Home Office

Offensive Weapons Homicide Reviews

Statutory Guidance

MARCH 2023

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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 rose by about a third between 2014 and 2022. It has become the fourth leading cause of death for men aged 20-34 (behind suicide, drug overdoses and road traffic collisions). The cost of homicide is significant and is annually estimated to be more than £2.6bn in 22/23 prices.

Homicides involving offensive weapons make up a large and growing proportion of all homicides – analysis suggests 347 of 696 homicides in 2021/22. The Government are concerned that many of these homicides are not currently formally reviewed by multi-agency partners to 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 696 offences initially recorded as homicides in 2021/22, we estimate that 483 did not meet the criteria for an existing review[1], and that 220 of the unreviewed homicides involved an offensive weapon.

The Police, Crime, Sentencing and Courts Act 2022[2] ("the Act") introduced a requirement on the police, local authorities in England and Wales and integrated care boards 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.

Section 34 of the Act requires a pilot to be carried out ahead of a decision to roll out the Offensive Weapons Homicide Review (OWHR) policy across England and Wales. Following the approval of the Police, Crime, Sentencing and Courts Act 2022 (Offensive Weapons Homicide Reviews) Regulations 2022[3] ("the OWHR Regulations"), the laying of the Police, Crime, Sentencing and Courts Act 2022 (Commencement No. 1) (England and Wales) Regulations 2023[4] ("the Commencement Regulations") and this Statutory 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 in London (the London Boroughs of Barnet, Brent, Harrow, Lambeth and Southwark), the West Midlands (the areas of Birmingham and Coventry City Council), and Wales (the police force area of South Wales).

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[1] Statistic includes those that did not meet the criteria for a Domestic homicide review or Child Death review.

[2] https://www.legislation.gov.uk/ukpga/2022/32/contents/enacted

[3] The Police, Crime, Sentencing and Courts Act 2022 (Offensive Weapons Homicide Reviews) Regulations 2022 (legislation.gov.uk)

[4] The Police, Crime, Sentencing and Courts Act 2022 (Commencement No. 1) (England and Wales) Regulations 2023 (legislation.gov.uk)

OWHRs in Wales will be delivered as part of the Welsh Government's Single Unified Safeguarding Review[5] (SUSR) process, reflecting their support for the policy.

The pilots will be evaluated to ensure OWHRs meet the needs, expectations, and ways of working of all those involved. Under section 34(3) of the Act a report must be laid before Parliament on the pilot, before a decision is made on further implementation of OWHRs across England and Wales. This Statutory Guidance will be reviewed in light of the findings and learnings from the pilot and updated ahead of any wider introduction of OWHRs across England and Wales.

[5] https://www.gov.wales/single-unified-safeguarding-review-guidance

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 for the Home Office, as Statutory Guidance under section 32 of the Act. It applies to review partners as defined in section 36 of the Act (chief officers of police and local authorities in England and Wales, and Integrated Care Boards (ICBs) in England and Local Health Boards (LHBs) in Wales) and has been produced to support review partners exercising the functions placed on them by the Act in respect of OWHRs.

TO NOTE: As set out in the Commencement Regulations, from 1st April 2023 the OWHR provisions come into force for the purposes of pilot partners, for the pilot period. Unless where stated (publication, information sharing etc), these provisions do not currently apply across England and Wales.

1.2 In the development of this guidance, consultation has taken place 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 weapons homicide review?

1.3 An OWHR is to be arranged as set out in section 24(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 (see paragraphs 1.8 – 1.11 of this guidance), and

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

The duty only applies to deaths occurring, or likely to have occurred, on or after the commencement of the Regulations.

1.4 Under section 24(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.

The criteria set out in the legislation confirms that for a homicide to be considered for an OWHR the victim must be over 18. An alleged perpetrator can be included in a review at any age, including under 18.

1.5 An offensive weapon is defined, for the purposes of an OWHR, in section 1 of the Prevention of Crime Act 1953[6] as:

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

This may include, for example, knives, firearms, acids and other corrosives, glass bottles, bricks and baseball bats. It captures items which are offensive per se (i.e. items made for the use of causing injury to the person, such as a butterfly knife), which are adapted for use (e.g. a bottle deliberately broken), and items intended by the person who possesses it to use it to cause injury. The list set out here is not intended to be exhaustive, given the nature of the test in the definition.

1.6 The Act provides for the Secretary of State to make regulations under section 24(7)(a) so as to alter the meaning of 'qualifying homicide'. This has been provided to allow for situations where it may be considered appropriate, for example through feedback, intelligence, or a threat change in the future, that homicide reviews would be helpful in tackling other types of homicide such as those that do not involve offensive weapons or in relation to different age groups of persons. Any future regulations under this section would allow the meaning of 'qualifying homicide' to be changed, for example to incorporate these or other homicides which involve different weapons from the definition in the Prevention of Crime Act 1953. Regulations are not being introduced in this area at this time.

1.7 Furthermore, there is no duty to arrange an OWHR where another statutory review applies (see section 26 of the Act and paragraphs 1.18 – 1.21 below).

[6] https://www.legislation.gov.uk/ukpga/Eliz2/1-2/14/contents

Additional conditions for an OWHR – the Police, Crime, Sentencing and Courts Act 2022 (Offensive Weapons Homicide Reviews) Regulations 2022

1.8 The Police, Crime, Sentencing and Courts Act 2022 (Offensive Weapons Homicide Reviews) Regulations 2022[7] set out, in Regulation 4, the other conditions which trigger the need for a review (in line with section 24(1)(c) of the Act). These require that:

(a) one of the following has been located –

i. the body of the person who has died, or

ii. part of the body of the person who died,

(b) the identity of one of the following has been recorded -

i. the person who died, or

ii. at least one person who caused, or is likely to have caused, that person's death,

(c) one or more review partners has information about, or would reasonably be expected to have information about -

i. the person who died, or

ii. at least one person who caused, or is likely to have caused, that person's death,

"Information" means information that there is a risk a person may commit, or be a victim of, antisocial or criminal behaviour and such information—

i. includes information relating to the person's education, antisocial or criminal behaviour, housing, medical history, mental health, and safeguarding, and

ii. does not include information that only became known to a review partner after the death of the person.

(d) the death is not a 'death or serious injury matter' within the meaning of section 12(2A) of the Police Reform Act 2002[8] (a death caused by a police officer in the course of their official duties).

[7] The Police, Crime, Sentencing and Courts Act 2022 (Offensive Weapons Homicide Reviews) Regulations 2022 (legislation.gov.uk)

[8] Police Reform Act 2002 (legislation.gov.uk)

1.9 These conditions will aid in ensuring that cases are only required to be reviewed where partners have had some previous involvement and knowledge of an individual (or where it's reasonable to expect they should have been in contact), thereby ensuring practical recommendations can be made and directed towards partners to improve performance in the future. It would also disapply in situations for example where a fight in a pub between two strangers, with no previous interactions with review partners, results in a fatality because of a brain injury sustained as a result of the use of a broken snooker cue, for example but which would unlikely produce recommendations for change if an OWHR were conducted. The regulations refer to information relating to the person being at risk to provide a minimum threshold for when the legal duty to arrange a review is triggered. For example, it is not intended that an individual who is only 'known' to the police due to being stopped for speeding or to local authorities for not paying council tax etc, is within the scope for this condition. The regulations also confirm that this does not include information which became known to the review partners after the individual died.

1.10 Section 24 (6)(b) of the Act provides flexibility for homicides to be considered where a death may not have been caused by an offensive weapon, but the events surrounding it, involved the use of an offensive weapon. This flexibility allows for these homicides to be considered for review, as the wider circumstances of the death may mean it is likely that lessons may be relevant to be learnt from the homicide. If the additional conditions set out in the OWHR regulations are met in this instance, it would be suggested that an OWHR should be considered.

1.11 Review partners must decide whether the conditions set out in the regulations have been satisfied and whether the threshold for a review has been triggered.

Relevant review partners

1.12 Review partners are defined in section 36 of the Act as: a chief officer of police and a local authority in England and Wales, and an Integrated Care Board (ICB) in England or a Local Heath Board (LHB) 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 in relation to Wales is defined as a county council or a county borough council.

1.13 A number of partners may fall into the category of a 'review partner' and may hold information relevant to the review such as:

a. those review partners in the area the death occurred,

b. those review partners in a current or previous area the victim resided in, or

c. those review partners in a current or previous area the perpetrator(s) or alleged perpetrator(s) resided in.

Each of these review partners should actively contribute to the review and provide the information they hold when requested. Of these, one set will be identified as responsible for arranging and conducting the actual review for the death – they will be known as the relevant review partners.

1.14 In recognition of the complexity of many offensive weapons homicides, section 25 of the Act allows for the Secretary of State to make regulations for identifying which review partners are the relevant review partners in respect of a person's death. The OWHR Regulations[9] set out that the relevant review partners in respect of a person's death will be–

(a) those in whose area the death occurred or is likely to have occurred, or

(b) if the location or likely location of the death is not known, —

i. those in whose area the body of the person who died, or part of the body of the person who died, is recorded to be found, or

ii. if parts of the body are recorded to be found in more than one area, in the area where the first part of the body is recorded to be found.

If more than one person died in the same incident the relevant review partners are those –

(a) in whose area the deaths occurred or are likely to have occurred, or

(b) if the location of the deaths is not known or if there is more than one recorded location, in the first area that it is recorded a body of a person who died, or part of a body, has been found.

If the above circumstances do not apply, the Secretary of State may give a direction specifying which partners are the relevant review partners.

1.15 Under section 36(2)(a) of the Act, the Secretary of State can, by future regulations, amend the definition of 'review partner'. This would allow for additional bodies to be added to the requirements to carry out an OWHR or for any of the current statutory bodies to be removed.

1.16 The Act provides for regulations which specify who the relevant review partners are to also provide (in accordance with section 25(5)(a) and (b)) that:

a. a group of review partners can agree with another group of review partners to be the relevant review partners in respect of a person's death instead of that other group;

b. for review partners of a description specified in the regulations to agree between them which of them is a relevant review partner in respect of a person's death.

Regulations are not currently being introduced in this area as the OWHR regulations make clear which review partners will be the relevant review partners for a person's death (as set out in paragraphs 1.12 – 1.14 above). This power will be considered for future use if feedback and analysis provide evidence of a need to make changes in this area.

[9] The Police, Crime, Sentencing and Courts Act 2022 (Offensive Weapons Homicide Reviews) Regulations 2022 (legislation.gov.uk)

1.17 Once identified, the relevant review partners should begin the process of establishing if the death is a qualifying homicide. For clarity, from this point in the guidance the 'relevant review partners' are referred to instead of 'review partners'. While the legislation references 'review partners' this was included to provide for situations where the relevant review partners may not have been identified at the outset of the OWHR. As the regulations make this identification process clear, 'relevant review partners' are used from this point on to avoid confusion as to who may be responsible for taking forward a particular role. For clarity:

Relevant review partners – as set out in the OWHR regulations: police, local authority, and integrated care board/local health board in the area the death occurred or was likely to have occurred, or where the body or part of the body was first found (or the first body/part of the body in the case of multiple deaths).

Review partners – police, local authorities, and integrated care board/local health boards in England and Wales who are not relevant review partners. For example, the authorities for a current or previous area where the victim resided, or in a current or previous area the alleged perpetrator/s resided in, as long as this area is different from that where the death occurred or was likely to have occurred, or where the body or part of the body was first found.

Appropriate bodies – those appropriate to contribute to a review. These will be in addition to the relevant review partners/review partners and are those that may have had contact or could reasonably be expected to have had contact with either the victim, or alleged perpetrator/s, and could include those in the community with wider expertise of serious violence, criminality, exploitation, and societal and economic risk factors. See paragraph 2.30 for a suggested list of appropriate bodies.

Local partners – is used to describe the collective partners/agencies involved in the delivery of crime prevention and community safety in an area and can include both statutory and non-statutory partners. This is not specific to OWHRs only.

Relationship with other reviews

1.18 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 26(1) of the Act provides that the duty to undertake an OWHR 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[10]),

b. the death may be the subject of a domestic homicide review (see section 9 of the Domestic Violence, Crime and Victims Act 2004[11]), 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[12]).

The duty to arrange an OWHR is also disapplied by section 26(3) of the Act, where a Safeguarding Board (including a Safeguarding Children, Adult or Joint Board) in Wales is required to undertake a review of the death (by regulations made under section 135(4)(a) of the Social Services and Well-being (Wales) Act 2014 (anaw 4).

1.19 In advance of the commencement of OWHRs, the review partners should clarify a process to ensure that checks are made as early as possible following a death, to confirm if another statutory review is applicable to the death.

1.20 Section 26(2) and (4) of the Act provides for regulations to be made so that the duty to conduct an OWHR is disapplied where the death is caused by persons receiving or having received any health services relating to mental health and:

a. the death may or must be investigated under arrangements made by NHS bodies (these are known as mental health homicide reviews or Independent Investigations for Mental Health Homicides); or

b. 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.

Regulations are not being introduced in this area at this time. However, further guidance has been provided at paragraphs 2.43 – 2.45 to aid the implementation of OWHRs where an alleged perpetrator may have received mental health services.

1.21 Further information has been provided at paragraphs 2.46 – 2.56 on multiple homicides, linked homicides, Multi-Agency Public Protection Arrangements (MAPAA) and homicides with a Prevent link.

[10] Children Act 2004 (legislation.gov.uk)

[11] Domestic Violence, Crime and Victims Act 2004 (legislation.gov.uk)

[12] Care Act 2014 (legislation.gov.uk)

The purpose of an OWHR

1.22 As detailed in section 28(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 28(3) where it is considered that it would be appropriate for a person to act in relation to those lessons learnt, (see paragraph 8.2), the relevant review partners/lead agency or independent chair if delegated to, must inform that person. See paragraphs 3.12 – 3.19 for full details on delegations and the role of a lead agency/independent chair.

1.23 Lessons learnt are covered in more detail in chapter 8 'Ensuring effective learning', and could include:

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

b. to identify what can be 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.

1.24 Additional strategic objectives of an OWHR are:

a. to establish what lessons can be identified in approach and whole service response for all qualifying homicides, 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 other persons connected with the death, and the ways in which they interact with relevant services.

1.25 In the pursuit of these objectives, it is recommended that the review examines the actions of individual partners/bodies 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 victim, alleged perpetrator(s) and other 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.

1.26 OWHRs are not investigations into the death of the victim or designed to identify culpable parties. OWHRs are also not disciplinary processes. Where a disciplinary issue emerges during an OWHR, it should be handled separately to the OWHR and in line with relevant organisational disciplinary processes. Accordingly, OWHRs should act to empower professionals to explore the ways that their organisation and the wider system they operate in, could be improved to protect people from serious violence and prevent future homicide. Innovation in investigative methods and approaches, and the ability to challenge existing narratives, practice, and policy will be required to ensure a meaningful OWHR.

1.27 OWHRs should also seek to contribute to a 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, alleged perpetrator(s) 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.

1.28 Relevant review partners and independent chairs are required to consider equality and diversity issues at all times and comply with the requirements of the Public Sector Equality Duty under section 149 of the Equality Act 2010. 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.

1.29 Reviewers and appropriate bodies 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 with and influence the events leading up to the qualifying homicide.

1.30 The OWHR process has been designed to ensure that best practice and lessons are taken forward and changes implemented where needed. To aid in this process an OWHR Oversight Board has been established to monitor and oversee the implementation of actions, and to draw together thematic learning at a national level. Further detail is provided in paragraphs 8.11 - 8.17.

1.31 As set out in chapter 8, a collaborative relationship of open dialogue is encouraged between local review areas and the OWHR Oversight Board to resolve any queries/issues during the course of the review process. These matters should first be discussed locally, including with the local oversight process (see paragraph 2.6 – 2.7). If they cannot be resolved, the OWHR Oversight Board can be contacted to aid in finding a solution. As set out at paragraphs 7.21 – 7.22, neither the OWHR Oversight Board nor the Secretary of State have a quality assurance function within the Act. 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. Due to this it is important that if queries or issues do arise that partner areas use the support offered by the OWHR Oversight Board to assist in resolving them at as early an opportunity as possible.

2: Delivering an OWHR

2.1 The process chart at paragraph 3.1 sets out a step-by-step guide to the OWHR process. It is recommended that local partners discuss with their local oversight structures (see paragraphs 2.6 – 2.7 below) the process which they wish to follow in their area when a qualifying offensive weapons homicide occurs. This could include identifying a lead agency (see paragraphs 2.8 – 2.9 below) or team to coordinate all of their OWHRs, the oversight organisation/process, and an agreed quality assurance process. Clarity should also be reached on whether this 'lead agency' role will continue for particular stages of the review, for the lifetime of the review, or if this role will continue into the future to engage with the OWHR Oversight Board (see paragraphs 8.11-8.17), as recommendations are taken forward. This information should be shared with partners and organisations who are likely to be involved in an OWHR in their area, including Senior Investigating Officers (SIOs).

2.2 When a suspected qualifying offensive weapon homicide has been identified by one of the review partners, or by the SIO of the police force investigating the death, they should inform the likely relevant review partners of the incident. This is suggested to be carried out within 24-72 hours of the death.

Qualifying homicides in Wales

2.3 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, avoiding duplication of resource and saving time and costs by undertaking multiple reviews. The SUSR will be implemented in Wales in 2023 as the mechanism to conduct Adult Practice Reviews, Child Practice Reviews, Domestic Homicide Reviews, Mental Health Homicide Reviews and Offensive Weapons Homicide Reviews in Wales. Further information on the process to follow in carrying out an OWHR in Wales is included at chapter 5 of this guidance with full details of the SUSR process provided in the SUSR statutory guidance Single Unified Safeguarding Review | GOV.WALES.

Homicides with a mental health context

2.4 For incidents where an alleged perpetrator may have been in receipt of mental health services, it is suggested that early contact is made with NHSE Regional leads, to prevent duplication of investigation processes, see paragraphs 2.43 – 2.45 for further details.

Determine who the relevant review partners are

2.5 As set out at paragraphs 1.12 - 1.13 there may be a number of review partners who hold information relevant to a review. However, only one set (police, local authority, ICB/LHB) will be the relevant review partners, and these should be identified in accordance with the OWHR Regulations. The relevant review partners are under a requirement as set out by the Act, to arrange, cooperate in and contribute to an OWHR in the case of a qualifying homicide.

Establishing local oversight for the OWHR process

2.6 It is recommended that local partners discuss what local oversight process they would like to use to support the delivery of OWHRs in their area. Structures which bring together local partners in various fora already exist and it is a local decision as to which may be the most appropriate existing structure to support the OWHR process or if a new structure would be preferable. OWHRs could take place with the support of, and under the oversight of, the local Community Safety Partnership (CSP), Violence Reduction Unit (VRU) or Police and Crime Commissioner (PCC) or Deputy Mayors for Policing and Crime (from here on referred to as PCCs)). In some areas, the PCC may have an active role in the oversight/monitoring function of both a VRU and CSP, so initial engagement with PCCs is recommended. However as circumstances vary across England and Wales the most appropriate process for the locality should be followed. Areas may be content for established structures also to be used for the purpose of OWHR oversight and support. Or, alongside this they may wish to set up their own designated group such as a 'Case Review Group' or a 'review panel' (see paragraph 3.7 concerning roles and responsibilities) to support the process.

2.7 The support and oversight function can assist relevant review partners in the early stages of an OWHR by coordinating meetings, collating information, and assisting in key decisions. In the later stages of the review process, they can perform the quality assurance process for the report, as well as aiding in the sharing of learning and coordination of the response to recommendations. From this point in the guidance this role will be referred to as the "local oversight process". For OWHRs in Wales, the OWHR process should be followed within the Single Unified Safeguarding Review (SUSR) process[13], which includes its own support structures, (see chapter 5 of this guidance, 'Delivering OWHRs in Wales').

Consider appointing a lead agency for the initial stages of the process

2.8 Depending on the local arrangements put in place, it is recommended that, if not already established, that relevant review partners consider if they wish to select among themselves a lead agency for the initial stages of the process. This is not a requirement under the legislation and does not release the relevant review partners from the legal requirements placed on them by section 25 of the Act. However, it is suggested to assist the relevant review partners to be able to progress the initial stages of the review process swiftly. Some areas may decide to allocate a lead agency to coordinate all reviews going forwards, while others may wish to keep this option open for a decision on a case-by-case basis. This is prior to an independent chair/relevant review partner/lead agency formally being delegated (see paragraphs 3.14 – 3.19) to lead the review and instead provides for one of the relevant review partners, or a subset of them, to be appointed to lead on the coordination role. The lead agency could be responsible for organising support from the chosen local oversight process or a case review group/panel if set up, checking basic information about the homicide and coordinating the signing and sending of the notification (see paragraphs 2.19 - 2.26) to the Secretary of State (further information on the lead agency is set out under roles and responsibilities in paragraph 3.7).

[13] https://www.gov.wales/single-unified-safeguarding-review-guidance

2.9 As set out at paragraph 2.8, the lead agency role can be made into a formal delegation, with the requirements placed on relevant review partners able to be formally passed to one of themselves (the review partners) or an Independent Chair. See paragraphs 3.14 – 3.16 for delegations.

Determining whether an OWHR should take place

2.10 Once the relevant review partners are identified, a chosen local oversight process is in place to support the implementation of the OWHR and a lead agency confirmed (if required), work needs to begin to enable them to determine whether an OWHR should take place.

2.11 The starting point for the OWHR process is when a review partner becomes aware of such facts that make it likely that the conditions requiring an OWHR to take place (set out in section 24(1)(a) - (c) of the Act) are satisfied in relation to the death. Evidence will need to be considered to establish whether the conditions (see paragraphs 1.3 – 1.5) are satisfied, and to decide whether there is a duty to arrange an OWHR. Section 29(1) of the Act includes a power, which a relevant review partner can use to request information from a person for the purpose of assisting any functions set out in sections 24 to 28 of the Act, (including to establish whether a review is required), where that person's functions or activities mean that it is likely they will have information that would enable or assist the review. Such a request must be complied with, subject to provisions in section 30 of the Act. In addition, section 29(7) allows review partners to share information with another review partner for the purpose of the review. Further detail and guidance on information sharing has been provided at chapter 6 'Information and Data Sharing' and the following paragraphs should be read in conjunction with that chapter.

OWHRs and the criminal investigation

2.12 An OWHR is expected to progress alongside any criminal investigation and criminal proceedings. There is no pause option for a review, so the OWHR process must be carried out in a way which does not jeopardise the integrity of, or undermine, the criminal investigation or criminal justice proceedings. By not waiting for the resolution of a criminal investigation and proceedings it may mean certain detail is excluded from the review. This is balanced against the benefits of learning being identified in a timely manner and action taken which may help others to avoid becoming victims or perpetrators of homicides or serious violence in the future.

2.13 In the initial stages of an investigation the police are likely to be dealing with multiple considerations with regards to the victim, suspect(s), witnesses, evidence, and intelligence, with some information classified as sensitive, including information in relation to active lines of enquiry and potentially vulnerable witnesses. Due to this, in the days immediately following the death, a discussion should be held between the relevant review partners and the SIO investigating the death to agree which individuals (such as the victim and alleged perpetrator(s)) should be included as part of their information gathering process. It is suggested that alleged perpetrators are only included in the review process after charge, although this is a decision to be made locally, dependent on the case under consideration and the evidence available.

2.14 At this early-stage evidence is only being collated to establish if the conditions (see paragraphs 1.3 – 1.5), which could be in relation to either the victim or alleged perpetrator(s), or both) are satisfied. Due to this information returns may be able to be provided with a limited level of detail. It is expected that only information that can be disclosed should be shared as part of this initial process. If a decision on if a death qualifies for an OWHR, is unable to be reached with the available evidence, but other information may be able to be shared in the weeks that follow, a notification could be submitted to the Secretary of State, confirming that a decision has not yet been able to be made. A further notification should be submitted once a decision has been finalised (see paragraph 2.19).

2.15 In summary, in determining whether the conditions for an OWHR are satisfied, the relevant review partners should, within the one month notification period, work through all the steps below:

a. confirm that they are the relevant review partners for the death, in line with regulations made under section 25 of the Act, see paragraphs 1.12 - 1.16);

b. confirm with the SIO/wider safeguarding partners that discussions have taken place and any immediate action taken which would be 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 any learning shared appropriately;

c. establish who will provide local support and oversight for the OWHR process;

d. determine if a lead agency is required, or if the relevant review partners will continue as a collective to meet the requirements placed on them;

e. determine whether the death is subject to any other statutory review as set out in section 26 of the Act (see paragraphs 1.18 - 1.21). Discussions should also be carried out with NHSE Regional leads in cases where an alleged perpetrator may have been in receipt of mental health services to avoid duplication of investigation processes (see paragraphs 2.4 and 2.43 – 2.45);

f. in the context set out at paragraphs 2.12 – 2.14, gather the facts about the case, as far as they can be readily established, by checking their own records as relevant review partners and also contacting all appropriate bodies and asking them to produce a brief overview of their engagement with the victim and alleged perpetrator(s) (agreed, as appropriate, with the SIO). Information from review partners (police, local authorities, ICB/LHBs) from the areas where the victim/alleged perpetrator(s) lived or have previously lived may be relevant to confirming if a death is a qualifying death, and effort should be taken to obtain the relevant information from these partners within the one-month deadline. A meeting or structured briefing could be considered as part of this process (inclusive where possible of appropriate bodies). A template of suggested key questions to ask is included in Annex 1. As set out in paragraph 6.5, data protection legislation must be complied with in relation to any personal data disclosed;

g. determine if the conditions as set out in the Act and the OWHR Regulations (see paragraphs 1.3 - 1.11) have been satisfied and whether the death is, or is likely to be, a qualifying homicide which occurred, or is likely to have occurred, in England or Wales.

