Home Office

Offensive Weapons Homicide Reviews

Draft statutory guidance

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Introduction

Every homicide is a tragedy and the Government wants to do all it can to prevent them and tackle serious violence.

Homicide has risen by about a third between 2014/15 and 2018/19 and has become the fourth leading cause of death for men aged 20-34 (behind suicide, drug overdoses and car accidents). The cost of homicide is significant and is annually estimated to be more than £2.5bn.

Homicides involving offensive weapons make up a large and growing proportion of all homicides – analysis suggests 354 of 732 homicides in 2019. We are concerned that many of these homicides are not currently formally reviewed by multi-agency partners to rapidly learn and share lessons; in the way that happens when a person aged under 18 dies, a vulnerable adult dies, a person dies due to domestic violence, or someone in receipt of mental health care commits homicide.

Of the 732 offences initially recorded as homicides in 2019, we estimate that 510 did not meet the criteria for an existing review, and that half of the unreviewed homicides involved an offensive weapon (251).

The Police, Crime, Sentencing and Courts Act ("the Act") introduces a requirement on the police and local authorities in England and Wales and the clinical commissioning groups in England and local health boards in Wales to review the circumstances of certain homicides where the victim was aged 18 or over, and the events surrounding their death involved, or were likely to have involved the use of an offensive weapon.

The purpose of these reviews is to ensure that when a qualifying homicide takes place, local partners identify the lessons to be learnt from the death, to consider whether any action should be taken as a result, and to share the outcome. The intention is that these new reviews will improve the national and local understanding of what causes homicide and serious violence, better equipping services to prevent weapons-enabled homicides, and in so doing, save lives.

TO NOTE: This document has been prepared in consultation with local and national stakeholders and as this engagement is planned to continue into 2022, this guidance document should be regarded as in draft form. Where details and responsibilities have yet to be conclusively decided, text is differentiated in a purple box to signify that it reflects the present situation and that further consideration and legislation is required to provide precise detail. Additional detail on the powers conferred on the Secretary of State to make regulations has also been highlighted in the same way using white boxes. Any regulations necessary to implement OWHRs will be made in advance of the pilot commencing.

Section 1: What is an Offensive Weapons Homicide Review (OWHR) and what is its purpose?

Status and purpose of this guidance

1.1 This guidance is issued by the Secretary of State as statutory guidance under section 31 of the Act. It is for review partners as defined in section 35 of the Act (Chief Officers of police and local authorities in England and Wales, and clinical commissioning groups in England and local health boards in Wales), and has been produced to support review partners exercising the functions conferred on them by the Act in respect of OWHRs .

In the creation of this guidance, consultations have been made with:

a. persons representing potential review partners,

b. the Welsh Ministers, so far as the guidance relates to a devolved Welsh authority,

c. other relevant national and local stakeholders in England and Wales.

What is an offensive weapon homicide review?

1.2 An OWHR is to be arranged as set out in section 23(1) of the Act, where a review partner considers that:

a. the death of a person was, or is likely to have been a qualifying homicide,

b. the death occurred, or is likely to have occurred, in England or Wales,

c. such other conditions specified by the Secretary of State in regulations are satisfied,

d. the review partner is one of the relevant review partners in respect of the death.

1.3 Under section 23(6) of the Act, the homicide of a person is a qualifying homicide if:

a. the person was aged 18 or over, and

b. the death, or the events surrounding it, involved the use of an offensive weapon.

1.4 An offensive weapon is defined, for the purposes of an offensive weapons homicide review, in section 1 of the Prevention of Crime Act 1953 as:

> "any article made or adapted for use to cause injury to the person or intended by the person having it with him for such use by him, or by some other person."

1.5 Where regulations have been made by the Secretary of State under section 23(1)(c) of the Act review partners must decide whether the conditions set out in those regulations have been satisfied and whether the threshold for a review has been triggered. The regulations require partners to be satisfied that the conditions relating to 23(1)(c)(i-iii) have been met, when making their decision.

The regulations as set out in Section 23 (1)(c)(i-iii) may for example, include conditions as set out in the Act relating to:

(i) the circumstances of or relating to the death,

(ii) the circumstances or history of the person who died, or

(iii) the circumstances or history of other persons with a connection to the death,

1.6 Furthermore, there is no duty to arrange an OWHR where another statutory review applies (see section 25 of the Act and para 1.9 below), or in certain cases as set out in section 23(3) to (5) of the Act (see para 1.9 below).

(i) Regulations – duty to arrange a review

The Act provides that the Secretary of State may make regulations under section 23(1)(c) which will set out other conditions as part of the criteria to confirm if a review partner is under a duty to arrange and carry out an OWHR. Further details will be provided in this section on the content of such regulations.

Relevant review partners

1.7 The Act specifies that relevant review partners are responsible for arranging and conducting an OWHR. Review partners are set out in the section 35 of the Act as: a chief officer of police and a local authority in England and Wales, and a clinical commissioning group in England or a local heath board in Wales. A local authority is defined in England as a county council, a district council, a London borough council, the Common Council of the City of London in this capacity as a local authority or the Council of the Isles of Scilly. A local authority is defined in Wales as a county council or a county borough council.

Section 24 of the Act confers a power on the Secretary of State to provide regulation making provision for identifying which review partners are the relevant review partners in respect of a death.

Section 24(3) of the Act specifies that the relevant review partners in respect of a person's death are:

a. a chief officer of police for the police force area in England or Wales in which the death occurred or is likely to have occurred,

b. a local authority in which the death occurred or is likely to have occurred or, if the death occurred or is likely to have occurred within the area of a district council whose area is within the area of a county council, both of those authorities, and

c. a clinical commissioning group (CCG) (England) or a local health board (LHB) (Wales) in the area in which the death occurred or is likely to have occurred.

