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| Oxfordshire Safeguarding Adults Board**Homelessness Mortality Review** – **Referral Form**  |

In the event of a person dying in Oxfordshire, who is without settled accommodation, professionals should check if the case meets the criteria for a Homeless Mortality Review (see Appendix A). If it does, then this form should be completed and sent to the Oxfordshire Safeguarding Adults Board (OSAB). Email: **HomelessMortality@Oxfordshire.gov.uk**

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| **Details of the person who died:** |
| **FIRST NAME of the deceased** |  |
| **SURNAME of the deceased** |  |
| **Any Aliases?**  |  |
| **Date of Birth** |  |
| **Date of Death** |  |
| **Age at Death** |  |
| **Last known address** |  |
| **Gender/Gender Identity** |  |
| **Sexuality** |  |
| **Faith/Religion** |  |
| **Nationality, Ethnic Origin & First Language** |  |
| **Disability? If so, in what respect are they disabled?** |  |
| **Marital Status** |  |
| **Parent/Caring Responsibilities** |  |
| **Socio-Economic Status** (*Employed, unemployed, claiming benefits, No recourse to public funds)* |  |
| **Did the person have a local connection to Oxfordshire? Which area?**  |  |
| **Where were they living? Please provide an address if possible.** |  |
| **Were they living in a supported housing provision? (When did they move in?)** |  |
| **Information required from the Notifying Agency:** |
| **Name of the Notifier** |  |
| **Job Role** |  |
| **Agency** |  |
| **Contact Details of Notifier** |  |
| **Date of Notification to OSAB** |  |
| **Relationship to the deceased** |  |

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| **Have you, or anyone in your organisation, notified any of the following about the death? Or do you know if they are aware?**  | 1. **Next of Kin**
 | **Yes/No** |
| 1. **Police**
 | **Yes/No** |
| 1. **Coroner’s Office**
 | **Yes/No** |
| 1. **GP**
 | **Yes/No** |
| 1. **Care Quality Commission**
 | **Yes/No** |
| 1. **Place of residence**
 | **Yes/No** |
| 1. **Any other please give details…………………………………………………….**

**…………………………………………………………….** | **Yes/No** |

*If anyone else has been notified about the death, please provide their contact details if you have them.*

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| **Do you have details of any family members/ Next of Kin/ Significant others?**  |  |
| **Have they been made aware of the HMR Process?** |  |
| **Are they willing to be involved in the process?** |  |
| **Please provide contact details: (***Name, Address, Telephone Numbers, email)* |  |

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| **Details of the Death:** |
| **Place of Death:** |  |
| **Address:** |  |
| **Official Cause of Death if available:** ***(As described on the Death Certificate 1a/1b/1c/2)*** |  |
| **What do you understand the cause of death to be?**  |  |
| **Were you surprised that the person died from this cause at this time? If so, why?**  |  |
| **Will there be a post mortem?** |  |
| **Will there be a Coroner’s inquest?** |  |
| **Will there be any other investigation into the death? If YES, please describe** |  |
| **In what capacity do you know the person who died?** |  |
| **Please give a summary of how you/your agency became aware that this person had died.**  |
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| **Please provide a summary of the person’s history within the homeless services**: |
| *Length of time known to services, why they became homeless (if known) etc.,*  |

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| **Other Agencies known to the deceased:** |
| **Was the person receiving care or support from any statutory or non-statutory agencies?**  | **Contact details*****(Name of organisation/lead worker/e-mail &/or telephone contact)*** |
| **Supported Housing/Hostel services** | **Y/N** |  |
| **Local Housing Authority** | **Y/N** |  |
| **Adult Social Care** | **Y/N** |  |
| **GP** | **Y/N** |  |
| **Drug or Alcohol Services** | **Y/N** |  |
| **Mental Health Services** | **Y/N** |  |
| **Street Outreach Team** | **Y/N** |  |
| **Probation/CRC** | **Y/N** |  |
| **Other**  | **Y/N** |  |

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| **Did the deceased usually receive statutory or voluntary sector support?** | Yes / No / Don’t know |
| **If YES did they receive support:****(Delete as appropriate)**  | 1. Daytime only
2. Day and night (waking night)
3. Day and night (sleeping night)
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| **Who was the primary support/care provider?** |  |

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| **Outcome of Screening:***For OSAB use: (to be completed by the Homeless Mortality Review Officer for OSAB, on behalf of the HMR Sub-Group)* |
| **Outcome** | **Date** | **Reason** |
| Case closed without proceeding further than referral |  |  |
| Full HMR instigated |  |  |
| Case Referred on to SAR Sub-Group |  |  |