2.16 The relevant review partners 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, as set out at section 24(3) and (4) of the Act, after the initial information collection stage, they consider:

a. that any of the conditions for an OWHR in section 24(1)(a) to (c) of the Act (i.e. the conditions requiring an OWHR) are not satisfied in a particular case. In these circumstances they are no longer under a duty to arrange for there to be a review, and the review (if already underway) may be discontinued (see paragraphs 1.3 - 1.11);

b. that they are not one of the relevant review partners in respect of the homicide and so the condition in section 24(1)(d) is not satisfied. 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 relevant review partner is, in this circumstance, no longer under the duty to arrange the review into the death.

There is also no duty on a relevant 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 another specified statutory review is taking place (and so section 26 disapplies the duty) (see paragraphs 1.18 - 1.21).

If a death does not qualify for an OWHR

2.17 Where it is found that a homicide does not meet the conditions to qualify for an OWHR, local partners should still take the opportunity to review the information gathered and to discuss the case and the individuals involved with their local oversight process. As set out in paragraphs 2.58 – 2.59 some immediate learning may be identified following the initial information gathering stages of the process and this should still be shared in an appropriate forum (taking into account disclosure concerns and data protection). This early discussion and sharing of learning is important in enhancing knowledge of offensive weapons homicides and related serious violence, making local partners aware of any wider issues or context in which the incident may have occurred and to consider if alternative processes or procedures could be put in place to reduce the likelihood of such situations occurring again in the future. To aid in the wider understanding of the impacts of OWHRs, for monitoring purposes, it is suggested that this early learning is shared with the OWHR Oversight Board.

2.18 A notification will still be required to be sent to the Secretary of State confirming that the conditions to carry out an OWHR have not been met in relation to the death (see paragraphs 2.19 – 2.26).

Notifying the Secretary of State

2.19 When a decision is made in regard to a person's death, section 27 requires relevant review partners to provide notifications to the Secretary of State in respect of whether or not a review will take place. Notification must be made within the one-month notification period, beginning with the day the review partner became aware of the qualifying circumstances. A template for the notification to the Secretary of State is included in Annex 2 of this guidance and needs to confirm one of the following:

a. that the review partner is under a duty to arrange for there to be a review of the person's death, under section 24 of the Act;

b. that the review partner is not under a duty to carry out a review in respect of the death under section 24 of the Act; 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.

For **all** OWHRs in Wales under the SUSR process, a notification should be sent to both the Secretary of State for the Home Office and the First Minister for Wales.

2.20 Section 27(7) of the Act 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 <u>likely</u> that the conditions in section 24(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.

2.21 Any relevant 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 required by section 27(1) of the Act. Where all review partners agree, they may co-sign the same notification letter and this process may be supported by their local oversight process or coordinated by the lead agency (if in use). However, careful consideration should be given to the one-month notification period as this is likely to start earlier for some review partners than others, as detailed in paragraph 2.19. As it is a requirement on the review partners to provide a notification to the Secretary of State within that one-month period, it remains the individual review partners responsibility to ensure it is sent as required.

2.22 Other circumstances, set out in section 27 of the Act, where the Secretary of State must be notified about an OWHR are listed below:

a. Under section 27(4) if a relevant 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) they must send a further notification to confirm that. This situation might occur where, for example, it was thought that the death was a qualifying homicide, but it turned out not to be so, on further investigation.

b. Conversely, under section 27(6) if a relevant 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 such a duty, they need to notify the Secretary of State of that decision.

c. Under section 27(5), where an OWHR is discontinued because one of the conditions in section 24(1)(a) to (c) has not been met, they must notify the Secretary of State, (as noted above this situation may arise, for example, if on further investigation it was concluded the death was not a qualifying homicide).

As set out in paragraph 2.19, for **all** OWHRs in Wales under the SUSR process a notification should be sent to both the Secretary of State for the Home Office and the First Minister for Wales.

2.23 Under section 27(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 26, or regulations under section 26, due to another statutory review (see paragraphs 1.18 – 1.21) being applicable.

2.24 When completing the notification template at Annex 2, it is not expected that detailed personal information will be included, beyond that requested on the initial page of the notification. A summary (only) is expected to be provided to complete the 'additional explanation/supporting evidence' boxes and all returns should be completed with data protection legislation in mind. A local reference number should be allocated which includes the initials of the police force area, so that the case can be easily referenced locally and in discussions with the Home Office/ Oversight Board where needed, avoiding personal information being shared unnecessarily. Alongside this, an alleged perpetrator should not be named on the notification, unless they have been charged, see Annex 2.

2.25 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 and the First Minister for Wales (where appropriate) 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.

2.26 Section 25 (1) of the Act, and the accompanying regulations set out the criteria which needs to be met for a death to qualify for an OWHR. Through the support of their local oversight process, the relevant review partners need to establish if an OWHR is required and an agreement needs to be found locally to make this decision. The Secretary of State has no powers under the Act to make a decision on the relevant review partners' behalf or to overrule a decision once made[14]. If in the very rare occurrence an agreement is unable to be reached, it is we recommended that the partners contact the OWHR Oversight Board for informal advice, ahead of notifying the Secretary of State.

Establishing an OWHR

2.27 Once the relevant review partners, with support of their local oversight process, have established that an OWHR is required, and having notified the Secretary of State and the First Minister for Wales (where appropriate), it is suggested that the following should take place within the next 5 working days:

a. Agreement should be reached between the relevant review partners, to decide who will deliver the methodology of the OWHR (see paragraphs 3.14 – 3.16), either:

   i. an independent chair (if delegation is agreed they can begin the process of sourcing an independent chair from the list of trained independent chairs, provided by the Home Office);

   ii. a lead agency (if delegation is agreed);

   iii. or for the three relevant review partners to remain as the lead.

b. they should inform the SIO investigating the death (who will consult with the CPS where relevant) that an OWHR is required and arrange a meeting to discuss whether the alleged perpetrator(s) is likely to be included alongside the victim in the review. This meeting could be delayed until an independent chair (if delegated to) is in place, (see paragraph 2.28).

Suggested timeframes for the process going forwards are set out in chapter 3. It is recognised that depending on the complexity of the case the timescales for implementation may vary. It is, however, recommended that the review be taken forward as soon as is practically possible to ensure that learning is identified at an early stage and any action needed is taken as quickly as possible.

[14] The Secretary of State does have a power to direct which review partners are the relevant review partners in respect of a person's death (under section 25(5)(c) of the Act), but this will only apply where the ordinary circumstances set out in the OWHR Regulations (for determining who the relevant review partners are) are not met.

2.28 Depending on timescales for the commissioning of an independent chair (if delegated to) the relevant review partners/lead agency may at this point wish to continue with the next stages of the process to avoid delay. This could include, with the support of their local oversight process, following up on initial information returns, to request more detailed information and making contact with additional appropriate bodies that may hold relevant information on the victim or alleged perpetrator(s). Records should be kept of all interactions/requests and returns, so they can be shared with the independent chair (if appointed), once commissioned to carry out the review.

2.29 The questions provided at Part B of Annex 1, as highlighted at paragraph 2.15 (f), could aid in the collection of this information. The intention of Part B is to encourage local partners/bodies and practitioners to be professionally curious about the events which led up to the homicide. Importantly, the questions are not intended to focus on the conduct of individuals or organisations or apportion blame. Nor are the questions intended solely to evaluate whether procedure or policy were followed. Rather, the emphasis is on whether the policies and procedures in place allowed for effective interventions, working with local partners/bodies where required. Each partner should provide this information even where a service could not be offered. It should demonstrate referral points of the individual(s), their engagement and the effectiveness of pathways of support. This chronology will provide an overview of where services could not be given and the rationale behind these decisions.

2.30 Appropriate bodies which it may be relevant to contribute to a review, in addition to the relevant review partners/review partners, are those that have a specialist understanding of the dynamics of serious violence and the relationship with wider criminality, exploitation and societal and economic risk factors. This may include, but are not limited to:

- Police (from other areas)
- Local Authorities (from other areas)
- Integrated Care Boards (ICBs) (from other areas)
- Local Health Boards and Trusts (Wales) (from other areas)
- Community Safety Partnerships (CSP) and Wales Safer Communities Network
- Violence Reduction Unit (VRU or alternative e.g. VPU, VRN etc)
- Police and Crime Commissioners/ Deputy Mayors for Policing and Crime (PCCs)
- Safeguarding Adult Boards in England/The National or Regional Safeguarding Boards in Wales
- Safeguarding Children Partnerships in England /The National or Regional Safeguarding Boards in Wales
- NHSE Regional leads (mental health homicides)
- Public Health Services (include consideration for Early Help Teams for supporting families, 0-19 service and Local Authority Directors of public health)

- National and regional law enforcement agencies with a serious and organised crime remit
- Educational institutions
- Probation Service
- Multi-Agency Public Protection Arrangements (MAPPA) Strategic Management Board
- Crown Prosecution Service
- Prevent Leads
- Youth services and youth offending services etc
- Fire and rescue services
- Specialist Voluntary Sector Providers
- Family, friends, faith group, affected communities, and other social networks (with agreement from the SIO).

The information once received can be used to shape the terms of reference for the review, as well as giving an indication of which appropriate bodies it may be relevant to request further information/discussions with as the review is taken forward.

Scope and Terms of Reference for the OWHR

2.31 Determining the scope of the review and drafting the terms of reference is a key part of the OWHR process. If an independent chair is being delegated to, these processes should be taken forward with the chair, when in post.

2.32 Discussion on the scope and terms of reference of the OWHR should also include input, where relevant, from:

a) relevant review partners, lead agency, independent chair;

b) the SIO investigating the death(who will consult with the CPS where relevant);

c) local oversight process;

d) review partners; and

e) appropriate bodies

The relevant review partner/lead agency/independent chair should, where possible, enable consultation between these parties and record all information in compliance with data protection requirements. This consultation will also assist in the identification of other appropriate bodies to support the review. These discussions can take place in a variety of ways. For those OWHRs being implemented in Wales, the Review Panel will also play a key part in this process, see chapter 5 of this guidance and the SUSR statutory guidance.

2.33 The overarching strategic objectives for an OWHR are outlined in the Act and reflected at paragraphs 1.22 - 1.27. These should be reviewed alongside the following suggested areas for consideration when drafting the terms of reference/setting the scope of the review.

Scope of the review

2.34 A suggested timeframe for review is the 24 months preceding the death, but this is a guide only. Where individuals have had very active involvement with relevant review partners, it may be proportionate to focus on the 12 or 18 months prior to the death. Alternatively, there may be instances where it is decided that significant events - which could include for example exclusion from school, arrest, mental health support, instance of domestic abuse/violence, alcohol or drugs abuse etc - beyond the 24 months should also be considered. A guide of 24 months has been provided to ensure there is the flexibility to focus on the wider contextual issues while also including key touch points. A long and detailed chronology is not required as this could detract from the key areas of focus. The independent chair/lead agency/relevant review partners should set out in the Terms of Reference of the OWHR, the time frame which will be covered in detail, during the review. Wider information can also be included as contextual information within the review template at Annex 5.

2.35 It is critical that there is control over any information which is shared, and to ensure information does not jeopardise or undermine the criminal investigation or other criminal justice proceedings running in parallel to the OWHR. Due to this, the independent chair/lead agency/relevant review partners need to stipulate in their request which individual(s) - victim and/or alleged perpetrator(s) - are to be included in the request for information and the final review. It is suggested that for cases where an alleged perpetrator(s) is not charged in the initial weeks following the death, that there is some flexibility in agreement, or a process of review, for confirming the final scope of the review. This will enable the alleged perpetrator(s) to be included in a review, once charged. A degree of flexibility should be provided throughout the review, so if any new information comes to light, or if the family raise any new issues which should be covered in the review, these issues can be incorporated, if appropriate. It is, however, suggested that partners agree a deadline for when this flexibility should end, or it could risk extending the length of a review, especially if the new information would result in a substantial change to the review, such as an alleged perpetrator being added at too late a stage in the process.

2.36 As set out paragraph 2.12 – 2.14, it may not be appropriate to share information on the alleged perpetrator(s) at the initial stages of an OWHR as advised by the police SIO (who will consult with the CPS where relevant), if it could threaten the integrity of any criminal investigation and also any criminal proceedings. In rare circumstances this may remain the case for the duration of the review for very sensitive information and in that situation the review would be focused on the victim only.

2.37 It is acknowledged within the OWHR process that by not waiting for the resolution of criminal investigations and proceedings it may mean certain detail is excluded from the review. However, this is balanced against the benefits of learning being identified in a timely manner and action taken which may help individuals avoid becoming victims or perpetrators of homicide in the future. The legislation does not provide for a review to be reopened once completed, although partners are not restricted from conducting further reviews through making use of any other relevant powers.

2.38 Maintaining the integrity of any criminal investigation and proceedings has to be a paramount consideration for relevant review partners alongside ensuring that the safety of any person linked to the homicide is not compromised. It could be that unintended consequences arise from sharing certain information and, as such, **relevant review partners/review partners should agree what information will be shared and when.** More detail is set out in chapter 6 on the practicalities of information sharing.

Core tasks of the review process

- Review all information received in the first and second information gathering phase, produce a timeline leading up to the incident and an initial summary.

- Confirm over what time period events in the individuals' lives is to be reviewed, taking into account the circumstances of the homicide i.e. how far back enquiries should go and what is the cut-off point? What history/background information will help to better understand the events leading to the death?

- Outline which organisations information will be included as part of the review.

- Identify which appropriate bodies should be contacted for further information or if there are any additional individuals/appropriate bodies who should be approached as the review progresses. This could include those that have not come into contact with the individuals but might be expected to do so e.g. individuals may find it difficult/be reticent to engage with the authorities/services – lessons could look towards ways to improve engagement with individuals/communities.

- Seek contributions through appropriate channels and, at the appropriate time, from family members/next of kin and keep them informed of key aspects of progress. Consider if any other family, friends, or support networks should also be approached.

- Consider holding a briefing session/learning event for relevant review partners/review partners/appropriate bodies and identify required resources to establish what lessons are to be learned from the incident. Identify any immediate actions already taken/that should be taken to rectify an issue.

- Take account of any criminal investigation/proceedings related to the case or any other parallel investigations such as the coroner's inquiry. Maintain regular communication with the SIO/police force investigating the death/CPS and ensure that disclosure issues are taken into account.

- Consider which are the most important issues to address in identifying the learning from the incident.

- Establish whether there have been other OWHRs in the same local authority area. If so, establish whether there is relevant research or recommendations which should be taken into account alongside the current review's learning.

- Determine a timeframe for the completion of the review, including delivery milestones. This should aim to meet the 12 month timeframe set out in the OWHR process, (see paragraph 3.1).

2.39 As the review progresses:

- Produce a merged timeline, initial analysis, and hypotheses of early outcomes.

- Draft an OWHR report ensuring that the Terms of Reference have been met, the initial hypotheses addressed, and any additional learning identified and included in the final report.

- Agree conclusions from the review and recommendations. Make arrangements for a presentation to the local oversight process for them to produce an outline action plan to take forward.

- Consider how matters concerning family and friends, the public and media should be managed before, during and after the review, and who should take responsibility for this.

- Plan arrangements to give feedback to family members/next of kin and share the contents of the report following the conclusion of the review and before publication. See chapter 4 of this guidance for more information on engagement with family, friends and other networks in OWHRs.

Aims of the review process

2.40 If used, the questions at Annex 1 will steer the responses towards relevant outcomes. The following should be considered:

- Determine the level of engagement individuals had with local partners/bodies, both statutory and non-statutory; if they should have been in receipt of support; whether opportunities to intervene were missed or not taken fully.

- Determine whether decisions and actions comply with the policy and procedures of the named partners/bodies and whether these worked for the individuals involved.

- Whether previous relevant information or history about the individuals involved was known and considered in professionals' assessment, planning, decision-making and actions in respect of those individuals.

- Whether the actions identified to safeguard the individuals were robust, and appropriate for those individuals and their circumstances, taking into account any vulnerabilities.

- Examine inter-agency working and service provision for the individuals under review and understand the level of overlap/cooperation between local partners in their support. Consider whether there was any challenge regarding the effectiveness of the response/actions.

- Consider whether actions were implemented effectively, monitored, and reviewed and whether all local partners/bodies contributed appropriately to the development and delivery of the multi-agency actions.

- Determine whether there are operational, policy or strategic improvements that could be made in light of this incident. Identify areas of good practice and successful interventions which could be incorporated into general processes and system responses.

- Consider whether there were obstacles or difficulties in this case that prevented local partners/bodies from fulfilling their duties. This could include both organisational issues and other contextual issues.

- Determine whether improved data sharing could have had a positive effect on the case.

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

Recommendations and actions

2.41 Identify clearly what the lessons are, both within and between local partners/bodies, how and within what timescales they will be acted on and what is expected to change as a result. The areas that this might cover include:

- how to apply the lessons learnt to service responses, including changes to the policies and procedures as appropriate;

- how the lessons will help to prevent future offensive weapons homicides and improve service responses through improved intra and inter-agency working;

- how the lessons will contribute to a better understanding of the nature of serious violence and offensive weapons homicide; and

- whether, and what, good practice can be highlighted and disseminated.

Wider considerations during the process

2.42 Consideration should be given to:

- whether there are any specific considerations around equality and diversity issues such as age, disability (including learning disabilities), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation that may require special consideration;

- whether the individual immigration status had an impact on how local partners/bodies responded to their needs;

- whether the individuals had any vulnerabilities that may require special consideration such as in relation to mental health, domestic violence/abuse, alcohol or drugs use/offences or violence against women and girls; and

- whether the individual was subject to Multi Agency Public Protection Arrangements (MAPPA) and, if so, whether a request should be made for the release of an executive summary of any minutes (subject to relevant legal considerations) and whether this needs to be accompanied by a Memorandum of Understanding (see paragraphs 2.53 – 2.54).

These considerations, where relevant, could include consulting an expert to help understand these crucial aspects of the homicide and contacting a representative from a specialist organisation to provide additional advice (see paragraphs 7.11 – 7.12).

Other aspects to consider in relation to the scope of an OWHR

i. *Mental Health Homicide Investigations*

2.43 Section 26(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 cases where a death is caused by someone who is receiving or has received secondary mental health NHS services. NHS England assumed the responsibility for commissioning Independent Investigations following such deaths where appropriate. These are investigated under separate arrangements and are known as mental health homicide reviews or Independent Investigations for Mental Health Homicides. Guidance is available at NHS England » Patient Safety Incident Response Framework and supporting guidance. NHSE Publish mental health homicide reports at NHS England » Independent investigation reports

2.44 It has been decided to not disapply the duty to arrange an OWHR in these cases. This means both an OWHR and a mental health homicide review or investigation could be taking place in parallel. It is therefore important to prevent duplication of process and to ensure wider system learning. It is recommended that both processes are closely aligned. Where an OWHR is being considered and it is confirmed/or possible that the alleged perpetrator was in receipt of secondary mental health services, the relevant review partners/lead agency/independent chair should make contact with the responsible NHS England regional lead at the following email addresses:

Midlands and East of England midlands-investigations.england@nhs.net

London Regional Lead: ENGLAND.LondonInvestigations@nhs.net

Northeast and Yorkshire Regional Lead: england.ney-investigations@nhs.net

Southwest Regional Lead: sw-investigations.england@mhs.net

Southeast Regional Lead: se-investigations.england@nhs.net

Northwest Regional Lead: england.northwest-investigations@nhs.net

Where relevant, partners should work together to ensure that relevant areas in relation to mental health care and treatment of the alleged perpetrator are included within the scope of the OWHR and alignment of processes agreed with the NHSE Regional Lead.

2.45 For mental health homicides in Wales, reviews are carried out under the SUSR process (see paragraph 2.3 and chapter 5 of this guidance), so a single review will be delivered covering both OWHR and aspects relevant to a mental health homicide.

ii. *Multiple Homicides*

2.46 If one event results in multiple homicides, different statutory reviews may apply for the different homicides, and each process will have to comply with its own legislation. However, the same death will not be subject to an OWHR, if another statutory review applies (as set out in section 26(1) and (3) of the Act) and paragraphs 1.18 – 1.21.

2.47 If an OWHR is carried out alongside other homicide reviews, following a multiple homicide, the relevant review partners and independent chair (if appointed) should establish a clear process of communication between the review processes. It is suggested that information gathering processes are coordinated, including interaction with families and key partners, as well as the SIO (who will consult with the CPS where relevant) to avoid duplication of effort, and to reduce the impact on those key individuals. It may be beneficial for the terms of reference for each of the reviews to be shared and communicated between the reviewers/chairs. This could avoid duplication and, if appropriate within each reviews legislation, could allow for a particular focus in each review, e.g. some reviews are more victim than perpetrator focused. Alongside this, consent could be sought to disseminate joint information, as well as individual updates, to ensure processes are transparent and synchronously timed, to reduce the impact on families and other key individuals involved. These processes will need to be agreed within the appropriate information sharing and data protection legislation.

2.48 Regulation 8, of Part 3, of the OWHR regulations set out that where more than one person dies in an incident, and those deaths qualify for an OWHR, the relevant review partners will be identified as those in the area where the deaths occurred or were likely to have occurred or, if there was more than one location or the location is not known, in the location where a body or part of the body was recorded as found first, (see paragraph 1.14). This would provide for one set of relevant review partners to carry out an OWHR for all of the deaths which fall within the criteria of an OWHR.

iii. *Linked Homicides*

2.49 Linked homicides involve homicides occurring in an area within a particular period of time and where a clear link may be known between the deaths, such as in situations of gang feuds where retaliation may be taken for an earlier death. In this situation the relevant review partners may wish to carry out linked reviews. A three month time period is suggested to avoid unnecessary delay in completing the earlier review, but this can be decided based on the individual circumstances of the case. The OWHR process should however not be unduly delayed, waiting for a link to be made, which there may not be clear evidence for.

2.50 The requirements of an OWHR must still be met for each death which qualifies for a review, so two or more sets of notification will need to be sent to the Secretary of State and the First Minister for Wales where appropriate, and two or more reports produced etc. However, if agreed by the relevant review partners and their local oversight process, a single set of review partners, lead agency or an independent chair can be allocated to carry out more than one review, reducing duplication of effort.

2.51 If subsequent homicide(s) occurred in a different area from the first, a linked review will not be possible as a different set of relevant review partners will be under the requirement to carry out the review. In this situation information should be shared between the areas, as both will be classed as review partners for the others OWHR.

2.52 A slightly different scenario may arise if a linked death falls into the criteria for a different statutory review from an OWHR. Elements of the process set out at paragraphs 2.46 – 2.48 may be able to be followed and clear communication between the two processes is essential. However, as set out above, each review's individual statutory obligations must still be met under their own legislation. An example of this could be for a domestic homicide where a perpetrator kills their former-partner, and that person's new partner. The death of the new partner would fall outside the current scope of a domestic homicide review, and so an OWHR may be applicable, if the death is a qualifying homicide.

iv. *Multi-Agency Public Protection Arrangements (MAPPA)*

2.53 MAPPA was established through the Criminal Justice Act 2003 and the arrangements are designed to protect the public, including previous victims of crime, from serious harm by sexual and violent offenders. They require local criminal justice agencies and other bodies to work together in partnership when dealing with offenders. From time to time, offenders go on to commit further such offences and, when they do, the Strategic Management Board (SMB) in an area must consider the commissioning of a MAPPA Serious Case Review (SCR) to examine whether the MAPPA arrangements were applied properly, and whether the agencies worked together to do all they reasonably could to prevent further offending. There may be lessons for the future, or good practice to disseminate.

2.54 A MAPPA SCR could be considered for an alleged perpetrator of an OWHR or, in rare cases, for the victim of an OWHR if they were MAPPA eligible at the time or it was within 28 days of their discharge from the MAPPA scheme. OWHRs and MAPPA SCR will look at different aspects of the case and will have a different focus. However, to avoid duplication and any misunderstanding a MAPPA SMB, as set out in their guidance for practitioners, must have a system in place of identifying whether another review is taking place and of notifying other agencies when a MAPPA SCR is taking place. As with Domestic Homicide Reviews and MAPPA, both processes can be carried out alongside one another as long as there is consistent communication throughout the process. The relevant review partner/lead agency/ independent chair will need to discuss with the SMB if a request needs to be made for any relevant information (see paragraph 6.38).

v. *Homicides with a Prevent Link*

2.55 Where a statutory review (including an OWHR) has been triggered and the alleged perpetrator has a confirmed Prevent history, the statutory review process takes precedence and in the majority of cases a Prevent Learning Review will not be carried out. In these instances, Prevent practitioners (e.g. Prevent lead, Channel chair, Channel case officer) would be expected to feed into the statutory review. Initial inquiries to determine if an incident involves someone with a Prevent history should be directed to the local authority Prevent lead in the first instance, who can liaise with Counter Terrorism Police to seek confirmation.

2.56 Where a nationally led Prevent Learning Review (PLR) has been triggered, local practitioners may be asked to feed into the PLR process. Time stipulations for progression and completion of a PLR will be dependent on the specifics of the case, including consideration of ongoing investigative and judicial processes. If practitioners involved in this process require further information, they should again contact their regional prevent lead.