Depending on the circumstances of the incident, and accepting that there is likely to be a range of circumstances in which a death occurred, section 24(4) of the Act also enables the identification of relevant review partners in relation to:

a. the last known place of residence of the person who died.

b. an earlier place of residence of the person who died.

c. the place of residence of the person who caused or is likely to have caused, or of any of the persons who caused or who are likely to have caused, the person's death.

d. The police area in England or Wales of the police force that is investigating or has investigated the person's death.

In recognition of the complexity of many offensive weapons homicides, other criteria may be brought into consideration when identifying the relevant review partners which include:

a. if the location of the homicide is unknown (in the case of a body being transported or moved),

b. if the location of the homicide is largely separate from the victim and/or alleged perpetrators (in the case of violence, which can occur in local authorities who have had no engagement with any of the involved parties),

c. if a particular potential review partner has had strong engagement with the victim, the alleged perpetrator(s), or the facts of the events that led to the homicide.

(ii) Regulations – relevant review partners

The Act provides for the Secretary of State to make regulations under section 24 which make provision for identifying the relevant review partners for each death. Further details will be provided in this section on the content of such regulations.

1.8 The relevant review partners as identified by virtue of regulations made under section 24 of the Act must arrange for there to be a review, and where a review takes place they must cooperate and contribute to the delivery of the review, unless, after the initial information collection stage a review partner considers:

a. that any of the conditions for an OWHR in section 23(1)(a) to (c) of the Act are not satisfied in a particular case. In which case they are no longer under a duty to arrange for there to be a review, and the review (if already underway) may be discontinued.

b. that the condition in section 23(1)(d) is not satisfied, as they are not one of the relevant review partners in respect to the homicide. If the review has already been started in these circumstances, the review partner continues to be under a duty to arrange the review and the review must continue to prevent delay. If a review has not been started, the potential review partner in this circumstance is no longer under the duty to arrange the review into the death.

There is also no duty on a review partner to arrange for there to be a review where such a review has already taken place or has started to take place, under arrangements made by other review partners, or where section 25 disapplies the duty (see further overleaf).

Relationship with other reviews

1.9 There are other statutory and prescribed reviews which may be held when a death occurs. The OWHR is not intended to duplicate these, but to ensure lessons are learned in certain cases where such reviews do not apply. Accordingly, section 25(1) of the Act provides that the duty to undertake an offensive weapons homicide review does not apply where:

a. a child death review must or may be arranged in relation to the death (see section 16M(1) and (2) of the Children Act 2004),

b. the death must or may be the subject of a domestic homicide review (see section 9 of the Domestic Violence, Crime and Victims Act 2004), or

c. a safeguarding adult review must or may be established in relation to the death (see section 44(1) and (4) of the Care Act 2014)

1.10 The duty is also disapplied under section 25(3) of the Act, where regulations under section 135(4)(a) of the Social Services and Well-being (Wales) Act 2014 (anaw 4) require a Safeguarding Board to undertake a review of the death.

Section 25(2) and (4) of the Act also allows for the duty to conduct an OWHR to be disapplied where:

a. the death may or must be investigated under arrangements made by NHS bodies due to the death being caused by persons receiving or having received any health services relating to mental health (these are known as mental health homicide reviews or Independent Investigations for Mental Health Homicides)

b. the death is caused by a person who is receiving or has received any health services relating to mental health, where there may be a review of, or investigation into, the provision of that health care under section 70 of the Health and Social Care (Community Health and Standards) Act 2003.

(iii) Regulations – reviews in relation to mental health homicides

Section 25(2) and (4) of the Act provides that the Secretary of State may make regulations which provide that the duty to arrange an OWHR is disapplied in certain circumstances where a death is caused by persons receiving or having received any health services relating to mental health. Further details will be provided in this section on the content of any such regulations.

1.11 If one event results in multiple homicides, different statutory reviews may apply for the different homicides, each process would have to comply with its own legislation. However, the same death will not be subject to an OWHR if another statutory review as set out in section 25(1) and (3) applies and may not be subject to an OWHR if the Secretary of State makes regulations under section 31(2) or (4).

1.12 In Wales, the Single Unified Safeguarding Review (SUSR) is being developed to reduce the need for parallel reviews to be conducted in relation to the same single incident. This is to avoid duplication of resource and to save time and costs by undertaking multiple reviews. The SUSR will be implemented in Wales in 2022 as the mechanism to conduct Adult Practice Reviews, Child Practice Reviews and Mental Health Homicide Reviews in Wales. Other reviews such as Domestic Homicide Reviews may be added in the future.

(iv) Multiple homicides and linked homicides

After a process of stakeholder consultation and co-design with practitioners, this section will detail a suggested approach to take where an OWHR may be relevant in relation to an incident where there are multiple homicides which involved an offensive weapon; linked homicides occurring in the same area within a particular period of time or where multiple homicides occur where different statutory review processes apply.

Within Wales, the SUSR has been identified as the mechanism in which to conduct Mental Health Homicide Reviews.

The purpose of an OWHR

1.13 As detailed in section 27(2) of the Act, the purposes of an OWHR are:

a. to identify the lessons to be learnt from the death, and

b. to consider whether it would be appropriate for anyone to take action in respect of those lessons learnt.

Under section 27(3) where it is considered that it would be appropriate for a person to act in relation to those lessons learnt, the review partners must inform that person.

1.14 Lessons could include:

a. identifying factors that may have made it harder for those local professionals and organisations, working with the victim, alleged perpetrator(s) and with each other, to reduce the risk of violence to begin with

b. to identify what could have been done differently at an agency and system level to prevent future homicides and reduce serious violence

c. to identify areas of good practice and successful interventions which could be incorporated into general processes and system responses.

