting will be held to review the case and agree systems learning. This is an opportunity to understand local and organisational practices, policy and external factors such as legislation and statutory guidance. It will be a collaborative process with those involved in the review and is not to apportion blame.

Communication with family / next of kin / peers

4.8. Initial contact with next of kin and family to inform them of the death should be completed by the emergency services responding to the death. Oxfordshire Safeguarding Adults Board staff, or those providing housing-related support services are not expected to notify family or next of kin.

4.9. As a minimum, once the Board Officer (Homelessness) has been made aware of a death and they have contact details for next of kin, they will notify next of kin that a review is taking place. Where they want to, and where it aligns with consent to share information given prior to death, next of kin are invited to participate in the Review process. It is not appropriate, unless there was explicit prior consent, to share personal information with family members about the deceased persons relationship with services etc. Therefore, their contribution to a review is likely to be separate to information submitted by practitioners and statutory services.

4.10. As well as inviting next of kin to participate in the review process, Oxfordshire Safeguarding Adults Board is committed to recognising the importance of peer relationships for people experiencing homelessness. Recognising that for many people who experience homelessness, peers often play familial roles and the grief and distress they experience after losing a friend can often be underplayed or normalised by services supporting them. This will mean that friends and neighbours of the person who died will be told a review is being completed and asked if there is anything, they might want to contribute to it, about the person they know. It is not appropriate, due to issues of consent and privacy, to share personal information about the deceased person with peers and neighbours and therefore their contribution to a review will be separate to information submitted by practitioners.

Information Sharing

4.11. The Homelessness Mortality Review Procedure will be covered by the Information Sharing Protocol already established by the Oxfordshire Safeguarding Adults Board.

4.12. Data is not shared as part of the Homelessness Mortality Review Procedure based on consent, as the personal identifiable data relates to a deceased person.

4.13. The Data Protection Act 2018/GDPR provides a lawful basis for processing information as part of this procedure, under Article 6(e) and Article 9(h), which state:

- Article 6(e) - information can be shared where processing is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller.

- Article 9(h) - information can be shared where processing is necessary for the purposes of preventive or occupational medicine…medical diagnosis, the provision of health or social care or treatment or the management of health or social care systems and services.

4.14. The Care Act 2014, Section 45 requires any person or persons to supply information to the Board upon request for the purposes of exercising its functions. S.43(4) of The Care Act 2014 states a SAB "may do anything which appears to be necessary or desirable for the purpose of achieving its objectives", which is to help and protect adults in its area who have or are suspected to have a care and support need.

Scoping & Evidence Gathering

4.15. The death will be recorded and Scoping Forms circulated to members of the SAR Subgroup and any other relevant agencies noted on the referral form. The aim is to do this within 10 working days of receiving a referral form.

4.16. The Scoping Form has two aims:

i) To gather information which illuminates the circumstances of the person's death and the events leading up to it.
ii) To gather information about the role of professionals and services.

4.17. The aims of the scoping are achieved by contacting the known relevant partners and requesting information about any of their involvement with the deceased person with a detailed chronology of the **24 months** preceding their death and where relevant in the years previous. This information is requested in a timeline format and there is a **28-day** expected response time, to allow organisations time to accurately provide information.

4.18. It is not necessary for each organisation to provide details of every single interaction with the person. For example, a supported housing service may provide information about the dates of incidents, case conferences and notable changes in the persons living arrangements or support, but not about every conversation or key-work session that took place. The Chair of the SAR Subgroup will request additional information if deemed necessary.

4.19. Once partner agencies have responded about their relationship or involvement with the deceased person and a timeline of events provided, the Board Officer (Homelessness) will prepare an amalgamated chronology showing the input from all agencies involved over the last 24 months and this will be circulated to the relevant agencies, prior to the Multi-Agency Meeting, along with the organisations' views on their learning.

Conclusion and Actions

4.20. The review will seek to understand if, on balance, the death was avoidable. Reaching this decision will be a collaborative process with those involved in the review and will consider local and organisational practices, policy and external factors such as legislation and statutory guidance.

4.21. Board Officer produces the initial analysis report from the information gathered at the multi-agency meeting. This will be circulated to the attendees with a request for feedback within 2 weeks.

4.22. Following receipt of any feedback, any final adjustments are made to the report and this is then circulated to Senior representatives of the organisations that are involved in the HMR and presented at the next SAR Subgroup meeting.

4.23. Once the report is heard and signed off at the next SAR Subgroup meeting, an anonymised version will be circulated to all agencies for the purpose of sharing the learning within their organisations.

4.24. If there is a decision made that the case should be escalated to become a Safeguarding Adults Review (SAR), then it will be agreed within the SAR Subgroup meeting and the OSAB Manager will advise the independent Chair of the Oxfordshire Safeguarding Board.

4.25. A range of actions may be recommended and may relate to individual organisations or broader systems of practice and partnership. These actions will be SMART and will be followed up six months after review completion.

5. Governance & Quality Assurance

5.1. The Homelessness Mortality Review procedure is owned by the Oxfordshire Safeguarding Adults Board as part of its powers under Section 44 of the Care Act 2014. One of the key aims of the Review procedure is to provide assurance to the Oxfordshire SAB that vulnerable, homeless adults at risk, are being appropriately safeguarded.

5.2. While the process is owned by OSAB, they are not experts on housing and homelessness and cannot provide the level of strategic assurance required. This assurance will be delivered through the provision of a quarterly review to the **Homelessness Directors Group.**

5.3. Results and outcomes from HMRs, including analysis of emerging themes and the effectiveness of the review process, will be presented for discussion at **Countywide Homelessness Steering Group** on a quarterly basis.

5.4. An **annual thematic report** will also be produced and shared with all relevant partnership groups. This report will contain information about individual reviews, emerging themes and issues, as well as development and improvement work taking place in relation to safeguarding and homelessness.