Notifying the family and/or next of kin

2.57 Once the scope and terms of reference of the review have been agreed the relevant review partners/lead agency/independent chair should, in consultation with Family Liaison Officers, the SIO and other appropriate bodies, consider the best way to inform the family of the victim, of the decision to undertake an OWHR and outline the process, timeframes, and the ways in which they may be invited to contribute. Consideration should also be given to notifying the alleged perpetrators family although this will only be appropriate after they have been formally charged (see paragraph 4.1).

Sharing early learning

2.58 Some immediate learning may be identified following the initial information gathering stages of the process, both at the one month point and during discussions on the scope and terms of reference for the review. As set out in paragraph 7.16, a process should be agreed in advance as to the best route to feed actions back to an individual/organisation and at what level those messages should be shared, to confirm that the action is flagged to the most appropriate person or team/organisation.

2.59 This learning should also be shared with wider local partners/bodies in an appropriate forum (taking into account disclosure concerns and data protection) highlighting that this is initial learning which has emerged and caveating that further investigation will be carried out during the review. This early sharing of learning is essential in making local partners/bodies aware of any issues or emerging best practice from the case which could result in the decision to take immediate action or steps towards rectifying an issue, instead of waiting the 12 months or so for the OWHR to complete. To aid in the wider understanding of the impacts of OWHRs, for monitoring purposes, it is suggested that this early learning is also shared with the OWHR Oversight Board.

3: OWHR Process

3.1 The diagram below sets out best practice expectations for the delivery of OWHRs. The steps are sequential, and the recommended timescales build cumulatively throughout the delivery of the recommended process. To note that 'days' are working days, and not calendar days. A large scale copy of the diagram is included at Annex 6.

* Boxes with a red outline are legislative requirements.

Process Overview

3.2 Where the preceding chapters of this guidance have provided the statutory requirements for an OWHR and the rationale behind the main tasks to be completed, this chapter focuses on providing a clear process for each potential stage of the review. Each suggested step in the different stages of the review process have been articulated along with a set of suggested time frames, 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.

3.3 Establishing OWHR Applicability

Process Step	1. Inform the likely relevant review partners of the death	2. Determine who the relevant review partners are	3. Establish local oversight. Determine lead agency (if required)	4. Determine if the death is subject to any other review processes	5. Make initial request for information	6. Establish whether the homicide meets the OWHR criteria	7. Make a decision on whether a review is required
Suggested timeframe	24 – 72 hours of incident occurring	Within 5 - 10 days	Within the same 5 -10 days	Within the same 5 – 10 days	Within the same 5 – 10 days	As early as possible, and in less than 1 month	As early as possible, and in less than 1 month
Description	Inform those considered to be the likely relevant review partners of the incident (para 1.12 – 1.13)	Establish who out of the review partners are the relevant review partners (RRPs), as set out in the regulations (para 1.12 – 1.17)	If not agreed in advance, confirm which local oversight process will support and oversee the OWHR (para 2.5) Determine if the RRPs continue to coordinate and commission as a three, or if agree to appoint one or a subset to carry out the role. (para 2.8)	Determine if the death is subject to any other review's - section 26 of the Act (para 1.18 - 1.21). Discussions with NHSE Regional leads in relevant cases to avoid duplication of investigation processes (see paras 2.3 and 2.43 – 2.45);	After speaking to the SIO, send and/or ask the questions in Part A of the template (annex 1) to all appropriate partners, to quickly ascertain the facts of the case	Analyse the information returns from RRPs, review partners and appropriate partners to establish if the homicide meets the criteria (para 1.3 - 1.11)	Make a decision on whether a review partner is under a duty to arrange an OWHR
Owner	Review partners or Senior Investigating Officer (SIO) / local police force where incident occurred	Review partners	Relevant Review Partners (RRPs) with support of local oversight process	Lead agency, RRPs, with support of local oversight process	Lead agency, RRPs, with support of local oversight process	Lead agency, RRPs, with support of local oversight process	Lead agency, RRPs, with support of local oversight process
Contributors	N/A	N/A	Local decision could include: Community Safety Partnership (CSP), Violence Reduction or Prevention Unit (VRU/VPU), Police and Crime Commissioner (PCC) or, case review group or local panel. See separate process for Wales at chapter 5.	NHSE Regional leads	Chief Officer of Police Local authority or authorities ICB/LHB (From all of the areas which may be relevant to the specific death) Other appropriate partners as set out at para 2.30	See list at 2.30 of partners who it may be appropriate to contribute information. Include information held by RRPs and wider review partners from areas the victim/alleged perpetrator(s) resided etc,	N/A

3.4 Delivering an OWHR

Process Step	1. Provide notification to the Secretary of State and First Minister for Wales (where appropriate)	2. Commission the OWHR / delegate to an independent chair (if applicable)	3. Inform the SIO/police that an OWHR has been approved	4. Further request for information and determine the scope of the OWHR	5. Inform the family/next of kin that an OWHR is required	6. Share early learning with the review partners and local oversight	7. Conduct and complete the OWHR
Suggested timeframe	As early as possible, and in less than 1 month	Within the next 5 days	Within the same 5 days	Within the next 1 month	As soon as is possible after the scope of the OWHR has been agreed	Within 1 month of the scope of the review being agreed	Within a suggested maximum of 12 months of the decision to conduct the review
Description	The Secretary of State and First Minister for Wales (where appropriate) 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 (para 2.19 – 2.26). A template for this notification can be found at Annex 2	The OWHR should be commissioned as soon as is possible after the notification is sent. If applicable the RRPs/lead agency should identify and commission an independent chair to take on responsibility for delivering the review. Refer to para 3.17-3.19, utilising the Home Office list of suggested individuals.	Inform the SIO from the police force investigating the death that an OWHR has been approved for this incident and to discuss which of the alleged perpetrator/s are able to be included in the review, alongside the victim.	Send a further request for information (see Part 2 of Annex 1), to determine the scope and terms of reference of the OWHR (para 2.31 – 2.56). Include consideration of wider issues such as mental health homicide investigation, multiple homicides, and linked homicides. OWHRs under the SUSR (Wales) to refer to chapter 5.	Inform the family/next of kin (see process set out at chapter 4) of the decision to conduct an OWHR and to outline the process and timeframes.	Some immediate learning may be identified following the early information gathering stages of the process (para 2.58 - 2.59). This should be shared with partners in an appropriate forum (taking into account disclosure concerns and data protection) to ensure that early awareness is shared of any issues or emerging best practice from the case.	Deliver the OWHR in line with the guidance. See para 2.39 – 2.41 and chapter 7 for methodology and report content.
Owner	Lead agency, RRPs, with support of local oversight process	RRPs/ lead agency	RRPs/ lead agency/ Independent chair	RRPs/ lead agency/ Independent chair	RRPs/ lead agency/ Independent chair	RRPs/ lead agency/ Independent chair	RRPs/ lead agency/ Independent chair
Contributors	N/A	Local oversight process	N/A	Local oversight process and partners who are contributing to the review	Appropriate local partners, family liaison officer as appropriate	Local partners who are contributing to the review	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 Secretary of State/First Minister for Wales	3. Inform those applicable that action should be taken	4. Publish approved OWHR report	5. Integrate learnings into local/ regional/ system action plan	6. Conduct and publish thematic analysis	7. Perform progress evaluations on action plans
Suggested timeframe	Immediately following the conclusion of the QA process	Immediately following the conclusion of the QA process	Immediately following the reports submission	30 days of receipt	3 months of the OWHR conclusion	Within 12 months of the conclusion of the OWHR	Within 12 months of the conclusion of the OWHR
Description	The final report following the OWHR needs to be quality assured using the agreed local oversight process, so that it is at a standard which is ready for publication (para 7.21 – 7.22)	The quality assured report is sent to the Secretary of State for the Home Office and where appropriate the First Minister for Wales, ready for publication (para 7.23 – 7.27)	Discuss the outcomes of the report and recommendation at a local level. Inform those that it has been found appropriate to take action in relation to these lessons learnt, to do so (para 8.1 – 8.8)	The Secretary of State publishes or makes arrangements for the publication of the report (see para 7.23 – 7.27). OWHRs in Wales will also be published on the Wales Safeguarding repository.	Incorporate the learnings from the report into action plans at a single-agency, regional and system-wide level (para 8.7 – 8.8)	Findings from OHWRs to be analysed as a whole to identify thematic learning points. These will be made available to partners in England and Wales, and to relevant partners across government (para 8.11 – 8.17)	Locally held action plans should be reviewed to ensure that learnings are being embedded and are influencing practice and policy (para 8.13 – 8.16)
Owner	RRPs/ lead agency/ Independent chair	RRPs/ lead agency/ Independent chair	RRPs/ lead agency/ Independent chair	Secretary of State	RRPs/ lead agency – with support of the local oversight process	OWHR Oversight Board	Review partners – with support of local oversight process
Contributors	Local oversight process	N/A	Local oversight process	Home Office/SUSR process	All of the local partners who contributed to the review	N/A	OWHR Oversight Board and all of the local partners who contributed to the review

Example timeframe for delivery of an OWHR

3.6 As set out at paragraph 3.1, the process diagram sets out a best practice expectation for the delivery of OWHRs. The steps are sequential, and the recommended timescales build cumulatively throughout the delivery of the recommended process. The following tables have been provided as an example of the step-by-step timeframes which could be followed after a suspected qualifying homicide occurs. It should be noted that these are suggested approaches and are not part of the legislative requirement but provide a proposed framework for undertaking a review. 'Days' are working days, and not calendar days. In the example below public holidays have also been reflected.

Establishing OWHR Applicability								
		Step 1	**Step 2**	**Step 3**	**Step 4**	**Step 5**	**Step 6**	**Step 7**
Timeframe	Death occurs	**Within 24-72 hours**	**Within 5-10 days**	**Within the same 5-10 days**	**Within the same 5-10 days**	**Within the same 5-10 days**	**In less than the same 1 month**	**In less than the same 1 month**
Example date	01 April 2023	03 - 05 April 2023	11 – 18 April 2023	11 – 18 April 2023	11 – 18 April 2023	11 – 18 April 2023	Before 04-05 May 2023	Before 04 – 05 May 2023

* To note timeframes will vary depending on when each relevant review partner was made aware of the likely qualifying homicide (see 2.20).

Delivering an OWHR							
	Step 1	**Step 2**	**Step 3**	**Step 4**	**Step 5**	**Step 6**	**Step 7**
Timeframe	**In less than the same 1 month**	**Within the next 5 days**	**Within the same 5 days**	**Within the next 1 month**	**ASAP after scope agreed**	**Within 1 month scope agreed**	**Max 12 months**
Example date	Before 04 – 05 May 2023	By 12 May 2023	By 12 May 2023	By 12 June 2023	ASAP	12 July 2023	02 April 2024

Following the review							
	Step 1	**Step 2**	**Step 3**	**Step 4**	**Step 5**	**Step 6**	**Step 7**
Timeframe	**Immediate**	**Immediate**	**Immediate**	**30 days**	**3 months**	**Regular points**	**Within 12 months**
Example date	By 02– 12 April 2024	By 15 April 2024	By 15 April 2024	By 28 May 2024	end of August 2024	Regular points	By end May 2025

Roles and responsibilities: overview

3.7 The following summary sets out suggested roles and responsibilities which relevant review partners with the support of their local oversight process may wish to put into place to assist in the delivery of an OWHR. The majority of these are not legislative roles and not all the roles may be required. The roles and responsibilities for OWHRs delivered in Wales are provided within the SUSR process as set out in chapter 5 of this guidance and in full, in the SUSR statutory guidance Single Unified Safeguarding Review | GOV.WALES

Local oversight process

3.8 As set out at paragraphs 2.6 - 2.7, it is suggested that local partners discuss what local oversight process they would like to use to support the delivery of OWHRs in their area. It is suggested that OWHRs could take place with the support of, and under the oversight of the Community Safety Partnership (CSP), Violence Reduction Unit (VRU) or the Police and Crime Commissioner (PCC). In addition to this areas may also wish to set up their own designated group such as a 'Case Review Group' or a 'review panel' (see below). The support and oversight function can assist relevant review partners in the early stages of an OWHR by coordinating meetings, collating information, and assisting in key decisions. In the later stages individuals can be identified to perform the quality assurance process for the report, agree any learning points, ensure that the report is submitted to the Secretary of State and First Minister for Wales (where applicable), aid in the sharing of learning through dissemination to local partners/bodies etc and to coordinate the response to recommendations.

Case Review Group

3.9 As set out above, the OWHR process should be supported in its area with a local oversight process. In addition to this an operational case review group could also be considered to be established, and which it might be appropriate to report into the chosen local oversight process. This is not a requirement under the legislation and does not release the relevant review partners from the legal requirements placed on them by section 25 of the Act. However, the case review group could comprise a group of partners as agreed by the relevant review partners/local oversight process or they could for example include the three relevant review partners, as well as wider review partners from the area the victim/alleged perpetrator(s) resided in. The role of the case review group could be to support and assist the relevant review partners/lead agency in delivering the early stages of the OWHR including establishing whether a death has already qualified for another alternative homicide review (paragraphs 1.18 – 1.21) and collating information (see paragraph 2.15f).

3.10 If agreed by the relevant review partners/lead agency/independent chair (if delegated to), the case review group could also have a role in the later stages of a review. This could be seen as more of a 'review panel' role and could include aiding to clarify the scope of the review and considering evidence and proposed recommendations as the review progresses.

3.11 As set out at 3.7, a case review group may not be considered to be required, as the local oversight process or a lead agency may deliver these roles. Or alternatively it could be beneficial for it to be put in place for particular roles/points in the review process instead of throughout. However, areas have the flexibility to put into place the most appropriate framework, to deliver the OWHR in their area.

Lead agency for the initial stages of the process and/or as a formal delegation to carry out the review

3.12 Alongside the local oversight process, and consideration of establishing a case review group, it is recommended that, within the one-month notification period, relevant review partners consider if they would like to select among themselves a lead agency for the initial stages of the process. As set out above, this is not a requirement under the legislation and does not release the relevant review partners from the legal requirements placed on them by section 25 of the Act. It is, however, a process suggested to assist the relevant review partners to be able to progress the initial stages of the review process swiftly. This is prior to an independent chair/relevant review partner/lead agency formally being delegated to lead the review and provides for one of the relevant review partners, or a subset of them, to be appointed to lead on the coordination and oversight role. The lead agency could be responsible for organising support from the chosen local oversight process or a case review group/panel if set up, checking basic information about the homicide and coordinating the signing and sending of the notification to the Secretary of State (and First Minister for Wales, where applicable).

3.13 As the review progresses, they could take responsibility, with the support of the local oversight process for commissioning the OWHR, contacting and sourcing the independent chair (if delegated to) and ensuring the process is followed by overseeing the various stages, getting sign off from all partners and where relevant organising a post-review debrief/ learning event. If a lead agency is not appointed, it remains the responsibility of the three relevant review partners to carry out these tasks. The lead agency role can be made into a formal delegation in accordance with regulations made by the Secretary of State under section 31 of the Act (the OWHR Regulations).

Delegating functions

3.14 Section 31 of the Act confers a power on the Secretary of State to make regulations which enable the relevant review partners to act jointly to delegate some or all of their functions. The Police, Crime, Sentencing and Courts Act 2022 (Offensive Weapons Homicide Reviews) Regulations 2022[15] (Regulation 11) allow the relevant review partners in respect of a person's death, to act jointly to delegate one or more of the following functions to one of themselves or another person (e.g. an Independent Chair):

(a) section 28(3) - informing a person that they should take action in respect of the lessons learned from the review;

(b) section 28(4) - prepare and send the review report on the review to the Secretary of State);

(c) section 29(1) - request a person provide specified information for the purposes of the review (section 28 of the Act);

(d) section 29(6) - power to enforce the duty to comply with the request for information, by applying to the High Court for an injunction in relation to a request made under sub-paragraph (c).

[15] The Police, Crime, Sentencing and Courts Act 2022 (Offensive Weapons Homicide Reviews) Regulations 2022 (legislation.gov.uk)

3.15 Section 31(3) of the Act confers a power on the Secretary of State to make regulations to 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 of a review partner (under sections 24 to 29 of the Act) specified in the regulations on behalf of the other. These regulations are not required for the operation of the pilot and so are not currently being introduced.

3.16 There are two primary reasons the relevant review partners might look to delegate one or more of the functions specified under relevant sections of the Act:

a. the relevant review partners delegate responsibility for the delivery of an OWHR to an independent chair (paragraphs 3.17 – 3.19 below); or

b. the relevant review partners select a lead agency from among themselves to delegate responsibility to, for the delivery of an OWHR.

This provides flexibility for the relevant review partners to enable them to delegate one or more of their functions to the most appropriate person. This decision should be made between all of the relevant review partners, and with the support of their local oversight function. This decision will relate to the specified homicide under review, so is on a case-by-case basis and not a blanket decision to be applied automatically to all OWHRs carried out in an area.

Independent Chair

3.17 As set out at paragraph 3.14 above, the OWHR legislation provides for relevant review partners to delegate a number of their required OWHR functions to one of themselves or an independent chair. Independent chairs are roles seen in other homicide review processes including domestic or safeguarding reviews and can provide an additional layer of confidence for practitioners and the community, that the review is being led by someone independent from the criminal investigation or the background of the case. This is also an opportunity to introduce an individual who is trained and experienced in delivering reviews, may have specialist understanding for example in mental health, gangs, exploitation etc and the context in which the incident occurred.

3.18 It will be for the relevant review partners, with the support of their local oversight process to commission an OWHR to an independent chair, including clarifying which functions they wish them to undertake. It is suggested that they be tasked with the delivery of the methodology of OWHRs including interviewing and data collection and authoring the final report by assessing the information and presenting it in a way which adheres to the statutory requirements for the report (set out in section 28 (4) – (6) of the Act). The chair should also be the primary contact for the victim and/or alleged perpetrator/s family and/or next of kin (if they wish to be involved) to maintain independence in this relationship.

3.19 Local review partners will be responsible for commissioning independent chairs for OWHRs; however, the Home Office have developed a comprehensive training package for independent chairs designed for the parameters of OWHRs. A list of individuals who have completed this training will be made available to review partners on request. The OWHR report template, provided at Annex 5 includes a statement which should be completed by an independent chair to confirm their independence from the case, as well as confirmation that they have completed the relevant training and are named on the list held by the Home Office, as detailed above.

The role of appropriate bodies and others with an interest in the OWHR process

3.20 OWHRs will be relevant and of interest to the relevant review partners, other partners and stakeholders, as listed in paragraph 2.30. These appropriate bodies may be asked to provide information for the purpose of the review, as they will be likely to have information that would enable or assist in the delivery of that review (if the disclosure is consistent with the requirements of section 29 and 30).

3.21 As well as providing evidence in the information gathering stage, it will also be relevant for a number of the organisations and appropriate bodies to provide support to the OWHR process as it continues, including in the implementation of the recommendations it produces. This can be within the agreed chosen local oversight role, as part of a case review group/review panel, or as part of other existing mechanisms. As set out at 2.1, in advance of the introduction of OWHRs it is suggested that local partners discuss with their local oversight structures the process which they wish to follow in their area through each stage of an OWHR.

3.22 In line with the consideration of the Serious Violence Duty (see paragraphs 8.9 – 8.10), ensuring the quality and effective implementation of OWHRs is in the interest of CSPs, VRU/VPUs and PCCs. With this in mind, it is recommended that these regional stakeholders take an active role in the dissemination and monitoring of OWHR recommendations across and beyond their local area. Those organisations with control of local sources of funding for improvements in violence reduction and prevention may be best placed to oversee the implementation of OWHR learning.

4: The role of family, friends, and other networks in OWHRs

4.1 It may be suitable for a number of individuals to engage with the OWHR process outside of the relevant local partners/appropriate bodies. As a minimum the family/next of kin of the victim should be approached as part of the formal OWHR process. Engagement with the alleged perpetrator(s) family as well as friends and representatives from wider support networks such as employers, faith communities and social activities etc for the victim or alleged perpetrator(s) should also be considered, where deemed appropriate. These individuals should be approached with caution and through the agreement/suggestion of the family/next of kin where possible, as well as with the agreement of the police SIO investigating the death (who will consult with the CPS where relevant). It is suggested that only a limited number of individuals be approached, targeting engagement to gain relevant information, and learning in relation to the case. For the family or others with a connection to the alleged perpetrator(s), engagement would only be appropriate after they have been formally charged. For reviews carried out in Wales under the SUSR process further guidance is available in chapter 6 of the SUSR guidance[16], as well as in the accompanying toolkit Single Unified Safeguarding Review: toolkit | GOV.WALES.

Why engage?

4.2 The involvement of family/next of kin, friends and other support networks may help to enhance the quality and accuracy of OWHRs while also having benefits for the individuals themselves. By giving them the opportunity to be involved in the review, important information may be gained about the wider context/circumstances surrounding the incident which may not otherwise be available to relevant review partners/the lead agency/the independent chair. It could help to identify potential learning around missed opportunities for intervention which may in turn help to improve service provision in the future. It is, however, recognised that involving families and friends in the OWHR process may bring with it a level of complexity and challenge given the potential sensitivities involved, particularly with the OWHR running in parallel with any criminal investigations and proceedings.

4.3 Experience from Domestic Homicide Reviews has shown that there are benefits to be gained from the involvement of family in a review and there may be similar benefits for OWHRs. These include:

- assisting the families with the healing process;
- giving the families the opportunity to feed into the OWHR if they wish. Their contributions, whenever given during the review process, should be afforded the same status as other contributions;
- helping the families feel that they can contribute to the prevention of other homicides involving offensive weapons;

[16] https://www.gov.wales/single-unified-safeguarding-review-guidance

- enable families to help inform the OWHR by providing a more complete picture of the lives of the victim and/or perpetrator and to see the homicide through their eyes. This may help the independent chair/lead agency/relevant review partners understand the decisions and choices the victim and/or alleged perpetrator/s made;

- providing relevant information or insights which would otherwise not have been available through information or records held by the relevant review partners/review partners/appropriate bodies. Families should be able to provide factual information as well as detail of the emotional effect of the homicide. The relevant review partners/independent chair/lead agency should be aware of the risk of ascribing a 'hierarchy of testimony' regarding the weight they give to statutory sector, voluntary sector and family and friends contributions;

- revealing different perspectives of the case, which might have learning for local partners/bodies in terms of improving service design and processes.

- enabling families to choose, if they wish, a suitable pseudonym for the victim/alleged perpetrator/s to be used in the report. Choosing a name rather than using initials, letters and numbers, nouns, or symbols, will humanise the OWHR and allows the reader to follow the narrative more easily. If this process is declined, it would be helpful to outline this in the report.

When to engage

4.4 It is suggested that the independent chair or the lead agency (if delegated to) is the primary point of contact for family members/next of kin, although) the police SIO (who will consult with the CPS where relevant), Family Liaison Officers (FLOs) and where necessary, the relevant review partners should be consulted before contact is made. Ensuring engagement is carried out through the independent chair where at all possible will ensure independence from statutory organisations. Trauma-informed engagement with the bereaved and local communities should form a key part of an independent chair's experience, training, and skillset.

4.5 The independent chair/lead agency/relevant review partners should ensure that there is clear and regular communication with the family/next of kin of the victim (as relevant) throughout the OWHR process and through to completion. They should, however, be aware of the potential sensitivities and need for confidentiality when meeting these groups during the review. In some cases, it may be that individuals are potential witnesses or even suspects or defendants in any future criminal proceedings. Before contact is made there needs to be liaison with the police SIO (who will consult with the CPS where relevant) on the timing of any approach to ensure that engagement does not undermine the integrity of investigations or proceedings and to ensure the safeguarding of all those involved. **Furthermore, any recorded discussions or interviews with the family would be disclosable under the Criminal Procedure and Investigations Act 1996 where relevant to a criminal investigation or prosecution.** A record should be kept of any meetings and discussions which do go ahead.

4.6 It is recommended that during all engagement with family/next of kin, friends, and others, that the independent chair/lead agency/relevant review partners clearly explain the purpose and process of the OWHR, the relationship and difference between it and the criminal investigation process, and carefully answer any questions to manage expectations from the outset. Those engaging with these groups should be equipped with a working knowledge of the specialist local and national support services available and how they may be able to access this support. There may also be a need to consider specialist and expert advocates to speak on behalf of the families.

4.7 As set out at 2.44, there may be cases where there has been an incident which has involved multiple homicides, or linked homicides. Any approach to the victim's family needs to be co-ordinated between the reviews to ensure that contact with, and any information being shared with the families on the review process, is synchronised in terms of timing and content and to avoid families being overwhelmed with multiple requests or versions of information.

4.8 It is important that family members and/or next of kin of the victim are notified promptly with any developments in the progress of OWHRs. The key milestones within the OWHR process that family members and/or next of kin should be aware of include:

a. First contact with the victim's family. This should be carried out when a decision has been made to undertake an OWHR, an independent chair has been appointed (if relevant) and the scope and terms of reference for the review has been confirmed. Contact should be made to explain the OWHR process, its purpose and to manage expectations.

b. Second contact with the victim's family and if appropriate contact could also be made with the alleged perpetrator(s) family (if charged). To ask if the family want to contribute or input into the review. If agreed their engagement may highlight other individuals it may be relevant to contact for further information.

c. Third contact with the victim's family, and if included in the review with the alleged perpetrator(s) family, should be made following the completion of an OWHR (around 12 months from the date of the death). A draft of the report should be shared with an explanation of the publication process including an indication of timing and where the review will be published. As part of this process, there should be further follow-up with the victim's family to discuss the draft report once they have had a chance to consider it more fully. It may also provide an opportunity for the family to provide feedback on their experience of the OWHR process.