1.15 Additional strategic objectives of an OWHR are:

a. To establish what lessons can be identified in approach and service response for all qualifying offensive weapon homicides within a period, and how they can be applied to prevent future homicides and serious violence.

b. To prevent offensive weapons homicide and related serious violence by developing a greater local, regional, and national understanding of the role of individual and system service provision and what improvements can be made in policy, practice, or law.

c. To contribute to an enhanced knowledge of offensive weapon homicides and related serious violence through improved understanding of the relationship between the victim and alleged perpetrator(s) and the ways in which they interact with relevant services.

1.16 In the pursuit of these objectives, it is advised that review partners seek to both examine the actions of individual agencies and practitioners, while also capturing how the system surrounding those involved in the qualifying homicide, shaped and interacted with the events that led to it. From this position, reviews are free to question not only whether procedure and policy were followed, but whether procedure and policy were sufficient/appropriate to protect the persons with a connection to the qualifying homicide in the first instance. A focus on identifying learning to enable a different system approach to addressing and preventing serious violence should be prioritised.

1.17 OWHRs should also seek to contribute to the broader understanding of serious violence, its drivers, and the experiences of those impacted by it in order to inform policy and practice. Reviews should seek to situate the report within the environment, community, and social network of the victim, and where possible, the other persons with a connection to the qualifying homicide. This will necessarily involve reviewers looking beyond service engagement alone, to the factors which may have precipitated a different outcome, for example, through different interventions.

1.18 OWHRs are not investigations into the death of the victim designed to identify culpable parties. OWHRs are also not disciplinary processes; where a disciplinary process emerges in an OWHR, it should be handled separately to the OWHR and in line with organisational disciplinary processes. Accordingly, OWHRs should act to empower professionals to explore the way their agencies and the wider system they operate in could be improved to protect people from serious violence. Innovation in investigative methods and approaches, and the ability to challenge existing narratives, practice, and policy will be required among review partners to ensure a meaningful OWHR.

(v) The roles and responsibilities of review partners and others with an interest in the OWHR process

After a process of stakeholder consultation and co-design with practitioners, this section will detail the collective functions of review partners in the delivery of strategic objectives of an OWHR, how these roles will be delivered, and the relationship between review partners and others with an interest in the OWHR process including:

a. the local area review partners with statutory obligations i.e. the local authority or authorities, Chief Officer of police and CCG/LHB.

b. regional level partners with an interest in the OWHR process i.e. the Community Safety Partnership (CSP), Police and Crime Commissioner (PCC), Violence Reduction Unit (VRU or alternative acronym e.g. VPU, VRN etc) and in Wales, also the Regional Safeguarding Boards.

c. the family, community and the voluntary and/or third sector

d. the OWHR Oversight Board

e. the Welsh Government

1.19 Review partners are advised to consider equality and diversity issues at all times and comply with the requirements of the Public Sector Equality Duty. Age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, ethnicity, sex, and sexual orientation may all impact the way a review is conducted, presented, and understood among the review partners and local communities.

1.20 Review teams should take tangible actions to mitigate against bias that may impact the conduct and outcome of the review, consciously or unconsciously. Issues around protected characteristics and intersectionality may be particularly present in an OWHR, and it is important that reviews seek to understand and represent the ways in which these factors interact and influence the events leading up to the qualifying homicide.

Section 2: Delivering an Offensive Weapons Homicide Review

2.1 When a suspected qualifying offensive weapon homicide has been identified by one of the review partners where the incident took place, they should inform the likely relevant review partners of the incident.

Regulations made by the Secretary of State will provide for the process of identifying the relevant review partners in each case. Such regulations may provide for the identification of relevant review partners by reference to particular matters relating a person's death, as set out in section 24 (see paragraphs 1.7 above):

The regulations may provide for the relevant review partners to be the Chief Officer of Police, local authority or authorities, and CCG/LHB for the area where the death occurred or is likely to have occurred. However, regulations may also provide, for example, for situations and circumstances in which relevant review partners could be from a different area from that in which the death occurred. In some circumstances the location of the death may provide limited context for the background to the homicide. Section 24 of the Act provides that regulations may provide for identification of the relevant review partners by reference, for example, to the place where the victim was last known to reside, or where a person who caused or was likely to have caused the death resided.

It is recognised that due to the often-complex nature of offensive weapons homicide reviews that there may be cases where there are several potential relevant review partners. Section 24 provides that regulations may, therefore, provide for the identification of the relevant review partners though agreement being reached between groups of review partners, for example, the Chief Officer of Police, local authority or authorities and CCG or LHB in the area the incident occurred and in the area where the victim last resided collaborate and agree who are the relevant review partners for that case, and make arrangements for the OWHR to be conducted in line with the requirements set out in legislation.

Regulations may also confer on the Secretary of State a power to give a direction specifying which review partners are the relevant review partners in a particular case. Should this power be conferred on the Secretary of State it would ensure that there will be no cases where there are no relevant review partners, for example, if the regulations permit review partners to come to an agreement between themselves about who the relevant review partners will be in each case, and no such agreement is reached in a particular case.

(vi) Regulations – relevant review partner direction

Section 24 of the Act confers on the Secretary of State a power to make regulations making provision for identifying which review partners are the relevant review partners in respect of a person's death. Further details will be provided in this section on the content of such regulations.

Determining whether an OWHR should take place

2.2 When a review partner becomes aware of such facts that make it likely that the conditions set out in section 23(1)(a) and (b) are satisfied in relation to the death, and that they are one of the relevant review partners in respect of the death they should begin the process of collecting information to determine whether the conditions in section 23(1) are satisfied, to decide whether they are under a duty to arrange an OWHR.