4.9 At the initial stages of the OWHR, the family should be informed of the decision to undertake an OWHR and also the decision to appoint an independent chair and their details. An initial template letter to the family is attached at Annex 3a. A leaflet for family members providing information on what an OWHR is, who will undertake the review, their involvement, what happens to any information that they share, the review process and timescales, is provided at Annex 3b. A further letter template for the family on the completion of the OWHR is provided at Annex 3c.

4.10 The relevant review partners/lead agency/independent chair also need to discuss with the police SIO (who will consult with the CPS where relevant) on the appropriateness of considering any approach to the family of any perpetrator(s) who has been charged with the homicide in case their family may have relevant information to offer. However, the independent chair needs to be mindful that the perpetrator(s) or others with a connection to the perpetrator may in some cases pose an ongoing risk of violence to the victim's family or friends, or vice versa. If the relevant review partners/lead agency/independent chair are concerned about any risk of imminent physical harm to any known individual(s) then they should contact the police immediately so steps can be taken to provide protection.

4.11 It may be that family members and/or next of kin of the victim are not ready to engage with the OWHR process. In these situations, where the family or next of kin respond and ask for more time before they feel able to engage, consideration should be given by the independent chair/lead agency in consultation with the relevant review partners on what might be a suitable period of time before it would be appropriate to follow-up with them. If the family and/or next of kin have an advocate, then they may be in a position to be able to provide advice on a suitable time period. If the family and/or next of kin decline involvement in the process, consideration needs to be given to contacting any advocate (if assigned) on the key milestones of the review process, particularly when the report has been completed and the draft report is ready for publication. The term "advocate" is broad as it could be an expert professional assigned to work with the family either through statutory services or from the voluntary sector or it could also be a lawyer, family friend or community leader who has consent or permission from the family to represent them and act on their behalf.

4.12 In terms of providing the family member and/or next of kin with a copy of the draft report, consideration will need to be given to whether any of the content requires redaction to ensure that no sensitive information is disclosed which might undermine any ongoing criminal proceedings or trial.

4.13 It may be that on providing a copy of the draft report to the family member that they ask for more time to be able to fully read the report. Consideration should be given to such requests, but a clear deadline should be agreed with the family member given the need to finalise the report and submit to the Secretary of State for publication. In some cases, this may involve drawing up a legal form of undertaking to maintain the confidentiality of an unpublished review.

Factors for consideration on engagement

4.14 If considered appropriate when meeting with family members/next of kin, and where suitable with friends and others, the independent chair/lead agency/relevant review partners should:

- offer to communicate directly or, if preferred by the family through a designated advocate, who has, where possible, an existing working relationship with the family

- confirm that engagement is voluntary. If the family decline to be involved in the process explain that further opportunities to engage will be offered including as a minimum, when the draft report is prepared

- take into account ethnic, cultural, accessibility and linguistic needs

- carefully consider the timing of contact with the family based on information from the advocate (if used) and taking account of other ongoing processes, for example, criminal investigations or proceedings and post-mortems etc

- offer initial contact in person but make clear that there are different ways in which they can contribute to the OWHR, for example, in writing or over the phone etc. The family should be provided with the relevant information leaflet at Annex 3b

- offer signposting to specialist and expert advocacy support services to those who do not have a designated advocate

- ensure regular engagement and updates on progress through the advocate (if assigned), including on the timing of the completion and subsequent publication of the review report

- explain clearly how any information disclosed (including personal information) will be used and whether this information will be published

- explain how their information has assisted the review and how it may help to prevent future homicides

- share the completed version of the OWHR with the family/next of kin prior to the review being sent to the Secretary of State and First Minister for Wales (where appropriate) for publication and explain why it is important for the OWHR to be published to inform future policy and practice

- ensure that the family is given adequate time to consider and absorb the report, highlighting any comments or concerns. Explanation should be given to the legal requirement placed on the Secretary of State under section 28(7) of the Act to publish or make arrangements for the publication of the report, as well as the caveats around that publication

- ensure that the family is made aware of the potential consequences of publication such as media attention and renewed attention in the homicide. The family should be fully cited on any media statements. The independent chair also needs to be mindful of key dates, such as birthdays, anniversaries etc.

Other aspects to consider

4.15 The independent chair/relevant review partners/lead agency also need to have regard to Threats to Life protocols and guidance. Threats to life are issues which can be quite common in relation to the types of homicides that OWHRs will focus on. As a result, this can cause problems if they are in contact with family members, friends, and peers of the victims. The independent chair/lead agency/relevant review partners will need to agree with the police SIO, what action can be taken with the family, friends, and others in relation to the case. The independent chair/relevant review partners/lead agency need to be mindful that the perpetrator or members of the perpetrator(s)' family might in some cases present an ongoing risk of violence to the victim's family or friends or vice versa with a risk of violence to the perpetrator or members of their family, including in retribution for the death. For example, engagement with a family member about their loved ones life might highlight information or issues which could add to feelings of anger and upset involving the incident, this could in turn lead to threats to the victim's/perpetrator's family or friends. If there are concerns about a risk of imminent physical harm to any known individual(s), these should be notified to the police immediately to allow action to be taken to protect the individual(s).

4.16 Consideration also needs to be given at an early stage to working with Family Liaison Officers (FLOs) and the police SIO to identify any existing advocates (if assigned) and the respective positions of the family, friends, and other support networks in relation to the homicide.

4.17 If the scope of an OWHR include aspects relevant to mental health homicides or Independent Investigations, perpetrators families are considered key to understanding care and treatment received. Victims' families are also key participants if they wish to be involved. See guidance at paragraphs 2.43 - 2.45.

4.18 It will be important that the independent chair/lead agency/relevant review partners are aware of what support and advocacy services may be available in their local area for the victim's and alleged perpetrator/s families and/or next of kin. As set out at paragraph 4.11 families and/or next of kin may not be ready to engage with the OWHR process at the start and may decline involvement or ask for more time before they feel able to engage. Due to this, information on support services should be made available to them throughout the process as their need/readiness to engage may change over time.

5: Delivering OWHRs in Wales

Single Unified Safeguarding Review (SUSR) Wales

5.1 The Government of Wales Act 1998 (GoWA 1998) provided for the transfer of executive functions from UK Government Ministers to the National Assembly for Wales (now Senedd Cymru[17]). Under GoWA 2006, those functions were transferred from the National Assembly for Wales to the Welsh Ministers. The Welsh Ministers now exercise the majority of the executive and subordinate legislative powers in relation to local government whether those powers are conferred by an Act of Senedd Cymru or an Act of the UK Parliament.

5.2 Section 108A of and Schedules 7A and 7B of GoWA 2006 establish the basis of the legislative competence of the Senedd to make primary legislation. Schedule 7A specifies the areas of policy in respect of which only Parliament can legislate. Any area not listed within Schedule 7A is within the legislative competence of the Senedd; Schedule 7B contains general restrictions on the way in which the Senedd may exercise its legislative competence. Accordingly, education and training, health services, housing, local government, social welfare, and Fire and Rescue, (all of which are relevant to any consideration of OWHRs) are therefore within the legislative competence of the Senedd

5.3 It can therefore be seen that in order for any review to be undertaken in Wales, it needs to ensure it is compatible with the devolution settlement and relevant processes established in Wales. As an example, over 80% of recommendations made within Domestic Homicide Reviews involve devolved Welsh authorities[18] in Wales. It is therefore essential for the Welsh Ministers to be fully engaged and appraised of the reviews. The Single Unified Safeguarding Review (SUSR) process in Wales provides this opportunity.

Purpose

5.4 The development and purpose of the SUSR in Wales is set out in detail in the SUSR statutory guidance[19].

The overarching purpose of the SUSR is to:

- create a single review process which incorporates a multi-agency approach where the criteria for one or more of the following Reviews is met: Adult Practice Review; Child Practice Review; Domestic Homicide Review; Mental Health Homicide Review and OWHRs.

- create a sole body that provides a co-ordination/operational role to deliver the end-to-end process (known as the SUSR Co-ordination Hub);

- ensure that the governance agreed is in place and effective; and

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17 References to the National Assembly for Wales now have effect as references to Senedd Cymru by virtue of section 150A(2) of the Government of Wales Act 2006 (c. 32).

18 See section 157A of the Government of Wales Act 2006 for the definition of “devolved Welsh Authorities” and Schedule 9A for the list of such authorities.

19 https://www.gov.wales/single-unified-safeguarding-review-guidance

- retain the final review report in a central repository (known as the Wales Safeguarding Repository WSR) to facilitate pan-Wales training and local, regional and national learning.

5.5 The SUSR has drawn together existing guidance and best practice from all the different review processes, creating a single process which provides a simplified yet concentrated approach to reviews. The Welsh Ministers have been able to adopt systems and processes which work in Wales, for Wales.

What does this mean for OWHRs?

5.6 In building the response to the delivery of OWHRs in Wales, the Wales Violence Prevention Unit are supporting the pilot in South Wales. The process followed by the SUSR will ensure compatibility with the national OWHR guidance and the devolved arrangements in Wales.

5.7 The SUSR process, which has been developed by practitioners following extensive academic and practitioner reviews, has been agreed by the Home Office and Welsh Government as the vehicle to deliver the OWHR in Wales. The SUSR statutory guidance has been cross referenced with the OWHR guidance to ensure it will deliver everything required from both the Home Office and Welsh Government perspectives.

5.8 In conclusion, whenever an incident of homicide involving an offensive weapon in Wales occurs thereby meeting the criteria to conduct an Offensive Weapons Homicide Review, an SUSR will be considered, and this process followed.

5.9 The SUSR Statutory Guidance can be read in full at Single Unified Safeguarding Review | GOV.WALES and the SUSR Toolkit at Single Unified Safeguarding Review: toolkit | GOV.WALES for templates of forms required to undertake an SUSR which encompasses Mental Health Homicides, Domestic Homicides, Adult/Child Practice Reviews and Offensive Weapon Homicide Reviews.

5.10 While OWHRs are to be delivered in Wales through the SUSR process there are some steps which need to be made in addition to the standard SUSR process to ensure that the OWHR legislative requirements are met for reviews in Wales.

5.11 The following tables provide a quick reference tool to identify the difference in functions for an OWHR carried out under the SUSR process. A diagram combining the two processes is available at Annex 4. Further detail of the SUSR process is available in the SUSR statutory guidance. Further explanation of the steps numbered under the OWHR process in the tables is available as a diagram at paragraph 3.1 and throughout this guidance.

TO NOTE: As the SUSR process will commence in Wales after the OWHR pilot, additional guidance is being provided to pilot areas to aid implementation during the intervening period. The SUSR statutory guidance, associated processes and standardised templates will be used in the delivery of an OWHR in Wales (through the SUSR process), even if not yet formally operational. The SUSR Team, Coordination Hub and Violence Prevention Unit will work closely with the pilot area to ensure all partners are fully briefed and supported during the review.

5.12 Establishing OWHR applicability

SUSR Process	OWHR Process	Practical impact
Homicide occurs - referral to the Regional Safeguarding Board (RSB)	Homicide occurs – inform the likely relevant review partners (RRPs) (para 1.12 OWHR Statutory Guidance)	Both entities need to be informed of the homicide at the earliest opportunity. Within 24-72 hours suggested for the OWHR process. RSB may also invite CSP to engage in the process if specific expertise is relevant to the case.
Referral passed to the Case Review Group (CRG)	Determine who the RRPs are (para 1.12 – 1.17)	If timings dictate the CRG will be convened for an ad hoc meeting to discuss the OWHR. Decision made with agreement of the relevant review partners and CRG, using the criteria set out in the OWHR legislation. Deconflict with any other review processes to confirm if this is an OWHR under the SUSR process or an alternative review under the SUSR process.
SUSR governance framework in place	Establish who will provide local oversight. Determine a lead agency (para 2.6 - 2.7)	No additional action needed – SUSR process provides the necessary oversight and structure needed for an OWHR.
Referral discussed at the CRG - all agencies represented	Make initial request for information (para 2.15e and chapter 6). Establish whether the homicide meets the OWHR criteria (para 2.10 – 2.16)	The RRPs need to be active participants in the case review group to meet the requirements placed on them by the OWHR legislation. The role of the CRG needs to include the collation and discussion of information from local partners/bodies, providing clarity of whether the OWHR criteria is met, as well as aims of the SUSR process.
Review decision by RSB Chair after receiving CRG recommendations	Review decision made by the RRPs/lead agency – with support of their local oversight process (para 2.10 – 2.16)	The decision to carry out a review needs to be made jointly between the RSB Chair and the RRPs. Meeting their legislative requirements, see para 2.11 of the OWHR statutory guidance.

5.13 Delivering an OWHR

SUSR Process	OWHR Process	Practical impact
Inform Welsh Government (Via SUSR Co-ordination Hub) and Home Office of the decision.	Notify the Secretary of State and First Minister for Wales of the decision (see para 2.19 – 2.26). Including follow-up notification if early decision not possible.	There is a legal requirement for notification to be provided within 1 month of the RRPs becoming aware of a homicide which is likely to qualify for an OWHR. The template at Annex 2 of the OWHR statutory guidance should be sent to the Secretary of State and First Minister for Wales. If no review is taken forward relevant paperwork should also be sent to the Wales Safeguarding Repository (WSR).
CRG recommend panel chair and reviewer from approved list	Commission the OWHR / delegate to an independent chair from the OWHR approved list (para 3.14 – 3.19)	CRG should follow the SUSR process, ensuring that the 'reviewer' (independent chair in England) has completed the OWHR training and is listed on the OWHR approved list.
Panel meetings	Inform the police that an OWHR has been approved (para 2.27). Make a further request for information (para 2.29)	SUSR Panel meetings should take place as per the SUSR process, with the RRPs/reviewer present. Ensuring that the police are made aware than an OWHR has been approved. The Panel discussion will include any further action which is needed to obtain additional detail in relation to the OWHR.
Primary Learning obtained from WSR utilising historical review data. Timeline agreed	Determine the scope and terms of reference for the OWHR (para 2.31 – 2.56)	SUSR Panel and reviewer should follow the SUSR process to determine the scope and terms of reference of the review, including its timelines.
Reviewers meet the family and principal individuals	Inform the family that an OWHR has been approved (para 2.57).	The SUSR process should be followed in the completion of this step. Consideration should be given to the detail provided in chapter 4 of the OWHR statutory guidance on family, friends, and other networks.
Mid Term Learning	Share early learning with review partners and local oversight (para 2.58)	Share early learning, as per the SUSR Learning Opportunities/ Links Diagram in the guidance. Share with OWHR Oversight Board.
Learning event	Conduct and complete the OWHR (see chapter 7)	SUSR process should be followed. Consideration should be given to chapter 7 of the OWHR statutory guidance. The SUSR template should be used for the report. Suggested to be completed within 12 months of the qualifying homicide.

5.14 Following the review

SUSR Process	OWHR Process	Practical impact
Draft report and action plan provided to the RSB	Quality assure final review report with local oversight involvement (para 7.21)	RSB consider, challenge, and contribute to conclusions of review (SUSR guidance) Follow the SUSR process/framework – have consideration to 7.21 of this guidance. Ensure that the draft has been shared with the family as relevant.
Final report to RSB for approval and publication and then to SUSR Co-ordination Hub and Secretary of State if applicable (OWH/DH)	Share the report with the Secretary of State and First Minister for Wales (para 7.23 – 7.27)	Co-ordination hub to ensure that the final report is shared with the Secretary of State, First Minister for Wales, and RSB/CSP/ Regional equivalent where appropriate. Publication by RSB and Wales Safeguarding Repository (WSR) within 1 month of the date the report is sent to the Secretary of State, unless notification is received in advance of that date, that amendments are needed.
Action plan signed off and monitored by RSB, SUSR Co-ordination Hub and SUSR Strategy Group and entered into WSR	Inform those applicable that action should be taken (para 8.1 – 8.6)	Action plan to be monitored and those recommended in the report to take action should be asked to do so (in line with the OWHR legislation)
Report sent to the Wales Safeguarding Repository (WSR) for analysis using machine learning, social science, and computer science.	Secretary of State to publish the report (para 7.23 – 7.27)	Report to be sent to the Secretary of State for publication. In Wales SUSRs will be individually published by RSBs. The WSR is not open to the public. Publication can be carried out by RSB and WSR within 1 month of the date the report is sent to the Secretary of State, unless notification is received in advance of that date, that amendments are needed.
Action plan signed off by RSB Primary, Mid Term and Final learning from all reviews disseminated by SUSR Co-ordination Hub and Bi-Annual Themed Dissemination Events	Integrate learning into local system action plan (para 8.1 – 8.8)	SUSR process to be followed (SUSR guidance) to ensure that the action plan is integrated into local processes. Have consideration to chapter 8 of the OWHR statutory guidance.
Ministerial Oversight Board (MOB) Chaired by First Minister	Conduct and publish thematic analysis - OWHR Oversight Board to monitor actions and publish thematic analysis (para 8.11 – 8.17)	MOB overarching governance model of devolved and non-devolved aspects of safeguarding with the purpose of providing leadership, oversight, and support. Engagement to be carried out with both processes on the review as requested
Action plan continues to be monitored. Update Reports submitted to RSBs, SUSR Strategy Board and Ministerial Oversight Board where necessary.	(7) Perform progress evaluation on action plans (para 8.7 – 8.7)	SUSR process to be followed, alongside engagement with the OWHR Oversight Board

6: Information and data sharing

Introduction

6.1 This guidance on information and data sharing has been prepared to support the disclosure of information for dealing with cases of OWHRs. It is intended to help local partners/bodies to understand what data can be disclosed for the stated purpose(s) and provide assurance that they have considered the requirements of data protection legislation.

Purpose of Disclosure

6.2 Sharing of personal data that is necessary and proportionate for the purposes of a review across local partners/bodies is key to the success of OWHRs. The relevant organisations who may be required to share data are outlined in paragraph 2.30. The aim of the process is to share the relevant information each organisation holds in relation to an individual, whether the victim, alleged perpetrator(s) or a person with a connection to the death, to ensure an OWHR can be carried out successfully. All disclosures must be necessary and proportionate – that is, only information relevant to the review should be shared.

6.3 It is critical that there is control over any information which is shared by partners as part of the OWHR process and that this is carried out in a way that does not jeopardise or undermine the criminal investigation or criminal justice proceedings running in parallel to the OWHR process. Partners should aim to be as open as possible in the information they share, looking to provide as full and detailed a picture as possible of the context and events surrounding the death and the individuals involved. There may be information concerning the alleged perpetrator(s) or some individuals with a connection to the death which may not be able to be shared at the initial stages of an OWHR by the police SIO or the CPS because it could threaten the integrity of the criminal investigation and any criminal proceedings. This may remain the case for the duration of the review for very sensitive information and this is acknowledged within the OWHR process. By not waiting for the resolution of criminal investigations and proceedings it may mean certain detail is excluded from the review. This is balanced against the benefits of learning being identified in a timely manner and action taken which may help individuals avoid becoming victims or perpetrators of homicide in the future.

6.4 Maintaining the integrity of the criminal investigation and proceedings has to be a key consideration for review partners alongside ensuring that the safety of any person linked to the homicide is not compromised. It could be that unintended problems arise from sharing certain information and as such **review partners should agree with the police SIO which individuals are to be included in the requests for information, clarifying what information cannot be shared and any restrictions on the timing of the release of information. This should be clearly stipulated in the request.** More detail is set out below on the practicalities of information sharing for each of the review partners.

What information should be shared

6.5 The purpose of an OWHR and its strategic objectives have been set out in detail in paragraphs 1.22 – 1.31). Only information relevant to the review is to be shared, aiding to identify any lessons to be learnt from the death and to consider whether it would be appropriate for anyone to take action in respect of those lessons learnt. The personal data shared should be necessary for, and proportionate to, the review.

6.6 When determining if a homicide meets the OWHR criteria (see paragraph 2.10 – 2.16), one of the conditions set out in the OWHR regulations[20] (and required to be met under section 24(1)(c) of the Act) is that:

> One or more review partners has information about, or would reasonably be expected to have information about –
>
> i. the person who died, or
>
> ii. at least one person who caused, or is likely to have caused, that person's death.

6.7 'Information', in this context, means information that there is a risk a person may commit, or be a victim of, antisocial or criminal behaviour and such information—

i. includes information relating to the person's education, antisocial or criminal behaviour, housing, medical history, mental health, and safeguarding, and

ii. does not include information that only became known to a review partner after the death of the person (specifically, the earlier of either the recorded time of death or the recorded death).

6.8 Information should be relevant to the review, providing possible insight into why an individual may have found themselves in a situation which through a series of events has resulted in the death of an individual (i.e. information that there is a risk a person may commit, or be a victim of, antisocial or criminal behaviour) and should not include any information that the record holder believes is unnecessary or disproportionate to disclose. Any information held which meets the criteria set out above in paragraphs 6.6 and 6.7 should be included in the return to the relevant review partners, noting the suggestion given at paragraph 2.14 regarding the level of appropriate information which may be able to be provided at the early stage of the review. A template has been provided at Annex 1 which provides two sets of example questions for review partners to ask themselves to aid in identifying the type of information which would be relevant to the review. This covers the initial return within the one-month period and more in-depth investigative questions for the full review.

[20] The Police, Crime, Sentencing and Courts Act 2022 (Offensive Weapons Homicide Reviews) Regulations 2022 (legislation.gov.uk)

6.9 A suggested timeframe for review is the 24 months preceding the death however, this is a guide and where individuals have had very active involvement with the authorities it may be proportionate to focus on the 12 or 18 months prior to the death. Alternatively, there may be instances where it is decided that significant events beyond the 24 months should also be considered (see paragraph 2.34). The independent chair/lead agency/relevant review partners should set out in the Terms of Reference of the OWHR the time frame which will be covered in detail, during the review. Further information can also be included as contextual information within the review template, see Annex 5.

6.10 Keeping the purpose of the OWHR in mind will aid in limiting the amount of information that may be relevant to share, compared to the volume which may be available on the victim, alleged perpetrator(s) or person(s) with a connection to the death. It is important that learning arising from the homicide is taken forward and shared within the review partners and local oversight structures at the earliest opportunity, where this does not compromise the integrity of relevant criminal investigations or proceedings. The sharing and implementation of this early learning may help to prevent similar homicides occurring in the future.

6.11 An OWHR is expected to progress alongside any criminal investigation and proceedings and the review should aim to be completed within the suggested timeframe (12 months). There is no pause option for a review, so the OWHR process must be carried out in a way which does not jeopardise the integrity of, or undermine, the criminal investigation or criminal proceedings. It may be that, during the course of the review, further information becomes available from review partners which can be fed into the review, for example, in relation to a perpetrator once they are arrested and charged. It is important that where further work is planned to be undertaken that the views of the police SIO and the CPS is sought to ensure that the criminal proceedings are not compromised by sharing this additional information. The Terms of Reference of the OWHR should outline timeframes for when additional information can be accepted and when this cannot be included, due to the limited time available until the review is completed, (see paragraph 2.35).

6.12 During the initial one-month notification period for an OWHR any data protection or information sharing issues should be identified and addressed in terms of what can be disclosed and shared. Discussion and specific actions should be developed through the Terms of Reference for an OWHR, as detailed at paragraphs 2.31 – 2.56.

Legislation

6.13 The Act creates an information sharing gateway but does not otherwise affect any existing powers or duties of review partners to disclose information. Section 29(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 them in the performance of their OWHR functions. These are the functions conferred by Sections 24 to 28 of the Act (including considering whether or not to establish a review), and as set out in Section 29(1) where the person to whom the request is made is a person who, due to their functions or activities, is considered by the review partner to be likely to have information that would enable or assist the performance of those functions. The Regulations under Section 31 of the Act (the OWHR Regulations) provide for the relevant review partners to jointly delegate this information requesting power to one of themselves or another person. This delegation could be to an independent chair or between a district and county council within the same area.

6.14 There is a legal requirement on any person receiving a request to comply (under section 29(5) and (6)). A relevant review partner can enforce this duty by making an application to the High Court or county court for an injunction. However, under section 30(1) of the Act the person may not be required to disclose information that a person cannot 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.

6.15 Section 29(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 under sections 24 to 28 of the Act. This ensures that review partners are able to share either information they already hold, or information they receive via a request made under section 29, with other review partners for those purposes.

6.16 Section 30(2) of the Act provides that a disclosure of information authorised or required by section 27 to 29 of the Act (being information contained in notifications to the Secretary of State, contained in the report of the review, and information disclosed under section 29) 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).

6.17 Sections 27 to 29 of the Act do not, however, require or authorise a disclosure of information which:

a. would contravene the data protection legislation[21] (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.

TO NOTE: Each data controller must satisfy themselves that they are not in contravention of data protection legislation and must undertake their own risk and impact assessments.

Disclosure and criminal proceedings

6.18 Disclosure is one of the most important issues in the criminal justice system and the application of proper and fair disclosure is a vital component of a fair criminal justice system. All disclosure issues should be discussed with the police SIO, the CPS and the HM Coroner's representative as appropriate. Regard must be given to the Criminal Procedure and Investigations Act 1996. All material generated or obtained by the OWHR whilst the criminal case is ongoing should only be requested by the police investigator or the prosecutor if it has been identified as relevant to an issue in the case. This will depend on the circumstances of the case, including any potential defence, and any other information informing the direction of the case.

[21] 'Data protection legislation' has the same meaning as in the Data Protection Act 2018 (see section 3(9) of that Act).

6.19 As in other criminal cases there may be homicides where the investigator or prosecutor believes that a third party (for example a local authority or social care organisation) has relevant material or information. In such cases, investigators and prosecutors have a duty to take steps to obtain, inspect and review the material. Material may be relevant to an investigation if it appears to an investigator or prosecutor that it has some bearing on the office under investigation or any person being investigated or on the surrounding circumstances of the case, unless it is incapable of having any impact on the case. Information held by the OWHR would be considered third party material.

6.20 The test for access to third party material for the purpose of criminal investigations and prosecutions and specifically how the issue of relevance is approached is set out in detail in the Attorney General's Guidelines on Disclosure 2022[22]. The Guidelines at paragraphs 28-34 set out the principles of accessing third party material and the obligation on the investigator to pursue all reasonable lines of inquiry, whether they point towards or away from the suspect, that may reveal material relevant to the investigation or the likely issues at trial. This obligation is the same in respect of material held by third parties within the UK.

6.21 It may be that material gathered in the course of an OWHR is considered capable of meeting the disclosure test of undermining the prosecution case against the accused or of assisting the case for the accused and the defence may seek to gain access to it. As an OWHR is likely to be conducted in parallel to a criminal investigation, the disclosure officer for the criminal investigation will be obliged to inform the prosecutor. Any information, documents etc provided as part of an OWHR may become disclosable. It is the responsibility of a disclosure officer to discuss this with the relevant review partners or independent chair. They would be responsible to ensure that there is a robust process in place for the purpose of disclosure of information to the disclosure officer responsible for the criminal investigation.

6.22 The Attorney General's Guidelines on Disclosure 2022 are clear that access to third party material (of which the OWHR would be considered to be one) should never occur as a matter of course and the potential relevance of the material needs to be established (see paragraph 30 of the Guidelines). There must be a properly identifiable foundation for the inquiry, not mere conjecture or speculation[23]. Where relevant, the Criminal Procedure and Investigations Act 1996 Code of Practice[24] at paragraph 6.16 refers to the need for the prosecutor to inspect sensitive material and assess whether it is disclosable and, if so, whether it needs to be brought before a court for a ruling on disclosure. Where relevant, the Criminal Procedure and Investigations Act 1996 Code of Practice[25] at paragraph 6.16 refers to the need for the prosecutor to inspect sensitive material and assess whether it is disclosable and, if so, whether it needs to be brought before a court for a ruling on disclosure. Where it is considered that the disclosure of sensitive material would create a real risk of serious prejudice to an important public interest, a court hearing would be required.

[22] Attorney General's Guidelines on Disclosure - GOV.UK (www.gov.uk)

[23] Bater James and Mohammed [2020] EWCA Crim 790 at paragraph 77

[24] Criminal Procedure and Investigations Act 1996 (section 23(1)) Code of Practice (publishing.service.gov.uk)

[25] Criminal Procedure and Investigations Act 1996 (section 23(1)) Code of Practice (publishing.service.gov.uk)

6.23 If there are family members, colleagues, friends or individuals that an independent chair, lead agency or relevant review partner may wish to speak to as part of the OWHR and who are connected or witnesses in the criminal case then they should consult with the police SIO (who will consult with the CPS) before any approach is made. They may be asked by the SIO or CPS not to contact them for interviews until after a certain time period, or in some cases there may be individuals that it is not appropriate for them to contact at all.

6.24 Clear processes and communication channels which keep operational and review personnel separate in OWHRs will reduce the potential for information sharing in OWHRs to have an impact on ongoing criminal investigations and criminal justice proceedings. This would include good record keeping and the responsible handling of information. As set out in paragraph 2.35, due to sensitivities around information, a decision may be taken locally for information on an alleged perpetrator not to be included in the early stages of an OWHR. This decision should be reviewed periodically, and it may be at the point of charge, it is appropriate for further information to be sought from review partners on the perpetrator. As outlined in paragraph 2.35 this will depend on the timing of this decision and if inclusion fits within the timeframes of the completion of the OWHR.

Practicalities of information sharing and disclosure

6.25 The Data Protection Act 2018 and UK General Data Protection Regulation governs the protection of personal data of living persons and places obligations on public authorities to follow “data protection principles”. OWHRs will run in parallel to criminal investigations and criminal proceedings and due to this there will be implications on what information can be shared with review partners and when. The purpose of this section of the chapter is to set out the practicalities of information sharing for each of the relevant partners.

Police

6.26 As set out at paragraphs 2.12 – 2.14 and 6.3 not all information may be suitable for disclosure during an OWHR due to the need to maintain the integrity of the criminal investigation and any prosecution. In the initial stages of the investigation the police will likely be dealing with multiple considerations with regards to the victim, suspect(s), witnesses, evidence and intelligence with some information classified as sensitive including information in relation to active lines of enquiry and potentially vulnerable witnesses. It is expected that only information that can be disclosed should be shared as part of the initial process in determining if the conditions of an OWHR are satisfied. The SIO would need to discuss and agree this with the relevant review partners although ultimately, the SIO would be responsible for determining what information can be shared.

6.27 To deal with issues around sharing sensitive information/intelligence the SIO should have a confidential meeting with the relevant review partners or independent chair to discuss the sensitivities and to agree what can and cannot be shared. There has to be a balance struck and key considerations given to whether it would benefit or adversely impact on the OWHR if that intelligence was not shared. These discussions should also include the potential impact a review may have on any criminal investigation, including the publication of the completed review. Information sharing is not a one-time process and regular reviews should be carried out to ascertain if information which could not be shared, can now be provided to the review. Information should be shared as early as possible.

6.28 The SIO would authorise the disclosure of information from the police to the relevant review partners or independent chair. The decision should be recorded to manage and document the information flow while ensuring that the SIO knows and can control what information is shared and with whom as part of the OWHR process.

Local Authorities (England and Wales)

6.29 There may already be existing and established data sharing agreements or protocols in place between the relevant review partners, including those under the Crime and Disorder Act 1998, which will allow the disclosure and sharing of personal information pertinent to the review. However, it is recognised that local authorities may face similar issues around the disclosure and sharing of personal information as other local partners, such as the police and Integrated Care Boards in England and Local Health Boards in Wales.

6.30 As a relevant review partner, local authorities will be required to share information about the victim and where appropriate, any information that they may hold on alleged perpetrator(s) or a person(s) who is connected to the death providing that this does not contravene data protection legislation. For example, where information is requested about alleged perpetrators who have been charged or about persons connected to the death then local authorities will need to consider carefully what information can be provided as part of the OWHR process. They will need to satisfy themselves that any sharing of personal information does comply with data protection legislation, including the UK General Data Protection Regulation (UK-GDPR) and the Data Protection Act 2018.

6.31 Where there are concerns that the full disclosure of information about a person of interest to the review is not appropriate, these should be discussed with the relevant review partners/lead agency/Independent Chair. In addition, if there is any requirement on local authorities to disclose to the individual concerned that their information has been shared with review partners due to their connection to the death, there would also need to be discussion with the relevant review partners or Independent Chair, who can discuss with the SIO the appropriateness of sharing the information. Any consideration of disclosure needs to be balanced against the priority to maintain the integrity of any ongoing criminal investigation or criminal proceedings.

Integrated Care Boards in England

6.32 As a relevant review partner, Integrated Care Boards may need to process and disclose information about the victim and, where appropriate, alleged perpetrators and other individuals who may be connected to the death. Among other legal considerations, data protection legislation must be considered whenever personal data of a living person is processed. The information processed by an Integrated Care Board or disclosed by a health professional is likely to include information concerning health, such as medical records, which are a special category of personal data for the purposes of data protection legislation in respect of which additional conditions apply. However, in relation to any obligation of confidence owed by an Integrated Care Board or health professional (e.g. the common law duty of confidence), the Act provides that a disclosure of information required or authorised by sections 27 to 29 of the Act (e.g. disclosure by an Integrated Care Board for the purpose of enabling or assisting an OWHR – see paragraphs 6.13 - 6.17 above) will not amount to a breach.

6.33 Clinicians and health professionals should co-operate with OWHRs and disclose all relevant information about the victim and, where appropriate, alleged perpetrator(s) who caused their death and any individual connected to the death. Where clinicians and health professionals consider that there are clear obligations and reasons why full disclosure of the information about a person of interest to an OWHR is not appropriate (such as due application of data protection principles or human rights considerations), then these should be discussed with the relevant review partner, lead agency or independent chair.

6.34 For those cases where there are individuals who are connected to the death then there needs to be discussion with the police SIO and independent chair/lead agency/relevant review partners about this information and whether this should be disclosed to avoid undermining the criminal investigation through alerting these individuals that their information has been shared with review partners as they are connected to the death.

6.35 The reason for concerns about disclosure or sharing information should be discussed with the independent chair/lead agency/relevant review partners and attempts made to reach agreement on the confidential handling of records or partial redaction of record content.

Wales

6.36 The Welsh Government have put in place the Single Unified Safeguarding Review process and have produced draft statutory guidance. Review partners in Wales undertaking an OWHR should have regard to the relevant sections of the Welsh Government guidance in relation to data protection considerations and data disclosure.

Other local partners/appropriate bodies

Crown Prosecution Service

6.37 The CPS may be requested by a review partner/lead agency or independent chair (if delegated to) to provide any relevant information that they hold on a victim or alleged perpetrator(s). Issues may arise in relation to what information can be provided without undermining or prejudicing the criminal proceedings and trial process. Where these issues arise, it is important that there is discussion between the CPS and the relevant review partners, or independent chair and agreement found on the way forward. These discussions should also include the potential impact a review may have on any criminal proceedings, including the publication of the completed review. OWHRs should take place as soon as possible to ensure that any learning is taken forward and implemented to prevent other similar homicides.

Multi-Agency Public Protection Arrangements (MAPPA)

6.38 As set out in paragraphs 2.53 – 2.54, a MAPPA SCR could be considered for an alleged perpetrator or, in rare cases, for the victim of an offensive weapons homicide, if they were MAPPA eligible at the time or it was within 28 days of their discharge from the MAPPA scheme. As with Domestic Homicide Reviews and MAPPA, both processes can be carried out alongside one another as long as there is consistent communication throughout the process. The MAPPA guidance sets out that request for information for reviews need to clarify what they need to know that is not or could not be provided by information from individual agencies. The relevant review partner/lead agency/independent chair will need to discuss with the SMB if a request needs to be made for any relevant information which will likely be in the form of an executive summary of any minutes (subject to relevant legal considerations) and which may need to be accompanied by a Memorandum of Understanding.

Prevent history/involvement

6.39 For those reviews where there is a Prevent history or involvement then there may be further sensitivities, and what information could be disclosed would need to be discussed and agreed with both the Local Authority Prevent lead and Counter Terrorism Policing regional co-ordinator for the relevant area.

Coroners' investigations

6.40 As well as the criminal investigation, the coroner's investigation also needs to be considered when carrying out an OWHR. The Coroner's Office should be informed by the relevant review partners/lead agency or independent chair that an OWHR is being commenced in relation to a death. Where the perpetrator is alive and criminal proceedings are being undertaken the Coroner's Inquest would be suspended whilst awaiting the outcome of the trial. In these cases, the coroner will likely want to have access to the final published OWHR report and may also wish to access relevant underlying information. Review partners need to be aware of the decision made by the High Court in the Worcestershire Case[26]. In this case, the High Court decision on a serious case review was that the coroner was entitled to full disclosure so that he could decide what witnesses to call and what issues should be considered at the Inquest. The public interest in the pursuit of a full and appropriately detailed Inquest may outweigh a public interest claim for non-disclosure of a report into a death, particularly when the disclosure is to the coroner rather than to the public. Coroners should therefore expect greater disclosure to them so that they may properly assess the scope of an inquest and the witnesses to be called, including any underlying reports as well as the overview report.

[26] Worcestershire County Council and Worcestershire Safeguarding Children Board v HM Coroner for the County of Worcestershire [2013] EWHC 1711 (QB)1

6.41 Early notification to the coroner will help manage the information flows and the identification of any data sharing or disclosure concerns. Discussions should be held in advance of any drafts of the final report being shared with family members etc and also in advance of planned publication. This will ensure no sensitive information is disclosed. For example, the post-mortem report on the victim may form part of the information provided by the police SIO to the OWHR and this should not be shared wider without the permission of the coroner. Certain information will need to be handled appropriately to ensure it is not shared publicly or with family members etc before it has been shared through official channels.

Production and publication of the review

6.42 The production and publication of reviews are subject to the Data Protection Act 2018. This is covered in more detail in chapter 7, but there are important considerations around information sharing and data protection which should be taken into account. There will be a need for the relevant review partners and the independent chair to consider the need for the redaction of any sections of the review for data protection purposes and to ensure that no information is published within the review which could undermine any ongoing criminal investigation or proceedings or jeopardise the safety of any person, such as the family of the victim or vulnerable witnesses. In cases where an OWHR involves an individual with a Prevent history, elements of Prevent involvement may require redaction before the report is published. Under section 28(6) of the Act, the review partners must not include in the report sent to the Secretary of State any material that they consider might jeopardise the safety of any person or might prejudice the investigation or prosecution of an offence.

6.43 Under section 28(7) of the Act, the Secretary of State must publish, or make arrangements for the publication of the report, unless the Secretary of State considers it inappropriate the report to be published. If this is the case, then Secretary of State, under section 28(8) of the 2022 Act must publish or make arrangements for the publication of, so much, of the contents of the report as she considers appropriate to be published.

Lawful basis

6.44 For the purpose of an OWHR, the potentially available lawful basis for processing personal data under data protection legislation are as follows:

GENERAL PROCESSING (as defined by the UK- General Data Protection Regulation)
UK General Data Protection Regulation (GDPR) Article 6 – lawful basis: • Art 6(1)(c) Necessary for compliance with a legal obligation • Art 6(1)(e) Necessary for a task carried out in the public interest or in the exercise of official authority • Art 6(1)(f) Necessary for your legitimate interests or the legitimate interests of a third party, unless there is a good reason to protect the data which overrides those interests (this is not available to public authorities processing data for official tasks) UK GDPR Article 6(1)(c) and (e) require a basis in domestic (UK) law (see Article 6(3) UK GDPR). Chapter 2 of Part 2 of the Act would provide such a basis for any processing by relevant review partners for the purposes of undertaking a review and any act of data sharing by others who have received a request to provide information from a review partner for the purpose of the review.
If processing involves special categories of data, as defined within the Information Commissioner's Office guidance[27] a special category condition must also be met in accordance with UK GDPR Article 9. • Art 9(2)(c) Vital interests of the data subject or a third party (where they are incapable of giving consent). • Art 9(2)(g) Necessary for reasons of substantial public interest. UK GDPR Art 9(2)(g) requires a basis in UK law (see section 10(3) of the Data Protection Act 2018 (DPA 2018). This in turn refers to the need to meet a relevant substantial public interest condition in Part 2 of Schedule 1 of the DPA 2018. The potentially relevant conditions are: • *preventing or detecting unlawful acts – Condition 10* • *safeguarding of children and of individuals at risk – Condition 18* (The detailed legislative provisions of each condition must be considered on a case-by-case basis).
If processing criminal convictions data (including criminal offences or related security measures) either "official authority" or a specific condition in Part 3 of Schedule 1 of the DPA 2018 for processing this data must also be met (Article 10 UK-GDPR). • *Vital interests of the data subject or a third party (where they are incapable of giving consent) – Condition 30* • *Preventing or detecting unlawful acts - Condition 36* • Safeguarding of children and of individuals at risk – Condition 36

[27] https://ico.org.uk/for-organisations/guide-to-data-protection/guide-to-the-general-data-protection-regulation-gdpr/lawful-basis-for-processing/special-category-data/

PROCESSING FOR LAW ENFORCEMENT PURPOSES
(processing by competent authorities as defined by the Data Protection Act 2018)

DPA 2018 – use of personal data for law enforcement purposes - section 31

For the purposes of this Part, "the law enforcement purposes" are the purposes of the prevention, investigation, detection or prosecution of criminal offences or the execution of criminal penalties, including the safeguarding against and the prevention of threats to public security.

DPA 2018 – section 35(2): lawful processing

- The processing is based on law and necessary for the performance of a task carried out for a law enforcement purpose by a competent authority (section 35(2)(b) DPA 2018)

In the case of sensitive processing,
35(5) - The processing is strictly necessary for the law enforcement purpose,
meets a relevant condition in Schedule 8 and the controller has an appropriate policy document in plate at the time of the processing (see section 42).

The relevant condition is likely to be:

- *Condition 1 – statutory etc purposes*
- *Condition 3 - vital interests of the data subject or a third party*
- *Condition 4 – safeguarding of children and individuals at risk*

(Note the detailed legislative provisions of each condition must be considered on a case-by-case basis).

Section 35(8) defines "sensitive processing" in the law enforcement provision as:

"(a) the processing of personal data revealing racial or ethnic origin, political opinions, religious or philosophical beliefs or trade union membership

(b) the processing of genetic data, or of biometric data, for the purpose of uniquely identifying an individual;

(c) the processing of data concerning health; and

(d)the processing of data concerning an individual's sex life or sexual orientation."

TO NOTE: Each data controller will need to consider whether they are processing data under the UK-GDPR or Part 3 of the DPA 2018, and the applicable lawful basis (or bases), and additional conditions, on a case-by-case basis depending on the particular purpose and individual circumstances of each disclosure.

The guidance from the Information Commissioner's Office[28], and the detailed provisions of each lawful basis or condition in the legislation, should be consulted.

Data of the deceased victim is not personal data within the meaning of data protection legislation.

Information security

6.45 Review partners and other organisations required to share information for the purpose of an OWHR will need to ensure that individual access to the data is limited to those who have a legitimate purpose to view, use or otherwise access it. Appropriate measures will be taken to ensure the confidentiality of the data is maintained where necessary.

6.46 Practitioners carrying out the functions outlined in this guidance should make themselves aware of, and adhere to, their organisation's data protection, confidentiality and information security policies and procedures.

6.47 All partners must ensure that adequate and appropriate training on the subjects of data protection, confidentiality and information security is provided to all staff with access to personal data.

6.48 In relation to the production of a Data Protection Impact Assessment (DPIA) on the OWHR process, the review partners should use their own local templates. However, if required review partners can request a copy of the Home Office's DPIA template from OWHR-Team@homeoffice.gov.uk.

[28] https://ico.org.uk/for-organisations/

7: OWHR methodology, report and publication

Recommended review methodology

7.1 Below are the suggested core components of delivering an OWHR. The reviews should be taken forward by the independent chair/lead agency/review partners in a sequential manner, starting with the initial rapid review of information in the first month which will determine if a likely qualifying homicide has met the criteria for an OWHR. As set out in the scoping questions template at Part A of Annex 1, a chronology of touchpoints and engagement with service(s) should be included. The individual(s) (victim and/or alleged perpetrator(s) to be included will be stipulated in the formal request for information (see paragraph 2.15e).

7.2 After the notification period has passed and an OWHR has been formally commissioned, a second more detailed request for information will be made, as set out in Part B of the questions to appropriate partners template (Annex 1), (also see paragraphs 2.28 - 2.29). The independent chair/lead agency/relevant review partners may choose to follow-up on the information received using a number of formats which may include interviews on a 1:1 basis, group briefings (where appropriate), or communication in writing. An approach should also be made to the family/next of kin (see chapter 4). Any further information should then be requested to support the review.

7.3 The intention of Part B is to encourage local partners/bodies and practitioners to be professionally curious about the events which led up to the homicide. Importantly, the questions are not intended to focus on the conduct of individuals or organisations and apportion blame. Nor are the questions intended to solely evaluate whether procedure or policy were followed. Rather, the emphasis is on whether the policies and procedures in place allowed for effective interventions, working with local partners/bodies where required. Each partner should provide this information even where a service could not be offered, it should demonstrate referral points of the individual/s, their engagement and the effectiveness of pathways of support. Therefore, this chronology will provide an overview of where services could not be given and the rationale behind these decisions.

7.4 The time frame for the chronology is suggested as the 24 months preceding the death. However, this is a guide and where individuals have had very active involvement with local partners/bodies it may be deemed proportionate to focus on the 12 or 18 months prior to the death. Alternatively, there may be instances where it is decided that significant events which could include for example exclusion from school, arrest, mental health support, instance of domestic abuse/violence, alcohol or drugs abuse etc, beyond the two years should also be considered, (see paragraph 2.34). The independent chair/lead agency/relevant review partners should set out in the Terms of Reference of the OWHR the time frame which will be covered in detail for the review. Further information beyond the chosen timeframe can also be included as contextual information within the review template.

7.5 Family and/or next of kin engagement should happen once the scope and terms of reference for the OWHR has been agreed and an independent chair or lead agency (if delegated to) is in place (see chapter 4 for detailed guidance on this engagement). It is very important that the first engagement with the victim's family and/or next of kin focuses on clearly explaining the process of an OWHR, the differences to a criminal investigation, what they can expect and what they should not expect from the process in order to manage the expectations of this group of stakeholders in the first instance.

7.6 The next substantial engagement with family and/or next of kin would include second contact with the victim's family and if appropriate contact could also be made to the alleged perpetrator(s) family, although we would suggest this only occur if after they have been charged, and with agreement of the SIO. This engagement should be offered to ask if the family want to contribute or input into the review and could be in the form of a one-to-one meeting with the independent chair. The purpose is to gather important information on the details of the case, the context of the victim/alleged perpetrator(s) and their engagement with services including their assessment of the service engagement and support, and what could have been done differently. As set out in paragraph 4.3, the families may wish to agree a suitable pseudonym for the victim/alleged perpetrator(s) which can be used in the report. If this process is declined, it would be helpful if that were also reflected in the report.

7.7 Templates have been included alongside this guidance document at Annexes 1 and 5 to provide a framework both for consistent evidence gathering and for the consistent presentation and structure of the final report. The questions asked within the templates should drive professional curiosity, asking practitioners to look at the drivers and rationales for the level and type of engagement between the victim and/or alleged perpetrator(s) and their service, with the final report focused on the interaction between these services - assessing the quality and effectiveness of the whole system response.

How to ensure independence and mitigate against bias

7.8 Ensuring independence and mitigating against bias will be critical to the functioning of an offensive weapons homicide 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 led by an independent chair with family, friends, and other networks to inform the OWHR

c. adherence to the Public Sector Equality Duty under the Equality Act 2010 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.

7.9 The governance of OWHRs will be key to ensuring the independence of the process. It is important that all review partners overseeing the OWHRs are separate from operational personnel involved in the case. Not only does this act to combat any bias that may stem from a review partner knowing the victim, the alleged perpetrator, other persons connected to the death, or any other details of the case personally; a clear separation greatly reduces the chance that providing information for OWHRs may impact ongoing criminal investigations. Where review partners already have in-house review teams, these should be utilised for the purpose of OWHRs. Where review partners do not have specialist teams, more care will be required to ensure the separation of review partners from direct experience with the qualifying homicide and those connected to it.

7.10 Independence in an OWHR is likely to be best served by the appointment of an independent chair to perform the primary delivery role. As set out at paragraphs 3.17 - 3.19, Independent chairs can be tasked with a number of functions including the delivery of the methodology of OWHRs, interviewing and data collection, and authoring the final report by assessing this information and presenting it in a way which adheres to the statutory requirements of the Act (see section 28(4) to (6)). The independent chair could also be the primary contact for the family and/or next of kin (if they wish to be involved) to maintain independence in this relationship. Both the OWHR report template (Annex 5) and the SUSR report template[29] includes a Statement of Independence to be completed by the independent chair/reviewer as well as confirmation of the individual's membership on the independent chair/reviewers list. The relevant review partners/lead agency should ensure this is completed prior to the start of the review.

Additional expertise

7.11 Considerations could also be given to consulting an expert to help understand crucial aspects of the homicide such as a representative from a specialist organisation that can advise on protected characteristics such as age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation. This additional expertise could also focus on wider issues where relevant such as whether the individual had any vulnerabilities, for example related to mental health, domestic violence/abuse, alcohol or drugs use/offences or violence against women and girls. Other areas of expertise could be sought out to advise on intersectionality as well as particular cultures or communities which will aid in understanding the wider context and environment that the incident occurred within.

7.12 Expertise can be provided in a number of ways so where an individual from a local organisation may not always be able to attend meetings in person, they may be able to do so online, or information shared by national representatives through presentations or written briefing. Considerations should be given to the impact of engagement in the review process for experts particularly third sector representatives to mitigate against any impact on resources. This could include consideration of remuneration for their time and expertise. The relevant review partners/lead agency/independent chair should as part of their role be carrying out research into the communities of the individuals involved, ensuring they understand the wider context and environment which the incident occurred within.

[29] https://www.gov.wales/single-unified-safeguarding-review-guidance

Report content

7.13 In line with the strategic purpose of OWHRs as outlined in section 28(2) of the Act, the emphasis of an OWHR report should be to focus on learning, and where appropriate for action to be taken in respect of those lessons. This should be at both a system level and a single organisational level, and not seek to ascribe blame to individual professionals or organisations. 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 local partners/bodies. All content in the report should be directed towards defining actionable positive outcomes at a local and system-wide level, as set out in the question templates at Annex 1 and should include sharing of good examples/best practice which could be communicated to other local partners/bodies/areas to aid in improving their own practices. **The scope and terms of reference for the review, as guided by paragraphs 2.31 to 2.56 provide a suggested framework of areas to cover in the report.**

7.14 At minimum, to meet the legislation an OWHR report must include (see section 28(5) of the Act):

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, including those where it has been considered appropriate for a person to take action in respect of those lessons.