2.3 Section 28(1) of the Act provides a power for a review partner to request information from a person where the request is made for the purpose of enabling or assisting in the performance of functions conferred on a review partner by sections 23 to 27 of the Act, and where the person to whom the request is made is a person whose functions or activities are considered such that the person is likely to have information that would enable or assist the performance of functions conferred on a review partner by sections 23 to 27 of the Act. Such a request must be complied with, subject to provisions in section 29 of the Act.

2.4 Section 28(7) also provides review partners with the power to provide information to another review partner for the purpose of enabling or assisting the performance of functions conferred by sections 23 to 27 of the Act, subject to provision in section 29 of the Act.

2.5 Before notifying the Secretary of State of their decision, as required by section 26 of the Act, in determining if the conditions for an OWHR are satisfied, review partners should, in the one month notification period:

a. gather the facts about the case, as far as they can be readily established at the time, by contacting all relevant persons/bodies and asking them to produce a brief overview of their engagement with the victim or a person with a connection to the death. A meeting or structured briefing could be considered as part of this process (inclusive of statutory and voluntary partners). The data protection legislation must be complied with in relation to any personal data disclosed.

b. discuss and examine whether there is any immediate action required to ensure wider safety in the locality, or directly within the victim/alleged perpetrator(s) peer group and/or family linked to either the incident or wider connections with criminality and/or exploitation, and share any learning appropriately. Any issues should initially be raised with the Senior Investigating Officer of the Police.

c. determine whether the death is subject to any other review's as set out in section 25 of the Act (see paragraph 1.9),

d. determine if the conditions as set out in the regulations under section 23(1)(c) have been satisfied, whether the death is, or is likely to be a qualifying homicide, which occurred, or is likely to have occurred in England or Wales.

e. determine the relevant review partners in line with regulations made under section 24 of the Act.

(vii) Information sharing

Key to the success of OWHRs will be the facilitation of information sharing across organisations. Section 28(1) of the Act provides the power for a review partner to request information from a person where the request is made for the purpose of enabling or assisting in the performance of functions conferred on a review partner by sections 23 to 27 of the Act, and where the person to whom the request is made is a person whose functions or activities are considered such that the person is likely to have information that would enable or assist the performance of functions conferred on a review partner by sections 23 to 27 of the Act. Such a request must be complied with. Section 28(7) also provides review partners with the power to provide information to another review partner for the purpose of enabling or assisting the performance of functions conferred by sections 23 to 27 of the Act.

Section 29(2) provides that a disclosure authorised or required by sections 26 to 28 do not breach any obligation of confidence owed by the person making the disclosure, or any other restriction on the disclosure of information (however imposed). However, section 29(1) provides that the power in section 28(1) cannot be used to require the disclosure of information subject to legal professional privilege. Section 29(3) also provides that the provisions in sections 26 to 28 do not authorise or require a disclosure of information that would contravene the data protection legislation (as defined in section 3(9) of the Data Protection Act 2018), or is prohibited by any of Parts 1 to 7 or Chapter 1 of Part 9 of the Investigatory Powers Act 2016.

After a process of stakeholder and expert consultation further information and templates to aid the process will be included in this section.

Notifying the Secretary of State

2.6 Section 26 requires review partners to provide notifications to the Secretary of State in respect of whether or not a review will take place. If a review partner becomes aware of qualifying circumstances in relation to a death, they must notify the Secretary of State within the notification period, being one month beginning with the day they became aware of the qualifying circumstances, of one of the following:

a. that the review partner is under a duty to arrange for there to be a review under section 23 of the person's death,

b. that the review partner is not under that duty in respect of the death, or

c. that the review partner has not been able to take a decision on the matter. If this is the case, a notification must be made to the Secretary of State confirming the decision once made.

2.7 Section 26(7) sets out that a review partner becomes aware of the qualifying circumstances in relation to a death if they become aware of such facts as make it likely that the conditions in section 23(1)(a) and (b) are satisfied (that the death was, or is likely to have been a qualifying homicide, and the death occurred, or is likely to have occurred, in England or Wales), and the review partner is one of the relevant review partners in respect of the death.

2.8 Any review partner who becomes aware of the qualifying circumstances must notify the Secretary of State of their decision, or that they have not been able to take a decision, as set out in section 26(1), not just those who are identified to be the relevant review partners. Where all review partners agree they could co-sign the same notification letter, however consideration should be given to the one month notification period as this will likely start earlier for some review partners than others, as detailed in point 2.10.

2.9 Other circumstances set out in section 26 of the Act where the Secretary of State must be notified about an OWHR are listed below.

a. Under section 26(4) if a review partner notifies the Secretary of State that they are under a duty to arrange an OWHR, but before the review starts to take place, makes a decision that they are not actually under a duty, see section 23(3) and (4) of the Act. This situation might occur where for example, it was thought that the death was a qualifying homicide, but it turned out not to be on further investigation.

b. Conversely, under section 26(6) if a review partner had previously notified the Secretary of State that they were not under the duty to arrange an OWHR, but on further investigation decides that they are under the duty, they need to notify the Secretary of State of that decision.

c. Under section 26(5), where an OWHR is discontinued because one of the conditions in section 23(1)(a) to (c) has not been met (as noted above this situation may arise, for example, if on further investigation it was concluded the death was not a qualifying homicide).

2.10 Under section 26(2) of the Act there is no requirement to notify the Secretary of State where:

a. a review of the death has already taken place, or has started to take place by other review partners, or

b. the duty to conduct an OWHR is disapplied by section 25, or regulations under section 25), due to another review as set out in section 25 being applicable.