7.15 As set out, OWHRs enable all the relevant local partners and bodies to come together to develop an understanding of the wider context and circumstances that surround a death. By reviewing their work and identifying any learning (both best practice and where improvement may be needed) they can consider whether any actions should be taken, or changes made in policies or practices to aid in preventing future homicides involving offensive weapons. Actions should be realistic, achievable and have operational as well as strategic relevance for those they are attributed to, and we would suggest that the independent chair/lead agency/relevant review partner discuss the draft report and proposed learning points with the local oversight process/wider appropriate partners to test their understanding and to provide the opportunity to discuss the recommendations as there may be occasions where alternative actions could be more beneficial. See more on effective learning/actions at paragraphs 8.1 – 8.6.

7.16 It is recommended that local partners discuss with their local oversight process what the best route is to feed actions back to an individual/organisation and at what level those messages should be shared. As above, this is not a process of individual accountability, so it is important to ensure that the action is flagged to the most appropriate person or team to ensure the action is implemented. Personal details of individuals should not be included so suitable pseudonyms or team/organisation should be used.

7.17 When the report is sent to the Secretary of State, under section 28(6) it must not include material that the review partners consider:

a. might jeopardise the safety of any person, or

b. might prejudice the investigation or prosecution of an offence.

7.18 A template for the report has been provided at Annex 5 which aims to focus the report, the main aspects include:

- an outline of the circumstances which resulted in the review,
- relevant equality and diversity considerations,
- involvement of family/next of kin and other relevant persons
- contextual information, summarising key significant events prior to the agreed timeline.
- a timeline of local partner/appropriate bodies involvement, within the agreed timeline.
- learning and best practice identified during the review, addressing the scope of the review and the key lines of enquiry
- recommendations on what could be done differently in the future to improve practice.

OWHRs completed in Wales under the SUSR process should use the SUSR template provided in the SUSR statutory guidance[30].

7.19 In advance of drafting the report, the independent chair/relevant review partners/lead agency should discuss with the SIO any concerns they may have around publication, ensuring any information which might jeopardise the safety of any person or might prejudice the investigation or prosecution of an offence is not included. If reports are too heavily redacted it can risk losing the mean of recommendations and actions. Early discussions can aid in drafting the report while avoiding these issues, providing understanding to the background of any concerns the SIO may have while providing the opportunity for the independent chair/relevant review partners/lead agency to explain the detail behind the learning which has been identified. Decisions on the content of a report will need to be made on a case-by-case basis. Suitable pseudonyms should always be used throughout a report (see paragraph 4.3), for both the victim and alleged perpetrator(s), as well as key partners if any safeguarding concerns have arisen.

7.20 As set out at paragraph 4.8(c), the draft report should also be shared with the family/next of kin, talking them through the process, the key outcomes and recommendations and providing an explanation of the publication process including an indication of timing and where the review will be published. These discussions should also include an outline of the media communications plan (where appropriate) which should be put into place, setting out who will be responsible for overseeing public comments and responses to media interest in the local area.

[30] https://www.gov.wales/single-unified-safeguarding-review-guidance

Quality assurance

7.21 The responsibility for quality assurance of completed OWHR reports rests with the relevant review partners/lead agency and their local management structures. They will need to ensure that the report OWHR process has been followed correctly and the report completed. The local oversight process may wish to provide support in this area and could allocate an individual independent of the process to quality assure the final report.

7.22 Neither the OWHR Oversight Board or Secretary of State have a quality assurance function within the Act. 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

7.23 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 and this is at the core of the review process. As set out at paragraph 7.17 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, reports must not contain any information that would contravene the data protection legislation or that is prohibited from disclosure as communications data by the Investigatory Powers Act 2016 (any of Parts 1 to 7 or Chapter 1 of Part 9 of that Act), as set out in section 30(3) of the Act and outlined in chapter 6 of this guidance. Final reports for OWHRs completed in Wales through the SUSR process should be sent to both the Secretary of State and the First Minister for Wales.

7.24 Any concerns around publication and suitability of content for publication should be discussed with the local oversight process or if necessary, the OWHR Oversight Board, through the Secretariat. For particularly sensitive cases, consideration can be given to delaying the publication of the report as a whole, or to initially only publish the findings, however this approach should be reserved for cases where it is felt that even with redaction the anonymity required to safeguard could not be guaranteed.

7.25 Under section 28(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 then publish the remainder of the report.

7.26 The Home Office has committed to putting a process in place which will ensure that OWHR reports are published and so made publicly available. For the OWHR pilot, as a minimum, all of the reports will be published in a specified site on gov.uk, providing a single source of OWHR reports for England and Wales. OWHRs carried out in Wales under the SUSR process will also be published in the Wales Safeguarding Repository and as part of the SUSR process, on the relevant Regional Safeguarding Board website.

7.27 As set out at paragraph 4.7(c) the draft report should have been shared with the family/next of kin prior to publication. Discussions should include an explanation of the publication process including an indication of timing and confirmation of where the review will be published. These discussions should also include an outline of the media communications plan (where appropriate) which should be put into place, setting out who will be responsible for overseeing public comments and responses to media interest in the local area.

8: Ensuring Effective Learning

Dissemination of actions and monitoring process

8.1 The OWHR process includes two formal opportunities for learning to be shared, however, every opportunity should be taken for partners to discuss and review practices. As set out at paragraph 2.58, some immediate learning may be identified following the initial information gathering stages of the process, both at the one month point and during discussions on the scope and terms of reference for the review. Further learning will then be set out in the recommendations of the final report.

8.2 All local partners/bodies involved in the OWHR should look to identify applicable lessons from reviews and create plans to act on these lessons to improve practice where needed. Under section 28(3) of the Act where lessons have been identified in relation to the death, and the relevant review partners/lead agency/independent chair consider it would be appropriate for a person to take action in respect of those lessons they are required to inform the person. As set out in paragraph 7.16, a process should be agreed in advance on the best route to feed actions back to an individual/organisation and at what level those messages should be shared, to confirm that the action is flagged to the most appropriate person or team/organisation to ensure the action is implemented. When they have been informed, it should be recorded, and the information shared alongside the report, personal details of individuals should not be included so suitable pseudonyms or details of a team/organisation should be used.

8.3 All of this learning should be shared with partners in an appropriate forum (taking into account disclosure concerns and data protection). Dissemination processes should be agreed, ensuring that local partners/bodies, relevant services and professionals have received the report, acknowledged any actions allocated to their ownership/organisation and recognised the expected timeframes for delivery. Dissemination could be through a range of mediums to reinforce the sharing of key messages alongside the distribution of the formal report, this could include verbal briefing, learning events, setting up task and finish groups or through 7-minute briefings. The tick boxes provided at the end of the report template should be completed as part of this process (Annex 5).

8.4 Sharing of learning should include consideration of wider vulnerabilities which may have been relevant to the particular case such as mental health, domestic violence/abuse, alcohol or drugs use/offences or violence against women and girls. Ensuring that learning and wider understanding is shared with relevant teams outside of the immediate partners, this could include other teams who work on wider homicide review processes or other relevant teams in the local area. Recommendations which have a Prevent link may be subject to further governance oversight by the Home Office to ensure Prevent related recommendations and identified learning is progressed.

8.5 To maximise the value of the OWHR process, tackle serious violent crime and reduce levels of homicide, local areas should consider what governance mechanisms need to be put into place for monitoring delivery against OWHR action plans. It is suggested that arrangements be confirmed for the management of the action plan, including who will be responsible going forwards for its monitoring and delivery within the local oversight process. Discussions should include the allocation of each action to an appropriate owner with clear estimates for delivery alongside time periods for a review on progress.

8.6 It may be appropriate for the same local oversight process to support this process, as it has during the OWHR review itself, or it may be decided that a different structure will be in a better position to monitor and deliver the outcomes, sharing learning across the wider force area. The Police and Crime Commissioner (PCC), Community Safety Partnership (CSP) or Violence Reduction Unit (VRU) could all be considered, however the most appropriate process should be chosen for the locality. Ensuring that learning highlighted through OWHR action plans are integrated into the wider regional and/or local serious violence strategy.

Progress evaluations

8.7 As part of the monitoring and delivery of OWHR learning and its relevant action plan, local areas should undertake a progress evaluation within an appropriate time frame to observe how the recommendations have been actioned, and to identify any additional needs local partners/bodies may have in order to implement t 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.

8.8 Regional stakeholders may want to consider how to align their local funding streams to facilitate and/or remove any barriers to the meaningful implementation of OWHR recommendations. It is suggested that these progress evaluations are shared with the OWHR Oversight Board as part of their quarterly monitoring of delivery (see 8.13) and to assist their strategic thematic analysis. A specified contact should be identified in each of the organisations leading on monitoring, who will act as liaison with the Oversight Board.

OWHRs and the Serious Violence Duty

8.9 The Police, Crime, Sentencing and Courts Act 2022 introduced a new Serious Violence Duty, which came into force on 31 January 2023, to ensure specified authorities across England and Wales, being police, fire and rescue services, health, local authorities, youth offending teams and probation services work collaboratively, share data and information in order to put in place a strategy to prevent and reduce serious violence. Educational institutions and prisons/youth custodial institutions are also under a separate duty to co-operate with specified authorities and can also choose to collaborate voluntarily should they wish to do so. Local partnerships may wish to work closely in the development of the Strategic Needs Assessment and Response Strategy. These should also incorporate, align or refer to other related initiatives, such as OWHRs.

8.10 An understanding of offensive weapons homicides and the factors which led to their occurrence locally is essential to an understanding of serious violence. It is therefore recommended that where possible, and relevant to the drivers of serious violence and homicide in their area, OWHRs are aligned with the Serious Violence Duty.

The role of the OWHR Oversight Board

8.11 The OWHR Oversight Board ("Oversight Board") is a non-statutory committee composed of experts in safeguarding, preventing homicide and 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.

8.12 The Oversight Board will consist of, at minimum, individuals with expertise or background in policing, local authorities, and health. In order to ensure that we establish a diverse panel with a breadth of experience and expertise we are seeking members from the following areas:

1. Local Government
2. Public Health
3. Police
4. Education
5. Voluntary and Community Sector
6. Probation
7. Crown Prosecution Service
8. Welsh Representative (with experience of working in one of the areas 1-7, above, in Wales).

During the early stages of the pilot, the Chair and first member of the Oversight Board will be in position, these will be joined by further members as the pilot progresses and OWHR reports are completed.

8.13 The Oversight Board will be supported by a Secretariat provided by the Home Office. 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 reports.

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.

8.14 As set out in paragraph 8.4, learning from reviews should, where relevant to the case, include consideration of wider vulnerability issues related, for example, to mental health, domestic violence/abuse, alcohol or drugs use/offences or violence against women and girls. As well as ensuring this learning and wider understanding is shared at a local level, the Secretariat will work with the Oversight Board to ensure links are made within the Home Office and with other Government Departments, where relevant.

8.15 To this end, the core functions of the Oversight Board are:

a. to review each OWHR report against the guidance document and templates provided and to provide feedback to the relevant review partners/lead agency/independent chair if appropriate to improve future process or to recognise examples of good practice;

b. to develop collaborative relationships with local review areas, enable open dialogue to aid in resolving any issues that arise during the OWHR process which are unable to be solved locally and to provide expert challenge of local approaches and solutions;

c. to conduct quarterly reviews to monitor the delivery of report recommendations within local action plans (see paragraph 8.7);

d. to produce an annual OWHR report inclusive of an analysis of number of OWHRs completed, adherence to timeframes, delivery of recommendations and thematic analysis of key issues identified. This should be supported by a policy statement as to how cumulative findings will influence policy development; and

e. To deliver professional curiosity, keeping updated with relevant legislative, policy and societal developments in the areas of safeguarding, homicide prevention, serious violence and public protection and incorporating this learning and expertise into discussions and thematic analysis.

8.16 As set out in paragraph 2.58, to aid in the wider understanding of the impacts of OWHRs and for monitoring purposes, it is suggested that local review areas share early learning with the OWHR Oversight Board through the Secretariat. This may arise following the initial information gathering stages of the process, both at the one month point and during discussions on the scope and terms of reference for the review.

8.17 OWHR reports delivered in Wales under the SUSR process will be provided to both the OWHR Oversight Board and a Ministerial Board in Wales.

9: Frequently Asked Questions

The OWHR process

Q1: What consultation has taken place during the design of the OWHR process?

A: The Home Office worked with a consultancy company in 2021 in a process of engagement with stakeholders across England and Wales, including in the pilot areas. Evidence was gathered on the policy and practice of the current homicide review processes, as well as through interviews and discussion groups, national and practitioner surveys and engagement with academics and the voluntary and community sector. The OWHR process was co-designed with agencies to build on their experiences of existing reviews and to produce a review that is best placed to tackle homicide.

Q2: Has a rapid review process been considered for OWHRs?

A: Different processes were considered as a framework for the delivery of OWHRs. The proposed structure provides for an initial review of information within the first month of the incident, followed by a full review if the criteria is met for an OWHR. This process is provided for within the structure of the legislation (Police, Crime, Sentencing and Courts Act 2022).

While different from the rapid review process seen in some other homicide reviews, the Home Office recognises that the early sharing of learning is essential in making local partners and bodies aware of any issues or emerging best practice from the case and to allow immediate action to rectify an issue rather than wait for the OWHR to be completed.

As part of the process in delivering an OWHR early learning may be identified following the initial information gathering stages both at the one month point and during discussions on the scope and terms of reference for the review. The guidance is clear that this should be shared with partners in an appropriate forum, taking into account any disclosure concerns and data protection considerations, and highlighting that this is initial learning and that more may emerge during the review.

Q3: Why does the guidance refer to OWHRs only taking 12 months? Surely these will take longer given the experience of Domestic Homicide Reviews (DHRs) and potential complexities with weapons enabled homicides.

A: The purpose of OWHRs is to identify any learning and lessons to be learnt from the death and consider whether action should be taken as a result. Due to this, the government wants the reviews to be completed and published quickly to ensure that recommendations to safeguard and tackle homicide can be rapidly acted on and lives saved. The suggested timeframes for the completion of a review, as set out in chapter 3, is included with the aim for reviews to be completed within 12 months to ensure that any learning and action is timely and relevant.

It may be that for some more complex homicides, for example, those which involve multiple perpetrators, or are gang related, that a review may take longer. The process of scoping out the review and the first and second information gathering phases will help to determine the timeframe for delivery of the review and key delivery milestones.

Q4: How will the Home Office ensure compliance with the process?

A: The Home Office, and the pilot evaluator will be closely monitoring the progress of the pilot, working with each of the leads in the pilot areas to understand how OWHRs are progressing and providing support and advice if needed.

While the OWHR process includes an Oversight Board which will oversee the local delivery of OWHRs, drawing together national learning and monitoring the implementation of learning, its purpose is not to monitor compliance and it does not have a quality assurance function.

The OWHR process has been designed to provide flexibility for local areas and in line with that the Home Office does not expect to have any role in actively monitoring compliance. There are however clear statutory obligations on each of the relevant review partners which include providing notifications to the Secretary of State within a one month period from when they became aware of the likely qualifying circumstances (see paragraph 2.19 of the Statutory Guidance) and sending the final report to the Secretary of State for publication. Any review partner which failed to send a notification, arrange and conduct a review where the conditions were met or send the final report to the secretary of state would be acting in breach of their statutory duties.

Q5: What happens if review partners do not follow the OWHR statutory guidance?

A: The Act places a duty on review partners to have regard to the OWHR statutory guidance when carrying out the functions placed on them. Review partners must, therefore, consider the guidance and have good reasons if they take a different approach in particular cases. Any failure on the part of a review partner to have regard to the guidance could be subject to judicial review proceedings.

Q6: Why are OWHRs not looking at deaths of under 18s?

A: Offensive Weapons Homicide Reviews are designed to capture homicides not already captured by existing reviews. The policy was introduced under this criteria to avoid duplication of effort and resource. While not every death of a child will be subject to a current review, the initial policy intent of OWHRs is to ensure that partners consider cases of adults aged 18-25, typically involved in gangs, street crime and knife crime. Homicides amongst this group may not currently be reviewed at all. We also know that a large and growing proportion of homicides in England and Wales involve individuals from this age group.

Before consideration is given to national roll out, the Home Office want to ensure that OWHRs are the most effective tool possible for learning what can be done to prevent future homicides and will be piloting them for 18 months in three areas. This pilot will help to inform the decision whether to roll the policy out across England and Wales, including whether the criteria for a review strikes the right balance or whether it ought to be amended. An evaluation of the pilot will include a record of homicides that did not qualify for an OWHR under the current criteria.

The Act has intentionally been written to allow the OWHR criteria to be amended using secondary legislation, as this will allow the government to respond quickly and update the policy to meet any changing homicide trends or circumstances that might occur. The statutory guidance can also be updated quickly to respond to changing trends.

Q7: What about homicides where there is no body, or the victim or suspected perpetrator has not been identified

A: In a small number of cases the authorities may become aware of a suspected homicide where no body, or body parts have been found, or alternatively where a body is located but neither the victim or a suspected perpetrator is able to be identified.

These cases have been excluded from the requirement to carry out an Offensive Weapons Homicide Review (by the regulations prescribing additional conditions for a review) as we want to ensure that the review process provides for a detailed and thorough review to be completed. Without the identification of a victim or alleged perpetrator, or physical evidence to corroborate that a death has occurred the review will include limited substantial information.

Homicides that occur in the pilot areas, but which fall outside of the review criteria will be monitored as part of the pilot evaluation. This information will be considered ahead of national roll out and whether any changes should be made to ensure that more, or if needed less, homicides should be subject to an OWHR.

Q8: Where are deaths caused by or involving a police officer, using an offensive weapon in the course of their official duties excluded from OWHRs?

A: The exclusion relates to deaths which are considered a ‘death’ or ‘serious injury matter’ within the meaning of section 12(2A) of the Police Reform Act 2002.

This exclusion avoids duplication of effort and conflicts with other judicial and legal processes because any death occurring during or immediately following contact with the police must already be referred to the Independent Office for Police Conduct for consideration.

Q9: Will cases involving mental health issues be exempt from an Offensive Weapons Homicide Review?

A: While not exempt on the face of the Act, the legislation does include the power for the Secretary of State to make regulations to disapply the requirement to arrange an Offensive Weapons Homicide Review in certain cases in both England and Wales where a death was caused by a person who was receiving or had received mental health services.

Regulations are not being introduced in this area at this time. As set out in paragraph 2.43, practitioners are encouraged close working in incidents which involved a person who was receiving or had received mental health services. This enables relevant information in this context to be included within the OWHR itself.

As regulations have not been included in this area at this time it allows in those cases where the death in question must or may be investigated under arrangements made by NHS bodies in England or health services in Wales due to being caused by a person who is receiving or has received any mental health services, to continue alongside an OWHR where it is deemed necessary.

In Wales, it is planned that both homicides involving an offensive weapon, or which involved a person who was receiving or had received mental health services will be reviewed under their Single Unified Safeguarding Review.

Q10: Would an OWHR be considered for a multiple homicide?

A: An Offensive Weapons Homicide Review (OWHR) will be required in certain cases where the requirements for triggering an OWHR are met. Where one incident results in multiple homicides, different statutory reviews may apply for the different homicides, and each process would have to comply with its own legislation (see 2.46). The same death would not be subject to an OWHR if another relevant statutory review (listed in section 26 of the Act) applies.

Regulation 8 of Part 3 of the OWHR regulations set out that where more than one person dies in an incident, and those deaths qualify for an OWHR, that the relevant review partners will continue to be identified as those in the area where the death occurred or was likely to have occurred or, if there is more than one location or the location of the deaths is not known, the location where a body or part of a body was recorded as first found, (see 1.13). This would provide for one set of relevant review partners to carry out an OWHR for all of the deaths which fall within the criteria.

Q11: Why the relevant review partners in the area where the death occurred?

A: Offensive Weapons Homicide Reviews are intended to be an important tool in helping local partners tackle serious violence and homicide. When a death occurs in an area it is right that the review partners in that area are involved in the review of that death, they will provide local intelligence, help spot local patterns and trends, and help identify opportunities to intervene and prevent future deaths. It is therefore important to us that the responsibility for establishing and conducting these reviews rests with the local partners.

This does not however preclude these partners obtaining information or assistance from agencies in other areas, for example where the relevant individuals involved in the death live or lived in another area. This is likely to be necessary in many instances (see 2.15f).

Q12: How does an OWHR fit with any criminal investigation and prosecution?

A: Offensive Weapons Homicide Reviews are distinct from criminal investigations and prosecutions. Homicide reviews will focus on lessons learnt and recommendations to tackle serious violence and homicides.

Due to this, OWHRs are planned to take place alongside any criminal investigation or prosecution. As with current reviews, review partners will need to work with the police to ensure that any review does not interfere with or prejudice any criminal investigations or criminal proceedings (see paragraph 2.12).

The OWHR pilot

Q13: Why are you running a pilot instead of commencing the legislation across England and Wales?

A: Section 34 of the Police, Crime, Sentencing and Courts Act 2022 sets out that a pilot is required to be carried out in advance of rollout across England and Wales.

Before the government rolls out a national policy affecting partners, communities and families, it wants to ensure that the policy is designed to meet the needs, expectations and ways of working of all those involved. The design and pilot stages will help to achieve this this is why the requirement to carry out a pilot was included in the OWHR legislation.

Q14: Why were London, West Midlands and Wales selected to carry out the pilot, instead of other areas?

A: We are working with local partners in London, West Midlands and Wales to design and pilot OWHRs. These regions were selected to ensure they test the reviews in both England and Wales, and in areas with different profiles of homicide and serious violence.

The government wants to ensure that these reviews meet the needs, expectations, and ways of working of all those involved to help prevent future homicides.

Q15: How many reviews do you expect to be carried out during the pilot? What happens if homicides do not take place in the areas selected?

A: The Home Office have selected local authorities in London, West Midlands and Wales that, combined and based on historical data over the last 5 years. It is estimated that the areas may expect approximately 36 homicides [31]of adults involving an offensive weapon during the pilot period.

The Home Office currently intend for the pilot to last 18 months, to allow enough time for the review process to be tested. Regulations can be introduced under section 34(5) of the Act to extend the pilot, if considered appropriate and necessary.

Q16: How are you going to assess and evaluate the pilot?

A: The pilot evaluation is being carried out by an independent company. Data and information will be collated at regular intervals throughout the pilot, monitoring the outcomes and assessing the effectiveness of the current process and criteria.

As set out at section 34(3) of the Act, a report on the operation of the pilot will be laid by the Secretary of State in Parliament in advance of a decision being taken on roll out across England and Wales.

[31] https://www.gov.uk/government/publications/police-crime-sentencing-and-courts-bill-2021-overarching-documents

Q17: Won't the pilot evaluation only be able to look at the process of the pilot, rather than the outcome in reducing homicide?

A: The assessment and evaluation of the pilot is currently being designed by an independent company in conjunction with officials. The evaluation will predominantly focus on the effectiveness of the process and criteria however it will also monitor the outcomes of the reviews and the early dissemination of learning both locally and nationally, highlighting the impact the reviews can have going forward.

Delivering a review

Q18: Who is responsible for making the decision that a homicide qualifies for an OWHR?

A: The legislation and guidance is clear that the relevant review partners, with the support of their local oversight process (Community Safety Partnership, Violence Reduction Unit or the Police and Crime Commissioner) will be responsible for establishing whether the death is a qualifying homicide and making the decision on whether the conditions for an OWHR have been met. The relevant review partners for OWHRs are the police, local authorities, integrated care boards (in England) or local heath boards (in Wales).

Q19: Will the Home Office respond to notifications within a stated timescales?

A: The Home Office has no operational role within the delivery of an OWHR. Local areas should follow their standard operating processes following a death. When a notification is provided to the Secretary of State following a likely qualifying homicide, no response is required or needs to be provided before an OWHR can be commenced.

Q20: Why does the guidance suggest looking at the 2 years preceding the incident when conducting a review? How was this time frame reached?

A: A timeframe for review is set out at in paragraph 2.34, suggesting 24 months preceding the incident. This is a guide only and reflects there may be instances where only 12-18 months is focused on, or where significant events beyond the two years should be considered.

This time frame was reached through engagement with national and local stakeholders where the majority favoured a review which looked into 2 years or less of individuals lives. We wanted to ensure flexibility was available so an appropriate timeframe could be decided based on the individual case. We are keen to move away from very long reports with detailed chronology to instead provide the flexibility to include relevant touch points while considering the wider contextual issues the individuals have faced and if more could have been done to protect them.

Q21: What happens if further information comes to light such as through an ongoing criminal investigation, but the review has been completed?

A: If the OWHR has been completed there will be no requirement or duty for relevant review partners to re-open the review. It would be a local decision amongst the relevant review partners whether they wanted to carry out any further local investigations or discussions in light of the additional information that had become available, to see if any further learning or action had emerged. These are however not able to be carried out under the powers provided by the OWHR legislation. If the further information becomes available during the course of the review, and it is appropriate to do so, this can be fed into the review; see paragraph 2.35.

Q22: Does an SIO have to be involved in a Review process?