It should be noted that the notification period of one month within which to make a decision and notify the Secretary of State is a maximum period. It is recommended that the notification be made to the Secretary of State as soon as a decision is reached. An OWHR can then be established, as soon as is practicable. The quicker the process can get underway the better for partners in terms of successfully establishing the facts and maintaining the productive engagement of stakeholders.

Establishing an OWHR

2.11 Once the relevant review partners have established that an OWHR is required in respect of a death, and having notified the Secretary of State, we would suggest that they do the following within 5-10 working days:

a. make sure that the police force investigating the homicide is aware that an OWHR is required for this incident, which will likely require a review of the alleged perpetrator(s).

b. determine the scope and terms of reference of the OWHR, see paragraph 2.12 of this guidance.

(viii) The Single Unified Safeguarding Review (SUSR) process in Wales

A SUSR is currently in development in Wales which aims to bring together several different safeguarding reviews under a single process coordinated by a sole body.

After a process of stakeholder consultation, and expert consultation further information will be included in this section on the process that will be followed in integrating OWHRs into the SUSR.

2.12 The relevant review partners may wish to consult on the review's terms of reference with local statutory, voluntary and third sector partners that have a specialist understanding of the dynamics of serious violence and the relationship with wider criminality, exploitation and societal and economic risks factors. Appropriate bodies to contribute to a review in addition to the review partners may include, but are not limited to:

- Police (from other areas)
- Local Authorities (from other areas)
- Clinical Commissioning Groups (CCGs) (from other areas)
- Local Health Boards (Wales) (from other areas)
- Violence Reduction Unit (VRU or alternative e.g. VPU, VRN etc).
- Police and Crime Commissioners (PCCs)
- Safeguarding Adult Boards in England/Regional Safeguarding Boards in Wales
- Safeguarding Children Partnerships in England /Regional Safeguarding Boards in Wales
- National and regional law enforcement agencies with a serious and organised crime remit
- Educational institutions
- Probation service
- Crown Prosecution Service
- Specialist Voluntary Sector Providers
- Family, friends, faith sector, affected communities, and other social networks

2.13 The relevant review partner should, where possible, enable consultation between these parties and record all information in compliance with data protection obligations. This consultation will also assist in the identification of other relevant bodies to support the review.

(ix) How to involve family, friends, and other networks within the OWHR review process.

Through consultation to date it has been clear that engagement with family, friends, affected communities, faith sector and other social networks will be important to the review process as holders of key information. However, it is not the purpose of an OWHR to provide a platform for or support to the family and those affected, but rather to produce multi-agency learning and contribute to the knowledge of serious violence.

Further consultation and co-design will support pulling together a specific section of the guidance which is focused on:

a. the extent of the involvement with this group of stakeholders,

b. the role of the family, friends, communities, and wider networks in the delivery of the overarching OWHR strategic purpose,

c. the lead partner in engaging with the family, friends, and wider networks,

d. how this group of stakeholders will be engaged in a manner that supports the review process without resulting in re-traumatisation of family members or other related parties.

(x) Roles of non-statutory partners and others with an interest in the OWHR process.

The review partners for the purpose of the legislation are the Chief Officer of Police, Local Authorities and CCGs in England or LHB in Wales. In addition, OWHRs will be relevant and of interest to other partners and stakeholders, as listed in paragraph 2.12. After a process of stakeholder consultation and co-design with practitioners, this section will provide more detail on how local, regional, and national partners may contribute to the OWHR process.

2.14 The overarching strategic objectives for an OWHR are outlined in the legislation and reflected at paragraph 1.15 – 1.18 of this guidance, however in the early stages of the OWHR, partners may seek to:

a. determine how much the victim and alleged perpetrator(s) were engaged with local services, both statutory and voluntary – or if they should have been in receipt of such support and opportunities to intervene were missed or not taken fully.

b. understand the level of overlap/cooperation between services in their support of, or engagement with, the victim and/or alleged perpetrator(s).

c. Determine whether there are operational, policy or strategic improvements that could be made in light of this incident.

d. Determine whether improved data sharing could have prevented the homicide

e. Determine whether other organisations are likely to have information that may be relevant to identify lessons (e.g. educational institutions, probation services, voluntary organisations)

f. consider the potential for identifying improvements to methods of preventing serious violence and the use of offensive weapons, broadening understanding as to how to address serious violence from a systems perspective.

How to ensure independence and mitigate against bias

2.15 Through consultation to date it has been clear that ensuring independence and mitigating against bias will be critical to the functioning of an offensive weapons investigation review. Review partners should keep in mind consideration of the following areas:

a. assuring quality and providing rigorous challenge to the data and information provided by all partners.

b. independent engagement with family, friends, and other networks to inform the OWHR

c. adherence to the Public Sector Equality Duty and a specific reference to the importance of cultural awareness

d. support of the independence of the OWHR process across different geographical areas with differing demand and capability

e. consideration as to how the approach aligns to other review processes, including the SUSR process in Wales.

OWHRs and Information sharing

2.16 Section 28(1) of the Act provides that a review partner may request information from a person where the request is made for the purpose of enabling or assisting in the performance of functions conferred on a review partner by sections 23 to 27 of the Act, and where the person to whom the request is made is a person whose functions or activities are considered such that the person is likely to have information that would enable or assist the performance of functions conferred on a review partner by sections 23 to 27 of the Act.

2.17 Sections 28(5) and (6) also hold that the person who receives this request must comply with the request and the duty can be enforced by making an application to the High Court or county court for an injunction. Section 28(7) also provides review partners with the power to provide information to another review partner for the purpose of enabling or assisting the performance of functions conferred by sections 23 to 27 of the Act. However, under section 29(1) the person may not be required to disclose information that the person could not be compelled to disclose in proceedings before the High Court, meaning that a person cannot be required to disclose information subject to legal professional privilege.

2.18 Section 29(2) provides that a disclosure of information authorised or required by section 26 to 28 of the Act does not breach:

a. any obligation of confidence owed by the person making the disclosure, or

b. any other restriction on the disclosure of information (however imposed).

2.19 However, sections 26 to 28 of the Act do not require or authorise a disclosure of information that:

a. would contravene the data protection legislation[1] (but in determining whether a disclosure would do so, the duty imposed or power conferred by the section in question is to be taken into account), or

b. is prohibited by any of Parts 1 to 7 or Chapter 1 of Part 9 of the Investigatory Powers Act 2016.

2.20 Each data controller must satisfy themselves that they are not in contravention of the data protection legislation and undertake their own risk and impact assessments. As set out at (vii) additional information will be provided on information sharing and collection.

[1] In this section "data protection legislation" has the same meaning as in the Data Protection Act 2018 (see section 3(9) of that Act).

(xi) OWHRs and Information sharing

A key line of inquiry being explored in consultation with stakeholders, experts, and local practitioners is the relationship between the offensive weapons homicide review process and the criminal justice process attached to the qualifying homicide. It is recognised that reviewing the circumstances or history of other persons involved in the qualifying homicide, including the alleged perpetrator(s), may present some issues for review partners in terms of disclosure.

In the final guidance, after a process of co-design to understand the obstacles and practical implications of this requirement, this section of the guidance will detail definitively at what stage in a criminal investigation an OWHR is expected to commence, how this will interact with coroners investigations and the implications this has on concerns of data sharing and disclosure.

Delegating functions

Section 30(1) of the Act confers a power on the Secretary of State to make regulations which may enable the relevant review partners to act jointly to appoint:

a. one of themselves (the relevant Chief Officer of Police, Local Authority, or Authorities, or CCG/ LHB), or

b. another person,

to carry out on their behalf, one or more of the functions specified in the regulations. The Secretary of State may specify in the regulations some or all of the functions of a review partner under section 27 or 28 relating to a review under section 23 or a report on the review.

Section 30(3) of the Act confers a power on the Secretary of State to make regulation making provisions that enable a county council and a district council for an area that is within the area of the county council to agree that one of them carry out one or more functions specified in the regulations on behalf of the other. The Secretary of State may specify in the regulations some or all of the functions of a review partner under sections 23 to 28 of the Act.

Any such regulations that may be made under these powers may enable the following allocation of reviewing functions and responsibilities:

a. relevant review partners agree that one party is more suited to lead the OWHR,

b. a county council, and a district council that is within the area of the county council agree that one of them should carry out on behalf of the other one or more of the functions specified in the regulations,

c. relevant review partners may delegate responsibility to lead the review to a chair.

(xii) Regulations – delegating functions

The Act provides a power for the Secretary of State to make regulations under section 30(1) and (3), which may set out the process to delegate one or more of the functions specified of a review partner. Further details will be provided in this section on the content of such regulations.

Costs of an Offensive Weapons Homicide Review

(xiii) Costs of an OWHR

After a process of stakeholder consultation and co-design with practitioners, this section will detail the likely costs of running an OWHR and clarity on who will hold and control the budget for the provision of OWHRs. The different processes will be outlined for both England and Wales.

The Home Office will support the effective delivery of the OWHR process by providing funding to the review partners for the work they carry out in delivering an OWHR during the pilot phase, as well as funding the OWHR Oversight Board (paragraphs 4.3)

Section 3: Offensive Weapons Homicide Review Process

3.1 Where the preceding sections of this guidance have provided the detail for and the reasoning behind the main tasks to be completed in the delivery of an OWHR, this section focuses on providing a clear process for each potential stage of the reviews. Each suggested step in the different stages of the review process have been articulated along with a set of suggested timeframes, durations, owners, and contributing agents.

It should be noted that these are suggested approaches and are not part of the legislative requirement but provide a suggested framework for undertaking a review.

3.2 Determining whether an OWHR should take place

Process Step	1. Inform the likely relevant review partners of the homicide	2. Establish whether an OWHR is applicable	3. Determine relevant review partners
Suggested timeframe	24 - 72 hours of incident occurring	Within 5-10 days	Within the same 5-10 days
Description	Inform those considered to be the likely relevant review partners of the incident	Establish whether an OWHR is required in respect of the homicide, including de-conflicting with any other relevant review process	Establish who out of the review partners are the relevant review partners.
Owner	Local Police Force where incident occurred	Review partners	Relevant review partners
Contributors	N/A	Chief Officer of Police Local authority or authorities Clinical Commissioning Group (CCG) in England and Local Health Board (LHB) in Wales From all of the areas which may be relevant to the specific death (as set out in the regulations under section 24).	Chief Officer of Police Local authority or authorities CCG/LHB From one of the relevant areas

3.3 Notifying the Secretary of State

Process Step	1. Make decision on whether a review is required	2. Notify the Secretary of State of the decision
Suggested timeframe	Within one month of a review partner becoming aware of the qualifying circumstances	Within one month of a review partner becoming aware of the qualifying circumstances
Description	Make a decision on whether a review partner is under a duty to arrange an OWHR	The Secretary of State should be notified of the review partners' decision on whether they are/are not/have not yet decided, if they are under a duty to arrange an OWHR
Owner	Review partners (those which are relevant and those who have decided they are not relevant)	Review partners (those which are relevant and those who have decided they are not relevant)
Contributors	Police Local authority CCG/LHB Violence Reduction Unit (VRU or alternative e.g. VPU, VRN etc). Police and Crime Commissioner (PCC) Child or Adult safeguarding board/partnership (local authority) Education Probation Specialist voluntary sector providers Family, friends, affected communities, faith sector and other social networks etc	N/A