A: There is an expectation that in the days immediately following the death that there is an initial discussion between the relevant review partners and the SIO investigating the death to agree which individuals, such as the victim, alleged perpetrator(s) and persons with a connection to the death should be included as part of the information gathering process. The SIO is not expected to be involved in the review process itself. Communication between the SIO, relevant review partners /Independent Chair/lead agency will be necessary at relevant points including in sharing information, and when engaging with families and prior to drafting the final report, however this can be at a mutually agreed time/format.

Q23: How would the relevant review partners or lead agency involved in an OWHR know whether an incident involves someone with a Prevent history?

A: A Prevent Learning Review would not run in parallel with an OWHR unless the Home Office directed one to take place. As a statutory review process, the OWHR would take precedence; where this involves someone with a Prevent history, we would expect local relevant Prevent practitioners to be involved in the OWHR process. Initial enquiries to determine if an incident involves someone with a Prevent history should be directed to the local authority Prevent lead in the first instance, who can liaise with Counter Terrorism Police to seek confirmation.

Q24: Who would be responsible for ensuring any early actions/recommendations are implemented?

A: As set out in paragraph 7.13 a process should be agreed in advance on the best route to feed learning/actions back to an individual/organisation and at what level those messages should be shared, to confirm that the action is flagged to the most appropriate person or team/organisation. This learning should also be shared with wider local partners/bodies in an appropriate forum (taking into account disclosure concerns and data protection) highlighting that this is initial learning which has emerged and caveating that further investigation will be carried out during the review. This early sharing of learning is essential in making local partners/bodies aware of any issues or emerging best practice from the case which could result in the decision to take immediate action or steps towards rectifying an issue, instead of waiting the 12 months or so for the OWHR to be completed.

To aid in the wider understanding of the impacts of OWHRs, for monitoring purposes, it is suggested that this early learning is also shared with the OWHR Oversight Board.

Information sharing

Q25: Will personal information on the victim or alleged perpetrator(s) be included in the report and published?

A: The Act makes provision for review partners to request information that is relevant to the conduct of the review however the Act specifies that any report sent to the Secretary of State should not include information that might jeopardise the safety of any person or might prejudice any criminal investigation or criminal justice proceedings. The Act also allows the Secretary of State to remove any content that is included but which the Secretary of State does not consider appropriate to publish. Furthermore, the Act makes clear that any disclosure of personal data under these provisions must comply with UK data protection legislation, including the UK General Data Protection Regulation and Data Protection Act 2018.

Q26: In what situations would a police SIO not be able to share crucial information? Doesn't this prevent the review from going ahead?

A: Not all information may be suitable for disclosure during a review due to the need to maintain the integrity of the criminal investigation (see paragraph 2.12). For example, during the initial stages of the criminal investigation, the police are likely to be dealing with multiple considerations with regard to the victim, suspect(s), witnesses, evidence and intelligence with some information classified as sensitive, including information on active lines of enquiry and vulnerable witnesses. The police SIO would need to discuss and agree with the relevant review partners what information could be shared at the initial stages of the OWHR process.

This does not prevent the review from going ahead as there is a clear duty on the relevant review partners to determine whether the death is a qualifying homicide. However, it may mean that in the initial stages of the process that the focus is just on the victim unless a perpetrator has been arrested and charged. Again, further discussion would be required with the police SIO on what information could be shared on the perpetrator without compromising the criminal proceedings.

Independent Chairs

Q27: Will Independent Chairs be responsible for authoring the final OWHR report?

A: This will be a local decision made by the relevant review partners. The guidance is clear that it will be for the relevant review partners, with the support of their local oversight process, to commission an OWHR to an Independent Chair, including clarifying which functions they wish them to undertake. The guidance suggests that this could include interviewing, data and information collection and authoring the final report; (see paragraphs 3.14 - 3.19).

Q28: What is happening about the recruitment of Independent Chairs? Will pilot areas be expected to recruit them or will this be carried out nationally?

A: The Home Office has undertaken a national recruitment to establish a pool of up to 30 individuals to independently chair and undertake OWHRs during the pilot. Interviews have taken place and successful candidates have been notified and will be appointed pending the successful completion of due diligence checks and training.

As OWHRs will be delivered in Wales as part of the SUSR process, the Welsh Government have also identified independent reviewers who have been trained to carry out the reviews in South Wales.

Q29: Why will a list of Independent Chairs who have undergone training be held by the Home Office when no such system exists for DHRs?

A: For the purposes of the pilot, the Home Office has taken the decision to recruit a pool of Independent Chairs and to hold this list centrally. It was considered that this would reduce the burdens on partners within the pilot areas and avoid them having to run their own recruitment campaigns, while assisting review partners in easily sourcing independent chairs if they wish to commission them to lead and undertake the review.

Funding

Q30: What funding is available to local areas during the pilot period? How will this be allocated?

A: Research was undertaken to ascertain an estimate of the cost of undertaking OWHRs. This was based on other review types (with OWHRs not yet having been introduced).

In terms of the level of funding for each review, these were set out in the published Impact Assessment for the Police, Crime, Sentencing and Courts Act 2022 (Impact Assessment (parliament.uk)). The average costs per OWHR are estimated to be £1,222 per review per relevant review partner (police, local authorities, integrated care boards and local health boards) and £8,688 for the independent chair. In total, the estimated average unit cost of an OWHR is £12,354.

The costs for OWHR training and these per review costs will be met by the Home Office for the duration of the pilot via a grant. An update note on the estimated costs for the pilot as a whole have been published (Police, Crime, Sentencing and Courts Act 2022: overarching documents - GOV.UK (www.gov.uk). The Home Office and Welsh Government are working together to ascertain the most appropriate and simplest way for this funding to reach local areas conducting reviews.

Q31: What funding will be available after the pilot period if OWHRs are introduced nationally?

A: Funding arrangements if the policy is rolled out nationally will be confirmed after the pilot. However, part of the learning from the pilot evaluation will also be to consider whether current review costs are accurate.

Wales specific FAQs – SUSR process

Q32: How should the OWHR Pilots in South Wales use the OWHR Guidance and SUSR Guidance and related templates?

A: OWHRs in South Wales should be carried out using the SUSR process and templates however both the OWHR guidance and SUSR guidance should be used in tandem during the pilot to ensure a full awareness is gained of the OWHR purpose, aims and operation. Review partners in Wales have a statutory duty to have due regard to the OWHR Statutory Guidance.

Q33: If a qualifying offensive weapons homicide occurs during the pilot in South Wales prior to final publication and implementation of the SUSR, how will the process be delivered?

A: The Welsh Government and the Home Office have worked closely together to ensure that both OWHR Statutory Guidance and SUSR Statutory Guidance clearly set out how qualifying offensive weapons homicides will be delivered through the SUSR process. The SUSR statutory guidance, associated processes and standardised templates will be used, even if not yet formally operational.

As the SUSR process will commence in Wales after the OWHR pilot, additional guidance is being provided to pilot areas to aid implementation during the intervening period. The SUSR Team, Coordination Hub and Violence Prevention Unit will work closely with the pilot areas to ensure all partners are fully briefed and supported during the review.

Q34: What is the role of the Regional Safeguarding Boards in relation to OWHRs delivered under the SUSR process?

A: Regional Safeguarding Boards will establish and oversee delivery of OWHRs in Wales which form part of the Single Unified Safeguarding Review process. The detail of the role of the RSBs in OWHRs is set out in chapter 5 ‘Delivering OWHRs in Wales’, of the OWHR guidance. Further, more detailed information is included in the draft SUSR guidance. As set out at paragraph 5.12, the RSB may also invite the Community Safety Partnership (CSP) to engage in the process if specific expertise is relevant to the case.

OWHR is a review type captured as part of SUSR and this is the process that is followed in completing an OWHR. It is important to note that OWHR guidance published by the Home Office recognises the SUSR process and both sets of guidance have been designed to be complementary to one another.

Q35: What is the role of the Violence Prevention Unit in relation to OWHRs delivered in South Wales during the pilot?

A: The Violence Prevention Unit is a small multi-agency unit made up of Police, Public Health and Police and Crime Commissioner staff. The Unit commissions a number of interventions in South Wales to prevent violence. The Unit also conduct research and analysis on violence and its underlying causes.

Moving forward and for the duration of the pilot, the Violence Prevention Unit will;

- Remain active members of the task and finish group.
- Support communications in relation to OWHR. This includes both raising awareness of OWHR as well as the promotion of key learning from reviews.
- Using learning from OWHR to inform research and analytical products.
- Using learning from the Wales Safeguarding repository to inform thematic research and analysis.
- Utilise learning from reviews to prioritise commissioning of interventions.
- Providing a conduit to other VRU areas, sharing learning and thematic products where appropriate.

Q36: How will delivery of the OWHR guidance work in practice with engaging SIO's in determining the scope and terms of reference of the SUSR (OWHR)?

A: SIOs would play an initial role in determining with the relevant review partners which individuals, including the victim, alleged perpetrator(s) and any persons with a connection to the death should be included as part of the information gathering process for discussion at the Case Review Group whether the criteria for an OWHR has been met.

Going forward it will be the SUSR Panel and the reviewer to determine the scope and terms of reference for the review, including the timeliness.

Q37: What is the SIO's role relating to the Review Panel in the SUSR (OWHR)?

A: The SIO is not expected to be involved in the review process itself as representatives appointed to the Review Panel would be from those agencies involved in the case. The SIO would however have contact at certain points of the process. For example, with the relevant review partners and Case Review Group as part of the information gathering process to determine whether the homicide met the criteria for an OWHR, and during the information gathering to agree with the Case Review Group and relevant review partners which individuals should be included as part of the review.

There would also be communication between the SIO and the independent reviewer/relevant review partners at relevant points of the SUSR process including when the reviewer is planning engagement with the family/friends or in finalising the content of the report. However, this can be at a mutually agreed time/format.

Q38: What volume of homicides per year would have resulted in an OWHR in South Wales?

A: Since 2018, the numbers of homicides fitting the criteria for an Offensive Weapons Homicide Review was between zero and five per year across the whole of the South Wales area. In terms of wider context, homicides involving offensive weapons make up a large and growing proportion of all homicides – analysis suggests 347 of 696 homicides in England and Wales in 2021/22. Of the 696 offences initially recorded as homicides in 2021/22, we estimate that 483 did not meet the criteria for an existing review, and that 220 of the unreviewed homicides involved an offensive weapon.

Q39: Will reviews carried out in South Wales during the pilot be included in the pilot evaluation?

A: Specified areas of West Midlands and London will be taking part in the pilot alongside South Wales. While both these areas have significantly higher levels of homicide and therefore there is a likelihood of them conducting a higher number of OWHRs during the pilot, South Wales is still considered an equitable partner. Due to the uniqueness of the Welsh partner landscape in relation to devolved responsibilities, partnership structure and SUSR, the experience of South Wales will be considered at all stages of the pilot.

The OWHR pilot regions were selected to ensure we test the reviews in both England and Wales, and in areas with different profiles of homicide and serious violence. The OWHR pilot evaluation will be looking into how the process works in areas of both high and low levels of reviews, as it will provide invaluable insight which will be applicable when the policy is rolled out across England and Wales. The pilot evaluation is a process evaluation so will not be concentrated on volumes of reviews.

10: Appendices

Annex 1: OWHR scoping questions template and exploratory questions template for information gathering purposes with appropriate partners

PURPOSE

This document consists of two sections, Part A: Scoping Questions Template and Part B: Exploratory Questions Template. The purpose of Part A is to provide information about the individual/s (victim and/or alleged perpetrator/s), to the relevant review partners to enable them to decide whether or not to commission the OWHR. The individual/s to be included will be stipulated by the relevant review partners (following agreement from the SIO), in their formal request for information. The purpose of Part B is to gather more detailed information, encourage practitioners and organisations to be professionally curious, and to thereby encourage learning following the tragedy of the homicide.

TIMEFRAMES

Part A should be completed by appropriate partners and returned to the relevant review partners within the requested timeframes. To note: relevant review partners are under a legal requirement to provide a decision on the review within one month of becoming aware of the likely qualifying circumstances for the OWHR. Due to this the timeframe for returns will be short as they need to allow sufficient time for information to be received, a decision made locally, and for the notification to be sent to the Secretary of State. **It is the responsibility of the relevant review partners to make the deadline for returns explicit when providing this form**.

Part B should be completed by appropriate partners when requested and returned to the relevant review partners/lead agency or independent chair (as relevant). This additional information will be sought in the event that the OWHR is commissioned and to aid in setting the scope and terms of reference of the review. In this event, the Exploratory Questions Template may be supported by further scoping documents and detail provided by the requester. The nature of these documents will vary depending on the individual case circumstances however as a minimum they will stipulate the individual/s (victim, and/or alleged perpetrator/s) who are to be included in the request for information, as well as a guide to the time period a partner is being requested to search back into their records to identify information to fulfil the request.

PART A: SCOPING QUESTIONS TEMPLATE

OVERVIEW

Part A includes suggested questions so that the relevant review partners can decide whether the conditions set out in section 24(1) and 24(6) of the Act, as well as the accompanying regulations have been satisfied, whether the threshold for a review has been triggered (see chapter 1) and if so, which partners are likely to be required to contribute to that review.

As set out at paragraph 2.15(e), this process will enable the relevant review partners to gather the facts about the case, as far as they can be readily established at the time, by checking their own records as relevant review partners (in the area the death occurred or was likely to have occurred, or where the body or part of the body was first found, see paragraphs 1.12 - 1.17). While also contacting all appropriate bodies and asking them to produce a brief overview of their engagement with the victim and alleged perpetrator(s), (as agreed with the SIO). In addition to information held by the relevant review partners information from review partners (police, local authorities, ICB/LHBs) from the areas where the victim/alleged perpetrator(s) lived or have previously lived should also be requested, as this is likely to be key to confirming if a death is a qualifying death. Particular effort should be taken to obtain the relevant information from these partners within the one-month deadline.

In summary this could include information relating to the basic facts of the case such as:

- did the death occur in England or Wales;

- was the victim over 18

- did the death or events surrounding it, involve the use of an offensive weapon

- has the body, or part of the body been located

- has the identification of either the victim or an alleged perpetrator(s) been recorded

- can confirmation be given that the death was not a death caused by a police officer in the course of their official duties.

In addition to this, detail is needed to confirm that one or more review partners has information about, or would be reasonably be expected to have information about, the victim or at least of the alleged perpetrator(s). This ‘information’ would mean information that there is a risk the person may commit, or be a victim of, antisocial or criminal behaviour and such information includes information relating to the person’s education, antisocial or criminal behaviour, housing, medical history, mental health, and safeguarding, and does not include information that only became known to a review partner after the death of the person. See chapter 1 for further detail.

This Part A request enables information to be gathered about what was known to the review partners who were in contact with the individual/s included in the information request, prior to the homicide occurring.

The questions seek to better understand how the individual/s engaged with services, at what times, whether there was prior contact between them, and whether there is any further important information which the relevant review partners should be aware of when making their commissioning decision.

To be completed and returned to the relevant review partners within the requested timeframe. The individual/s (victim, and/or alleged perpetrator(s)) who are to be included in this request should be stipulated in the formal request for information.

Section 29(1) of the Act includes a power, which a relevant review partner can use to request information from a person for the purpose of a review, where that person's functions or activities mean that it is likely they will have information that would enable or assist the review. Such a request must be complied with, subject to provisions in section 30 of the Act. In addition, section 29(7) allows review partners to share information with another review partner for the purpose of the review. Further detail and guidance on information sharing has been provided at chapter 6.

INFORMATION REQUEST

In this section you will be asked to explain how your organisation was involved with the individual(s), and if they were not engaged, to provide further information as to why that may not have occurred/been relevant to do so. In addition, you will be asked to provide a brief chronology of your organisation's involvement with the individual(s). The following is suggested to be provided:

TITLE PAGE

a. Local reference number (including initials of police force area)
b. Identification of person/s under consideration in this template
c. Date of death under consideration for an OWHR
d. Name of your organisation, location, and lead practitioner completing this template
e. Submission date of Part A – Nil returns are required

CHRONOLOGIES AND NATURE OF ENGAGEMENT WITH PARTNERS

Please complete the below section based on your engagement with the individual/s included in this information request. Please complete a separate return for each of the stipulated individual/s.

THE INDIVIDUALS' ENGAGEMENT WITH YOUR ORGANISATION

a. Explain how the organisation was involved with the individual. If the organisation was not in contact with the individual, please provide further information as to why that may not have occurred/or may not have been relevant to do so.

b. If applicable, how did the individual get into contact with the organisation? Were they referred by another service/organisation, or by friends/family or a self-referral?

c. Provide a brief chronology that charts the involvement of the organisation with the individual. Please include details of the nature of the service provided and by whom, level of engagement and further signposting, or formal referral to other services.

d. If you have any initial information on the nature of the relationship between the individual/s, please could you outline this briefly.

INFORMATION KNOWN TO YOUR ORGANISATION

a. If applicable, provide a summary of the information known to your organisation about the individual.

b. Provide any other relevant facts or information about the individual, in addition to any other information relevant to this case.

c. Where possible, please share any relevant documentation related to the individual.

PART B: EXPLORATORY QUESTIONS TEMPLATE

To be completed when requested, **in the event that the Offensive Weapons Homicide Review (OWHR) is commissioned,** to aid in setting the scope and terms of reference of the review. This template should be supported by further scoping documents and detail provided by either the relevant review partners, lead agency or independent chair. The nature of these documents will vary depending on the individual case circumstances however as a minimum they will stipulate the individual/s (victim, and/or alleged perpetrator(s)) who are to be included in the request for information, as well as a guide to the time period a partner is being requested to search back into their records to identify information to fulfil the request.

OVERVIEW

Part B includes a list of recommended questions which partners should aim to address in their response. This template will provide the relevant review partners with further information to enable them to complete a robust, inquisitive and challenging OWHR.

The intention of Part B is to encourage organisations and practitioners to be professionally curious about the events which led up to the homicide. Importantly, the questions are not intended to focus on the conduct of individuals or organisations and apportion blame. Nor are the questions intended to solely evaluate whether procedure or policy was followed. Rather, the emphasis is on whether the policies and procedures in place allowed for effective interventions, working with local partners/bodies where required.

The exploratory questions in this template seek to understand whether the existing policy and procedure operates in the best interests of potential victims and alleged perpetrator(s) by asking if there are any lessons to be learned from this case? Additionally, are there any necessary policy and procedural changes to be made in order to improve future outcomes and prevent offensive weapons homicides from occurring? For example, could an adjustment in policy or procedure have safeguarded and supported the victim and/or alleged perpetrator(s) better?

Through adopting this challenging mindset, appropriate solutions to improve the safeguarding and support offered to vulnerable people who are at risk of becoming victims or perpetrators of offensive weapons homicide can be found. This aligns with the overall purpose of OWHRs which is to improve national and local understanding of what causes homicide and serious violence, and better equip services to prevent weapons-enabled homicides, thereby saving lives.

To be completed and returned to the relevant review partners within the requested timeframe. The individual/s (victim, and/or alleged perpetrator(s)) who are to be included in this request should be stipulated in the formal request for information.

Section 29(1) of the Act includes a power, which a relevant review partner can use to request information from a person for the purpose of a review, where that person's functions or activities mean that it is likely they will have information that would enable or assist the review. Such a request must be complied with, subject to provisions in section 30 of the Act. In addition, section 29(7) allows review partners to share information with another review partner for the purpose of the review. Further detail and guidance on information sharing has been provided at chapter 6.

INFORMATION REQUEST

TITLE PAGE

a. Local reference number (including initials of police force area)
b. Identification of person/s under consideration in this review
c. Date of death under review
d. Name of your organisation, location, and lead practitioner completing this template
e. Submission date of Part B – Nil returns are required

FOR PRACTITIONERS IN CONTACT WITH INDIVIDUAL/S SUBJECT TO REVIEW

Please complete the below section based on your engagement with the individual/s included in this information request. Please complete a separate return for each of the stipulated individual/s.

1. REFERRAL AND ASSESSMENT

a. How did the individual come into contact with your service? Did the individual self-refer, were they referred by another service, or family/friends?

b. How was the individual assessed by your service? Who was involved in this assessment?

c. Did the practitioners take action once the assessment and any relevant decisions were made in relation to the individual? Were practitioners clear on what actions they should take and which services they should refer to?

d. Did the organisation have policies, assessment criteria and procedures in place for dealing with concerns about violent behaviour and vulnerability? Were these policies, assessments and procedures put to use?

e. Were practitioners knowledgeable about the potential indicators of violence or vulnerability that the individual may have demonstrated? If so, were practitioners aware of how to act if they had concerns?

f. Were practitioners aware that the individual had previously had a weapon in their possession at any point prior to the homicide occurring?

g. What were the key opportunities for assessment and decision making in relation to the individual prior to the homicide? Does it appear that practitioners took advantage of these opportunities for assessment and decision making?

h. Do practitioners feel that there were any missed opportunities for assessment and decision making? If so, when?

2. SERVICES OFFERED

a. What services provided by your organisation did the individual access?

b. Did the individual access all of the relevant services that your organisation provides? Please explain the services that the individual accessed. If there are relevant services that were not accessed by the individual, please explain why not.

c. Did your organisation make a formal referral to another service for the individual?

d. To your knowledge, was the individual accessing any other services?

e. To your knowledge, was the individual in contact with a number of practitioners? If so, do you think the individual could have benefited from a single support person?

f. How accessible were the relevant services you provided to the individual?

g. Do practitioners feel that your organisation provided relevant services to the individual? Could your organisation have provided any additional services to the individual? If yes, what would they have been?

h. How was the organisation and practitioners sensitive to the intersectionality, wider vulnerabilities and protected characteristics of the individual?

3. OUTCOMES AND OUTPUTS

a. What was the outcome of the initial assessment carried out by your organisation?

b. Were practitioners' content with this outcome? Please explain.

c. If the individual was subsequently referred to another organisation or service, are you aware of the outcome of this referral? Please provide details.

d. Did your organisation monitor and audit the outcomes and outputs associated with the individual in this case? Please provide details.

e. Does your organisation have in place a means of monitoring and auditing the outcomes? Please provide details.

f. Do practitioners feel that this monitoring process is effective in practice? Please explain in what ways, with reference to this case and past experience where applicable.

g. Could an adjustment in policy, assessment or procedure have secured a better outcome for the individual? If so, please give details of the adjustments you would suggest.

4. INFORMATION SHARING

a. Did the organisation share information with other partners where necessary?

b. Were there any challenges in relation to data and information sharing between partners in this case?

c. Could an adjustment in the approach to information sharing with partners have improved the outcome in this case?

d. Are there any necessary changes to your organisations or the system-wide approach to information sharing in order to achieve better outcomes for individuals in future?

5. POTENTIAL LEARNING

a. What are the best practice examples and lessons to be learned from this case regarding the way in which your organisation and practitioners identify, assess and manage the risks posed by individuals?

b. In what ways could policies, assessments and procedures be improved to safeguard individuals more effectively in the future? Please consider changes within your organisation, within other organisations and system-wide.

c. Are there any system-wide lessons or best practice examples to be learned/shared from this case? Please explain.

d. If you were to go through this journey with the individual again, what changes would you like to see? These changes can be relevant to the service that your organisation provided, or they could be system-wide.

RELEVANT DOCUMENTATION

Please share any relevant documentation related to the victim and/or alleged perpetrator and/or other persons connected to the death.

Annex 2: OWHR Notification process template

OVERVIEW OF THE OWHR NOTIFICATION PROCESS AND PURPOSE

Section 27 of The Police, Crime, Sentencing and Courts Act 2022 ("the Act") requires relevant review partners to notify the Secretary of State as to whether an Offensive Weapons Homicide Review (OWHR) will take place. This must be carried out within one month of them becoming aware of such facts as make it likely that a qualifying homicide has occurred. The qualifying circumstances are set out in section 24(1) and 24(6) of the Act as well as the Police, Crime, Sentencing and Courts Act 2022 (Offensive Weapons Homicide Reviews) Regulations 2022 ('the OWHR Regulations 2022'). Guidance is provided at paragraphs 1.3 - 1.11 of the OWHR statutory guidance document.

If the death qualifies as an OWHR, the Act specifies that the relevant review partner/s are responsible for arranging and conducting the review, unless this requirement is delegated to one of themselves or another i.e. an independent chair (see paragraphs 3.14 – 3.19). The relevant review partners are identified by the criteria set out in section 25 of the Act and the OWHR Regulations 2022. Guidance is provided at paragraphs 1.12 – 1.17 of the OWHR statutory guidance document.

TIMEFRAME FOR OWHR NOTIFICATION

Once relevant review partners become aware of the qualifying circumstances of a death, the notification period begins. The notification period lasts a maximum of one month from the date that they become aware of the qualifying circumstances. Where all relevant review partners agree they could co-sign the same notification letter, and this process could also be supported by their local oversight process, however consideration should be given to the one month notification period as this will likely start earlier for some relevant review partners than others, as detailed in paragraph 2.21 of the guidance. As it is a requirement on the relevant review partners to provide a notification to the Secretary of State within that one month period it remains the individual relevant review partners responsibility to ensure it is sent as required. It is recommended that the notification be made to the Secretary of State as soon as a decision is reached by relevant review partners to enable the OWHR process to proceed in a timely manner.

For **all** OWHRs in Wales under the SUSR process we request that all notifications be sent to both the Secretary of State and the First Minister for Wales.

Please complete and submit the following template within one month of becoming aware of the qualifying circumstances.