3.4 Establishing an OWHR

Process Step	1. Commission the OWHR	2. Determine the Lead Agency (if role is set out in the regulations under section 30)	3. Determine the scope of the OWHR
Suggested timeframe	Within 5 days	Within the same 5 days	Within the next 5 days
Description	The OWHR should be commissioned as soon as practically possible after the notifications have been submitted to the Secretary of State	This decision is to be made in consultation with local partners and in line with the regulations	Determine the scope and terms of reference of the OWHR
Owner	Relevant review partners	Relevant review partners	Relevant review partners/ delegated lead
Contributors	N/A	Local partners who are contributing to the review, if appropriate	Local partners who are contributing to the review

Process Step	4. Inform the police that an OWHR is required	5. Inform the family that an OWHR is required	6. Conduct and complete the OWHR
Suggested timeframe	Within those 5 days	Within those 5 days	Within a suggested maximum of 12 months of the decision to conduct the review
Description	Inform the local police force that an OWHR has been approved for this incident, which may require a review of the alleged perpetrator(s)	Inform the family of the decision to conduct an OWHR and to outline the process and timeframes	DETAILS TO FOLLOW IN LINE WITH THE METHODOLOGY SET OUT IN THIS GUIDANCE DOCUMENT
Owner	Relevant review partners/ delegated lead (if included in the regulations)	Relevant review partners/ delegated lead (if included in the regulations)	Relevant review partners/ delegated lead (if included in the regulations)
Contributors	N/A	Local partners with a specified role in this area	Local partners who are contributing to the review

3.5 Following the Review

Process Step	1. Quality Assure the OWHR report	2. Share report with the Home Office	3. Publish approved OWHR report in the repository
Suggested timeframe	Immediately following the conclusion of the OWHR	Immediately following the conclusion of the QA process	DETAILS TO FOLLOW
Description	The final report following the OWHR needs to be quality assured at a local level to a standard which is ready for publication	The quality assured report is sent to the Home Office, ready for publication	The Secretary of State publishes, or makes arrangements for the publication, of the report or so much of the contents of the report as the Secretary of State considers appropriate to be published.
Owner	Relevant review partners / the delegated lead (if included in the regs)	Relevant review partners / the delegated lead (if included in the regs)	Secretary of State
Contributors	N/A	N/A	Home Office

Process Step	4. Integrate learnings into local/ regional/ system action plan	5. Conduct and publish thematic analysis	6. Perform progress evaluations on action plans
Suggested timeframe	3 months or 60 days of the OWHR conclusion	FREQUENCY TO BE CONFIRMED	Within 12 months of the conclusion of the OWHR
Description	Incorporate the learnings from the report into action plans at a single-agency, regional and system-wide level.	Findings from OHWRs to be analysed as a whole to identify thematic learning points. These will be made available to partners nationally.	Locally held action plans should be reviewed to ensure that learnings are being embedded and are influencing practice and policy.
Owner	Review partners	OWHR Oversight Board	Review partners
Contributors	All of the local partners who contributed to the review	N/A	All of the local partners who contributed to the review

Report content

3.6 In line with the strategic purpose of OWHRs as outlined in section 27(2) of the Act, the emphasis of an OWHR report should be to focus as much on learnings at a system level as at a single agency level, and not seek to ascribe blame to individual professionals or agencies. Whilst it is acknowledged that poor practice may emerge during the review, it is not the purpose of an OWHR to investigate blame and where a disciplinary process emerges it should be handled separately to the OWHR and in line with organisational disciplinary processes. OWHRs should not seek to replace the broader operational structures and performance evaluations of individual agencies. All content in the report should be directed towards defining actionable positive outcomes at a local and system-wide level.

3.7 At minimum, an OWHR report must include:

a. the findings of the review,

b. any conclusions drawn by the review partners, and

c. recommendations made in light of these findings and conclusions.

(xiv) Defining the scope and content of the report

After a process of stakeholder consultation and co-design with practitioners, this section will provide detail on the structure, methodology and content of the report. Engagement will take a specific focus on what content would be most useful in enabling learning and developing a view on the right balance between national standardisation and local flexibility. This will articulate what needs to be done during a review and which outputs are to be included in the report. Consultation will also focus on understanding how to best ensure diversity and intersectionality considerations are reflected throughout the review process and how this process can operationalise mitigations against unconscious bias and ensure representation throughout.

Quality assurance

3.8 Quality assurance for completed OWHR reports rests with the relevant review partners and their local management structures, which could if considered appropriate include regional bodies such as the CSP, VRU (or alternative e.g. VPU, VRN etc) etc. Neither the OWHR Oversight Board or Secretary of State have a quality assurance function within the legislation. Checks of the quality and delivery of an OWHR must be performed within local processes/hierarchy. Local partners should be confident that a report is at a standard ready for publication when it is submitted to the Home Office.

Publication

3.9 Following the completion of an OWHR, the review partners must provide a copy of the report to the Secretary of State for publication. There is an imperative for the findings to be published to inform future policy and practice. This is at the core of the review process however reports sent to the Secretary of State must not include any material that the review partners consider might jeopardise the safety of any person, or might prejudice the investigation or prosecution of an offence. Additionally, they must not contain any information that would contravene the data protection legislation or that is prohibited from disclosure by any of Parts 1 to 7 or Chapter 1 of Part 9 of the Investigatory Powers Act 2016, as set out in section 29(3) and outlined in section (vi) of this guidance.

3.10 Under section 27(7) the Secretary of State must publish, or make arrangements for the publication of the report unless it is considered inappropriate to do so, in which case, the Secretary of State will make arrangements to redact any information considered inappropriate to publish and publish the remainder of the report as submitted to the Home Office.