OWHR NOTIFICATION TEMPLATE

1. **IDENTIFICATION DETAILS**

Please note, review partners may agree to co-sign the same notification letter. If this is the case, please list the names of all partners in response to (d).

a. Local reference number (including initials of police force area)

……

b. Person/s under consideration in this notification - (name of alleged perpetrator to not be included prior to charge, just provide confirmation if an alleged perpetrator is expected to be included going forwards.)

……

……

c. Date of death under consideration for an OWHR

……

d. Date of submission of this notification letter

……

e. Name of your organisation, location, and lead practitioner completing this template

……

……

……

……

2. THE NOTIFICATION PROCESS

NOTIFICATION OF DUTY TO ARRANGE A REVIEW

As relevant review partner/s, you are required to decide upon one of the following actions. Please select which option you would like to notify the Secretary of State (and First Minister for Wales where relevant).

a. that you, the relevant review partner/s, are under a duty to arrange for there to be a review of the person's death, as set out in section 24 of the Police, Crime, Sentencing and Courts Act 2022 ('the Act'). **Please explain the reasons for this decision, referring to the qualifying criteria, in the free text box below.**	
b. that you, the relevant review partner/s, are not under a duty to arrange for there to be a review of the person's death, as set out in section 24 of the Act, because the death does not meet the qualifying criteria. **Please explain the reasons for this decision, referring to the qualifying criteria, in the free text box below.**	
c. that you, the review partner/s, are not under a duty to arrange for there to be a review of the person's death, as set out in section 24 of the Act, because you are not a relevant review partner. **Please explain the reasons for this decision, referring to the definition of a relevant review partner, in the free text box below**	
d. that you, the relevant review partner/s, have not been able to take a decision on the matter. **Please explain the reasons for this delay, including any factors prohibiting you from making a decision and a timeframe for the decision to be made, in the free text box below**.	

If you selected option d, a further notification must be made to the Secretary of State (and First Minister for Wales where relevant) confirming the decision once made.

When completing the additional explanation boxes, it is not expected that detailed personal information should be included, beyond that requested on the initial page of the notification. A summary (only) and all returns should be completed with relevant data protection legislation in mind. A local reference number should be allocated (which includes the initials of the police force area, so that the case can be easily referenced locally and in discussions with the Home Office/ Oversight Board where needed, avoiding unnecessary personal information being shared.

Please provide any additional explanation or supporting evidence for your decision.

OTHER NOTIFICATION REQUIREMENTS

In the event that circumstances change, or new information comes to light following the submission of the initial notification letter, section 27 of the Act sets out other circumstances where the Secretary of State must be notified. If applicable, please select which option you would like to notify the Secretary of State (and First Minister for Wales where relevant).

a. that you, as the relevant review partner/s have previously notified the Secretary of State/First Minister for Wales that you were under a duty to arrange an OWHR, but before the review started, you have made a decision that you are not actually under a duty, see section 24(3) and (4) of the Act. **Please explain the basis for this decision in the free text box below.**	
b. that you, as a relevant review partner/s have previously notified the Secretary of State/First Minister for Wales that you are not under a duty to arrange an OWHR, but on further investigation have decided that you are under the duty. **Please explain the basis for this decision in the free text box below.**	
c. An OWHR has been discontinued because one of the conditions in section 24(1)(a) to (c) has not been met. **Please explain which conditions have not been met and how this information was gathered.**	

Please provide any additional explanation or supporting evidence for your decision.

Annex 3: Templates to aid engagement with families/next of kin

Annex 3(a) - Initial letter to the family providing notification of the decision to carry out an OWHR

Suggested initial wording for an initial letter to the family. The final letter should be personalised for the victim's family, reflecting the circumstances of their loss.

For reviews carried out in Wales under the SUSR process further guidance and templates are available in chapter 6 of the SUSR guidance[32], as well as in the accompanying toolkit[33].

[*Please add the appropriate relationship of the letter recipient to the victim throughout the template – it currently refers to 'family'*]

Dear [*INSERT NAME*],

Firstly, I would like to offer my deepest sympathies and condolences to you and your family for the loss of [*INSERT VICTIM'S NAME*].

I am writing to inform you that a decision has been made to carry out an Offensive Weapons Homicide Review by the [*INSERT RELEVANT REVIEW PARTNER/LEAD AGENCY*] in relation to your [*INSERT RELATIONSHIP*]. I know that you and your family may find this a difficult letter to receive and that we appreciate and understand that it may raise feelings linked to the loss of your [*INSERT RELATIONSHIP*].

Offensive Weapons Homicide Reviews were introduced through the Police, Crime, Sentencing and Courts Act 2022 which places a requirement on the police and local authorities in England and Wales, integrated care boards 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 involved, or were likely to have involved the use of an offensive weapon. OWHRs are not investigations into the death or designed to identify culpable parties or disciplinary processes. They also do not form part of any criminal investigation or criminal proceedings.

The reviews are currently being piloted in certain areas of London, West Midlands and South Wales prior to a decision being made on whether they will be rolled out nationally across England and Wales. [*INSERT VICTIMS NAME*] died within one of these pilot areas and I would like to reassure you that this is a legal requirement applied to all homicides which meet the criteria and has not been progressed due to any particular concerns or circumstances specific to [*INSERT RELATIONSHIP*] death.

[32] https://www.gov.wales/single-unified-safeguarding-review-guidance

[33] https://www.gov.wales/single-unified-safeguarding-review-toolkit

These reviews enable all the relevant local partners to come together to develop an understanding about the wider context and circumstances that surround a death. These local partners and bodies will review their work and identify any learning, considering whether any actions should be taken, or changes made in policies or practices to aid in preventing future homicides involving offensive weapons.

To take forward the review [*INSERT INDEPENDENT CHAIR/RELEVANT REVIEW PARTNER/LEAD AGENCY*] has been appointed to oversee the review and the production of a report setting out the findings. They would welcome the opportunity to meet with you personally to ensure that you are informed about the process and can feed into the OWHR should you wish to. Participation in the review is voluntary and if you have been assigned an advocate and would wish for them to represent you at the meeting, then they would be happy to accommodate that.

Participation in a review can enable your family to help inform the OWHR by providing a more complete picture of the life of your [*INSERT RELATIONSHIP*]. It also provides the chance for your family to contribute towards the prevention of other weapons enabled homicides in the future.

Further information about Offensive Weapons Homicide Reviews and the review process is set out in the attached leaflet.

If you would like to meet to discuss the review, please contact [*XXX*] on [*INSERT PHONE NUMBER*] or [*INSERT EMAIL ADDRESS*] to arrange a time and venue convenient to yourself. You may of course bring someone with you such as a family member or friend to support you.

Yours sincerely,
[*INSERT NAME*]

Annex 3(b) - Information leaflet for family members

Offensive Weapons Homicide Reviews

Information leaflet for Family Members

What are Offensive Weapons Homicide Reviews?

Offensive Weapons Homicide Reviews were introduced through the Police, Crime, Sentencing and Courts Act 2022 ('the Act') and require the police and local authorities in England and Wales, integrated care boards 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 involved, or were likely to have involved the use of an offensive weapon.

These reviews are separate from any criminal investigations or criminal proceedings, and they are in addition to any Inquest or other form of inquiry, if applicable.

The purpose of Offensive Weapons Homicide Reviews are to identify any lessons which may be able to be learnt in relation to the death and to consider whether there is any action which should be taken as a result to aid in preventing future homicides. The review will bring together all the relevant local partners to develop an understanding of the wider context and circumstances that surround a death. These local partners and bodies will review their work and consider whether any changes need to be made in policies or practices to aid in preventing future homicides involving offensive weapons. The reviews are not investigations into the death or designed to identify culpable parties or disciplinary processes.

The reviews are currently being piloted in certain areas of London, West Midlands and South Wales prior to a decision being made on whether they will be rolled out nationally across England and Wales. If a decision is made to carry out a review it means that the death has occurred within one of these pilot areas, and the criteria has been met which requires a review to be completed. This is a legal requirement applied to all homicides which meet the criteria and is not due to any particular concerns or circumstances specific to a death.

Who will undertake the review?

As set out in the Act, and the Police, Crime, Sentencing and Courts Act 2022 (Offensive Weapons Homicide Reviews) Regulations 2022, the relevant review partners for a review are the police, local authority, integrated care board (in England) or local health board (in Wales) in the area where the death occurred. These partners will come together with their local oversight process (either the Community Safety Partnership, the Police and Crime Commissioner/Deputy Mayors for Policing and Crime, Violence Reduction/Prevention Unit or the Case Review Group in Wales), to consider the facts of the case and determine whether the death meets the criteria and if an Offensive Weapons Homicide Review should take place. Moving forwards either the three review partners (known as the relevant review partners), a lead agency chosen from the relevant review partners, or an

independent chair will be responsible for conducting the review as well as agreeing the scope or Terms of Reference for the review.

Your involvement in the review

As part of the review, family members, friends and other people who knew the victim, and where appropriate the alleged perpetrator/s, will be offered the opportunity to speak to the relevant review partners/lead agency or independent chair. While the review is based on information collated from partners and relevant organisations in the area where the incident occurred/the individuals lived, information from family members, friends and others help to provide a fuller picture of the individuals lives. Family and friends can help in providing wider context and a level of understanding of their life and experiences of an individual prior to the incident, which will otherwise be lost. Participation in the review is purely voluntary but family members may benefit from having the opportunity to have their voices and the voice of their loved one heard.

Taking part in the review

If you wish to take part in the review, you will be contacted by either the relevant review partners/lead agency or independent chair. They will provide further information on the purpose of a review, the process which will be followed and proposed timeframes for its completion and will then invite you to share your thoughts, memories and point of views on any aspect of this tragedy and the time leading up to it.

You can provide your thoughts and views in all or some of the following ways:

- in writing or via a recording;
- via a telephone conversation;
- face to face meeting with the relevant review partners/lead agency or independent chair. This meeting would be in a location of your choice, and you would not be asked to share your thoughts under oath. They would ask questions to assist the discussion and the whole process would last no longer than a few hours or as long as you feel able to participate.

If you do not feel able to participate directly in the review, you can suggest an alternative member of the family or a friend who could represent you at the meeting. Alternatively, if you have been assigned an advocate you can ask for them to represent you at the meeting.

What happens to the information you share?

The information you share will help to build a comprehensive picture of what happened before the incident and in turn help to identify any learning and whether any changes need to be considered to policies or practices to aid in preventing future homicides involving offensive weapons. Any recommendations would be put into an action plan.

Your input will be confidential, and you will not be named in the review report. Any information provided will be protected and held in line with the Data Protection Act 2018 and UK-General Data Protection Regulations. It will be held securely by the relevant

review partners/lead agency/independent chair. In certain circumstances, it might be shared under the Criminal Procedure and Investigations Act 1996 if deemed relevant to the criminal investigation or proceedings.

How long will the review process take?

Offensive Weapons Homicide Reviews will start one month after the incident. The reviews should normally be completed within about 12 months, although with very complex cases this may be longer. You will be kept updated on the estimated timeframes for the review.

What does the review produce?

The review will produce a detailed report which will include recommendations on potential actions. The Secretary of State must publish or make arrangements for the publication of the report. When nearing the end of the review process, the relevant review partner/lead agency/independent chair will be able to talk you through the final draft of the report and the publication process and timelines.

Next steps

The decision to take part in this review is entirely yours and if you do not wish to take part your decision will be respected. The relevant review partners/lead agency/independent chair will continue to keep you informed (through a method of your choice) at key points of the process, even if you do not choose to be directly involved. If you have an assigned advocate, you may wish for them to be your point of contact throughout the review.

Further information and support

[DN: Areas to identify suitable support services and helplines]

Annex 3(c) - Letter to family on completion of the review

[Please add the appropriate relationship of the letter recipient to the victim throughout the template – it currently refers to 'family']

Dear [*INSERT NAME*],

I am writing to you to let you know that the report for the Offensive Weapons Homicide Review in respect of your [*INSERT RELATIONSHIP AND NAME*] has been completed.

[If draft report is shared in advance of the meeting, then this text should be considered for use:

As the [*INDEPENDENT CHAIR/RELEVANT REVIEW PARTNER/LEAD AGENCY*], I would like to arrange a meeting with you at a time and venue convenient to you in the coming weeks. We have provided you with a copy of the report in order to give you the opportunity to read and consider it. When we meet, I would like to discuss the report with you before it is published. I would be grateful if you could contact me on [*INSERT PHONE NUMBER*] or by e-mail [*INSERT EMAIL ADDRESS*] to confirm a suitable location, date and time. You may of course bring someone with you such as a family member, friend or advocate (if assigned) to support you. I am conscious that receiving the report may be distressing and if you feel that you need more time to be able to fully read the report then please get in touch with me.

[If the draft report is being shared at the meeting, then this text should be considered for use:

As the [*INDEPENDENT CHAIR/RELEVANT REVIEW PARTNER/LEAD AGENCY*], I would like to arrange a meeting at a time and venue convenient to you in the coming weeks. At this meeting, I would like to share a copy of the report and discuss the content with you. I would be grateful if you could contact me on [*INSERT PHONE NUMBER*] or by e-mail [*INSERT EMAIL ADDRESS*] to confirm a suitable location, date and time. You may of course bring someone with you such as a family member, friend or advocate (if assigned) to support you.]

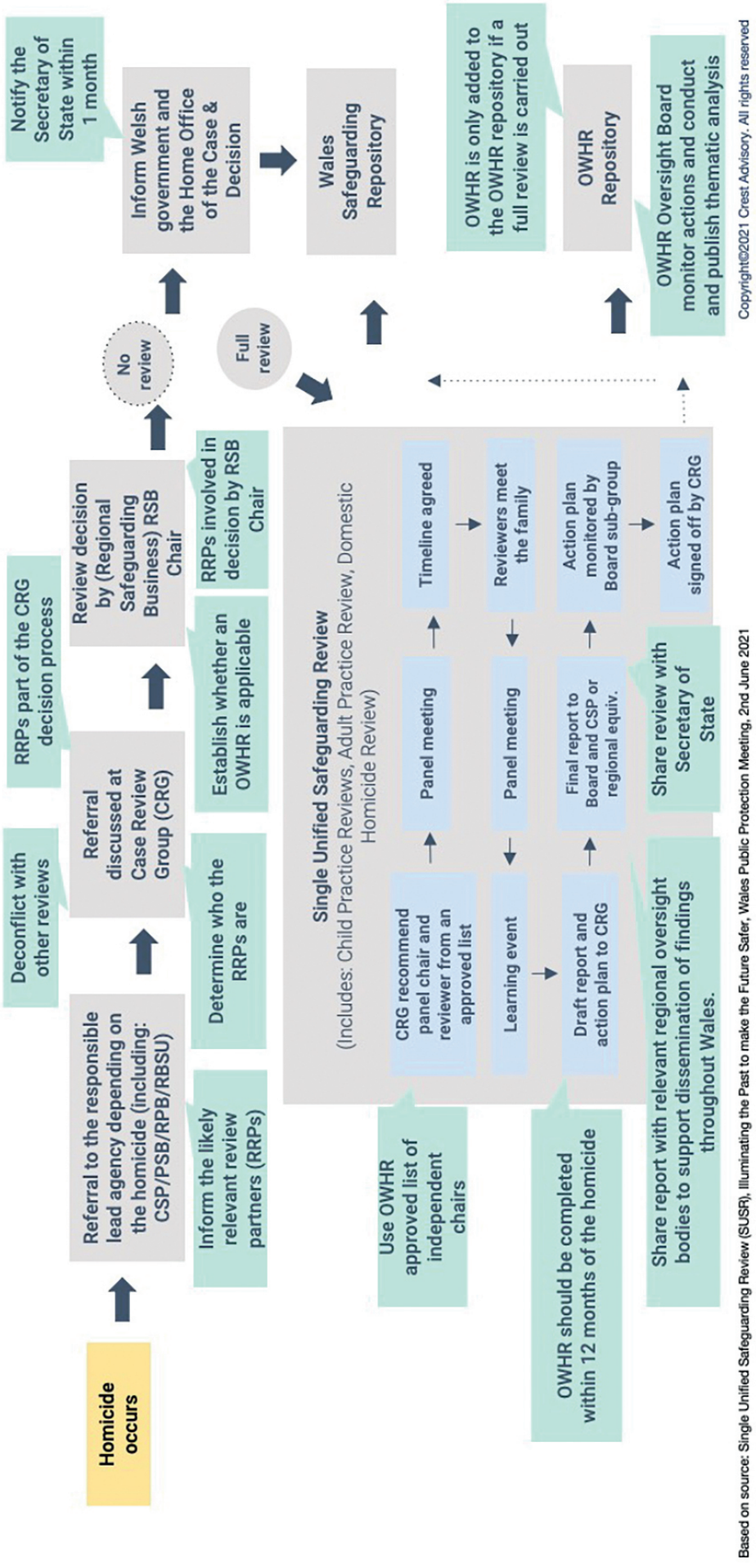
This meeting will allow us to discuss the content of the report and any recommended actions and how we have handled any contributions which have been provided by you or other family members. I will not be in a position to discuss anything related to any ongoing criminal investigations and criminal proceedings related to the death of [*INSERT VICTIM NAME*] as these are completely separate from the Offensive Weapons Homicide Reviews process. It will also allow me to set out the process for the publication of the report by the Home Office.

Should you decide that you do not wish to meet then please let me know at [*INSERT PHONE NUMBER*] or by e-mail [*INSERT EMAIL ADDRESS*]. If you have been assigned an advocate and would wish for me to meet them as your representative, then I would be happy to do so.

Yours sincerely,

[*INSERT NAME*]
[INDEPENDENT CHAIR/RELEVANT REVIEW PARTNER/LEAD AGENCY] of Offensive Weapons Homicide Review

Annex 4: Process chart for OWHR delivery within the SUSR in Wales



Annex 5: OWHR Review Report Template (England)

Note – the template contains drop down boxes which are accessible in the online version of the statutory guidance.

This template has been based on the SUSR report template for reviews in Wales. Amendments have been made to apply this form to OWHRs alone, as required in England. OWHRs carried out under the SUSR process in Wales should continue to use the SUSR template provided within the SUSR statutory guidance. Chapter 7 of the OWHR statutory guidance provides further detail on the completion of an OWHR report.

Name of Relevant Review Partners (*where an Offensive Weapons Homicide has occurred)*.

Case Reference Number:

Pseudonym 1:
Please copy and paste the appropriate number of pseudonyms.

Victim 1

Pseudonym 2:
Delete if N/A

Victim 1

Pseudonym 3:
Delete if N/A

Victim 1

Date of incident which led to the Review:
If unknown, please state this. Please keep this date vague (mm/yyyy) in order to ensure anonymity for the subject of the Review.

Or: Non Applicable

Date of death where applicable:
If unknown, please state this. Please keep this date vague (mm/yyyy) in order to ensure anonymity for the subject of the Review.

Or: Non Applicable

Review's start date (commissioned):

Review completion date (approved and signed off):

Publication date:

Explain any reasons for delay in completion (this should include any additional delays other than due to a criminal trial).

Outline of circumstances resulting in the Review:

To include here:

- Details of decision to undertake a Review. The methodology, what documents were used/whether interviews were undertaken. Make reference to the scope/Terms of Reference of the review.
- Reference to Review Panel Members and local oversight process for the OWHR.
- A succinct anonymised account of the circumstances resulting in the Review (background)
    - Where the subject of the Review lived and where the incident took place. Consideration of a pen-portrait as well as a synopsis of the incident.
    - If applicable/able to be disclosed, details of the Post-mortem and inquest and/or Coroner's inquest if already held. State the cause of death.
    - Anonymised summary of those with a connection to the death (if applicable)If applicable, how the victim and perpetrator had been ' connected' to each other and the duration of that connection.
    - If applicable/able to be disclosed, note the criminal justice activity associated with the incident, including relevant dates and outcomes. This could include detail on charges being brought, trial and sentence.
- Time period reviewed and why

An OWHR was commissioned by……. the Relevant Review Partners for the death, in accordance with the OWHR Statu*tory Guidance. The criteria for this Review are met under:*

Equality and Diversity:

Address the nine protected characteristics under the Equality Act 2010[34] to the Review. Include examining barriers to accessing services in addition to wider consideration as to whether service delivery was impacted.

Make reference to:

age; Or Non Applicable

disability; Or Non Applicable

gender reassignment; Or Non Applicable

[34] Equality Act 2010. Equality Act 2010 (legislation.gov.uk)

marriage and civil partnership; Or Non Applicable

pregnancy and maternity; Or Non Applicable

race; Or Non Applicable

religion or belief; Or Non Applicable

sex; Or Non Applicable

sexual orientation; Or Non Applicable

socio-economic disadvantage; Or Non Applicable

Involvement of family/next of kin and other relevant persons:

Include when people were contacted and by whom; the nature of their involvement and whether they have been provided with the relevant OWHR information leaflet. Add when involvement was not possible and why. Include whether identified family/next of kin and other relevant persons, where appropriate:

- have had the opportunity to access help of a specialist and expert advocate
- had the scope/terms of reference shared with them
- been updated regularly
- reviewed the draft Report in private with plenty of time to do so and have the opportunity to comment. Where comments from family members and principal individuals could not be met in the Report an explanation should have been provided back to them and explained in this section.
- All those contributing were able to do so using the medium they prefer after consideration of their specific needs.

Please consider chapter 4 'The role of the family, friends and other networks in OWHRs' in the OWHR Statutory Guidance and refer to it where appropriate.

Please copy and paste the appropriate number of instances.

Family declined involvement ☐
Please indicate which family member declined involvement:

Where appropriate provide further information on the decision of the family not to engage.

Please copy and paste the appropriate number of instances.
Alleged perpetrator(s) family declined involvement ☐
Please indicate which family member declined involvement:

Where appropriate provide further information on the decision of the alleged perpetrator(s) family not to engage.

Family History and/or Contextual Information:
Succinct summary of key significant events, prior to the agreed timeline.
Include any relevant information which falls outside the scope of the official agreed timeline for the Review. This space can be used to include any contextual information on the wider information which the incident occurred within, as well as other individuals with a connection to the death, which is **relevant to the learning in this case.**

Agency Timeline:
Succinct summary of key significant events, within the agreed timeline. Please see the OWHR Statutory Guidance for information on the scope of the Review.

Provide a succinct combined narrative timeline charting relevant key events/contact/involvement with the subject, the alleged perpetrator and their families by agencies, professionals and others who have contributed to the review process.
(If available, include an anonymised genogram at the start of the chronology)

Practice and organisational learning:
Identify each individual learning point arising in this case (including highlighting effective practice) accompanied by a brief outline of the relevant circumstances (how/why events occurred, information that was shared, decisions that were made, and actions that were/were not taken).

(Relevant circumstances supporting each learning point may be informed by what was learned from the victim/alleged perpetrator(s) contact with different services, the perspective of practitioners and their assessments and action taken, consider inclusion of family members' perspectives, evidence about practice and its impact, contextual factors, and challenges).

This section should address the terms of reference and the key lines of enquiry within them. It is also where any examples of good practice should be highlighted.

Improving Systems and Practice (National, Regional and Local):
To promote the learning from this case the review identified the following actions and anticipated improvement outcomes:

(Please consider each learning point in the above section. What needs to be done differently in the future and how this will improve future practice and systems to support practice? As set out in Section 28 (2) and (3) of the Act where it is considered that it may be appropriate for a person to take action in respect of those lessons learned, indicate if they have informed that person – personal details should not be included, see paragraph 7.14 of the OWHR statutory guidance) Tap to enter text.

Dissemination
List of recipients who will receive copies of the Review Report (in line with guidance and due to the recommendations of this Report): Please copy and paste the appropriate number of instances.

Date circulated to relevant policy leads:

Organisation	Yes	No	Reason
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	

OWHR process

To include here in brief:

- The process followed by the relevant review partners/lead agency/ independent chair
- Any information sharing session which was held and the services that attended

Final confidence check

This Report has been checked to ensure that the OWHR process has been followed correctly and the Report completed as set out in the statutory guidance.

I can confirm that this Report section is at a standard ready for publication ☐

Once completed this report needs to be sent to the Secretary of State for the Home Office. Tick to confirm this has been completed. ☐

Statements of Independence

Statement of Independence by Chair: Please read and sign the following statement. Consider the section on independence in the OWHR Statutory Guidance before completing
Chair 1:
Statement of independence from the case I make the following statement that prior to my involvement with this review: • I have not been directly involved in the case or any management or oversight of the case. • I have the appropriate recognised knowledge, experience and training to undertake the review. Therefore, I have met the criteria of an Independent Chair. • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference. I recognise that the purpose of this is to identify learning from the case, not to attribute blame to practitioners or agencies. • I have read and understood the equality and diversity considerations and will apply accordingly.
Please set out below how you meet paragraphs 3.14 – 3.19 of the OWHR guidance *Guidance: Explain the independence of the chair and give details of their career history and relevant experience. Confirm that the chair has had no connection with the relevant review partners or local oversight process for this review. If they have worked for any agency previously state how long ago that employment ended:* [ ]
Signature: [ ] **Name:** [ ] **Date:** [ ]

To be completed by the Home Office:

Please tick here to confirm that the Chair was appointed from the Independent Chairs List held by the Home Office: ☐
If the Chair is not a member of the Independent Chairs List, then please give detail to confirm how the alternative Chair fully meets the Competencies set out in the OWHR guidance. [ ]

Scope/Terms of Reference

To be included in line with section 2 of the OWHR statutory guidance

Annex 6: Large scale process map

* Boxes with a red outline are legislative requirements.

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