(xv) Repository

The Home Office has committed to creating and maintaining a repository of completed OWHRs. After a process of stakeholder consultation and co-design with practitioners this guidance will provide further detail on:

a. the platform for hosting the repository,

b. the accessibility of the repository (i.e. who will be able to access completed reviews),

c. the relationship with other homicide review repositories (including DHRs, and the Wales Safeguarding Repository (WSR)

Section 4: Ensuring Effective Learning

Dissemination of actions and monitoring process

4.1 All agencies involved in the OWHR should look to identify applicable lessons from reviews and create plans to act on these lessons to improve practice. To maximize the value of the OWHR process, tackle serious violent crime and reduce levels of homicide, local areas may wish to have governance mechanisms in place for monitoring delivery against OWHR action plans. In those areas with a Violence Reduction Unit (VRU or alternative e.g. VPU, VRN etc), these OWHR action plans could be integrated into the wider regional and/or local serious violence strategy.

(xvi) Serious violence Duty

This section of the guidance will provide further detail on the relationship between OWHRs and the Serious violence duty, as set out in section 7-22 of the Police, Crime, Sentencing and Courts Act.

(xvii) Local Oversight Forums and evaluation of progress

After a process of stakeholder consultation and co-design with practitioners this section of the guidance will provide further detail on the relationship between OWHRs and relevant local oversight forums like serious violence boards, including:

a. the types of local oversight forums which could be involved in an OWHR,

b. the conditions under which local oversight forums could be engaged in an OWHR,

c. a suggested process for engaging a local oversight forum in an OWHR and their proposed responsibilities,

d. the relationship with the SUSR Co-ordination Hub in Wales

4.2 It is suggested that within an appropriate time frame partners may wish to undertake an assessment to observe how the recommendations have been actioned in a local area, and to identify any additional needs agencies may have in order to implement the learning. These progress assessments should not be intended to be punitive, but rather to engage local areas in a collaborative exercise in order to:

a. identify and share areas of good practice,

b. identify areas where improvements are needed to deliver OWHR recommendations, and

c. create mutual strategies for the implementation of OWHR learning, including assessments of relevant training needs, personnel requirements, specialist skills etc.

(xviii) Progress evaluations

After a process of stakeholder consultation and co-design with practitioners this section of the guidance will outline more detail about the progress evaluation function, chiefly:

a. which body is the best placed to deliver this function and how,

b. what (if any) role is there for the PCC and the VRU (or alternative e.g. VPU, VRN etc), specifically in relation to assessing progress and understanding the barriers to review recommendation implementation,

c. how will independence be ensured in the quality assurance and progress monitoring processes

d. the relationship with the SUSR Co-ordination Hub in Wales

The role of the OWHR Oversight Board

4.3 The OWHR Oversight Board ("Oversight Board") will be a non-statutory committee composed of experts in safeguarding, homicide, serious violence, and public protection who will oversee the local delivery of the OWHRs and consider whether lessons learned from reviews are being acted upon, and shared locally and nationally. The Oversight Board will consist of, at minimum, individuals with expertise or background in policing, local authorities, and health. Further organisational representation is still being considered in consultation with stakeholders and practitioners.

The purpose of the Oversight Board is to:

a. oversee the local delivery of OWHRs,

b. ensure consistency in criteria and approach by reviewing and assessing completed OWHRs,

c. draw together OWHRs at a national level to assess and disseminate common learning, themes, issues in service provision, and areas of good practice at set intervals,

d. monitor the regional and national application of learning and implementation of recommendations in policy, approach, and delivery.

e. Share best practice and wider insight though learning events and opportunities.

(xix) The OWHR Oversight Board

After a process of stakeholder consultation and co-design with practitioners, this section will provide more detail on:

a. the membership of the OWHR Oversight Board,

b. it's terms of reference,

c. the expectations of and agreed intervals for the thematic reports produced by the Oversight Board

d. contact details for relevant review partners/delegated leads to contact the board during the OWHR review process in case of any queries or issues

e. details of forums and resources where best practice and learning opportunities can be accessed.

f. the relationship between the OWHR Oversight Board and the SUSR Ministerial Board in Wales

Section 5: Pilots

5.1 Section 33 of the Act requires a pilot to be carried out and a report laid before Parliament ahead of any decision to roll out the OWHR policy across England and Wales. Following the laying of necessary secondary legislation, and this guidance being published, the Government has committed to run an 18-month pilot of the OWHR process. The pilot will be carried out in several local authority areas of London, West Midlands, and Wales.

5.2 The pilots will be evaluated to ensure OWHRs meet the needs, expectations, and ways of working of all those involved. Under section 33(3) a report must be laid before Parliament before a decision is made on further implementation of OWHRs across England and Wales.

5.3 This guidance will be reviewed in light of the findings and learnings from the pilot and updated ahead of any introduction of OWHRs across England and Wales.

Section 6: Territorial Extent

6.1 The territorial extent of OWHRs is England and Wales. Section (viii) of this guidance provides further information on the OWHR process in Wales.

Section 7: Case studies and Appendices

(xx) Case Studies and appendices

After a process of stakeholder consultation and co-design with practitioners, this section will provide illustrative case studies of homicides which, under the new duty, would qualify for an offensive weapons homicide review. This is to illustrate the purpose and value of an OWHR process and the breadth of violent incidents which can be captured by it.

A series of templates and outlines will also be included to aid consistency in application, including:

a. an outline format for a notification to Secretary of State,

b. an outline format for an OWHR,

c. an example action plan,

d. a template data protection impact assessment (DPIA) for each of the relevant review partners to tailor to their own requirements.