Name of Relevant Review Partners West Midlands Police, Birmingham City Council and NHS Birmingham and Solihull Integrated Care Board.
Case Reference Number: BCSP OWHR 0003
Pseudonyms: Victim 1 - Khaled Perpetrator 1 - Michael
Date of incident which led to the Review: June 2023
Date of death where applicable: June 2023
Review's start date (commissioned): 01/09/2023 **Review completion date (approved and signed off):** 13/11/2024 **Publication date:** 08/05/2025 Delay in publication due to clarification of process at both the Home Office and local level.
Outline of circumstances resulting in the Review: **Summary of Incident:** During an evening in June 2023, at approximately 2000hrs, a call was received by West Midlands Police from West Midlands Ambulance Service reporting they were en route to a bus stop in Birmingham, following a report of a male with a stab wound to the chest. On officers' arrival cardiopulmonary resuscitation (CPR) was being carried out. The victim Khaled[1], a 42-year-old man was conveyed to hospital, however he succumbed to his injuries and was declared deceased within an hour of the incident. He died of a single stab wound from a knife to the chest. The

[1] Not his real name, this pseudonym for the victim will be used throughout the report.

stabbing occurred following a dispute between Khaled and the offender Michael[2], during a drug-dealing transaction.

Michael was identified and arrested two days later and subsequently charged with murder. At his trial in February 2024 for the murder of Khaled, Michael was convicted of manslaughter and subsequently sentenced to 17 years imprisonment.

In accordance with the criteria for review under Section 24 (1) of the Police, Crime, Sentencing and Courts Act 2022, an Offensive Weapons Homicide Review (OWHR) was commissioned by the Birmingham Community Safety Partnership (BCSP), on behalf of the Relevant Review Partners for the area where Khaled's death occurred.

Chris McKeogh, a Home Office Offensive Weapons Homicide Review Independent Chair was commissioned to lead the OWHR in September 2023. The review has been conducted in accordance with the prescribed methodology of the Offensive Weapons Homicide Review Statutory Guidance (March 2023). The report of the Review's findings was presented to the West Midlands Violence Reduction Partnership OWHR Strategic Oversight Group in July 2024.

The Review Partners were:

Birmingham City Council Housing Management (BCCH)
Birmingham Community Safety Partnership (BCSP)
Black Country Healthcare NHS Foundation Trust (BCHFT)
Black Country Integrated Care Board (BC ICB)
Birmingham and Solihull Integrated Care Board (BSOL ICB)
Sandwell Community School (SCS)
Sandwell Children's Trust (SCT)
West Midlands Police (WMP)

The Terms of Reference for the review were set to achieve the following Home Office OWHR strategic objectives:

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

[2] Not his real name, this pseudonym for the perpetrator will be used throughout the report.

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.

With the defined purpose (as specified in section 28(2) of the Act):
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.

Additionally,
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.

The scope of the review was set at 2 years prior to the incident for Khaled. For the perpetrator Michael, it was agreed it would cover his entire life (c18 years). Michael, whilst known to police had no previous convictions, was charged with murder and subsequently found guilty of manslaughter. He has had contact with partner agencies during his life and the Review Panel were keen to understand all touchpoints and interactions with the partnership system.

OWHR Methodology:
Review Partners returns of OWHR Guidance Part A (Scoping) and Part B (Exploratory) Questionnaires.
Review Partner Panel – challenge sessions (assumptions and conclusions), identify further and new key lines of inquiry.
Meetings with Review Partner leads.
Meeting with the victim Khaled's ex-wife, Khloe[3].

[3] Not her real name. This pseudonym will be used throughout the report.

Meeting with the perpetrator, Michael. Consult neurodiversity expert advisor, Professor Amanda Kirby. Review Violent Crime research papers (Eg. Crest Advisory). Draft report – Review Panel challenge session. Final Draft report – Review Panel ratification. Final Draft Report to BCSP OWHR Oversight Board.
Equality and Diversity: The Chair and the Review Panel considered the protected characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, and sexual orientation throughout the OWHR process. At the first meeting of the Review Panel, it was identified that the following protected characteristics would require particular consideration: **age**; Michael was 18 years old at the time of the homicide. He had no previous convictions and as a child was known by partner agencies to have special educational needs (social, emotional, health). Subsequently the Review has given attention to transitional support arrangements. **disability**; Michael was diagnosed with Attention Deficit Hyperactivity Disorder when he was 14 years old. **socio-economic disadvantage**; Khaled was unemployed, recently displaced from local authority housing, subsisting on state benefits. There are recognised 'adverse childhood experiences' for Michael. The consideration of any contributory effect of Michael's ADHD and adverse childhood experiences has benefited from the specialist advice of Professor Amanda Kirby[4].

[4] See Page 37 for Professor Kirby's biography.

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

Khloe is the ex-wife of Khaled and was visited by the Independent Chair in March 2023. The visit was facilitated by West Midlands Police Family Liaison and took place post Michael's conviction.
The timing of the meeting was set to accommodate the trial outcome and was previously agreed with Khloe. The terms of reference for the review were shared beforehand and she was able to provide valuable contextual information. Khloe later provided her preferred pseudonyms for her and Khaled. Khloe was complimentary of the support given by WMP and assured the Chair she was satisfied and had no further support needs.
A draft of the report was shared with Khloe who asked for a minor revision, which has been made for this final version.
The Chair visited Michael in prison, post his sentencing. He was amenable to the visit and provided contextual information to the homicide.

Family History and/or Contextual Information:

Khaled

1. Khaled came to England in 2006, stating he was from Kuwait and wished to claim asylum. He possessed and used documentation in a false name and in January 2008 was granted asylum under that name. He would later disclose to Khloe, that he was in fact Egyptian and that he had told authorities incorrect details in order to gain asylum in the United Kingdom.

2. He met Khloe in 2011, who was studying Islam and practising the religion. They married in 2012 and have three children who are 5, 10 and 11 years old. They were living together in social housing property. They separated in 2018 whilst Khloe was pregnant with their third child. Khaled had held a tenancy for a social housing flat since 2013, which he would regularly stay at during the marriage. He moved there permanently in 2018 following the separation.

3. Khloe describes Khaled as a man who was observant of Islamic traditions, helpful to others in the neighbourhood and adoring of his children. They primarily subsisted on state benefits, which Khaled would supplement with 'cash in hand' work as a chef. His wife was aware of occasional casual relationships he had with other women. She knew him to be a regular user of cannabis.

4. Khaled's mother and younger sister both live in Egypt. His father is deceased. Khaled was connected to 15 reports of crime prior to his murder, dating back to 2011. He was recorded as a victim on three of the reports, the last being a wounding assault in 2022. He has offences recorded against him for; soliciting another for the purpose of obtaining their sexual services (2017), possession of a Class B drug (cannabis) (2017); rape of a female aged 13-15 (2018). At the time of Khaled's death, he was awaiting trial for the alleged rape of a child aged 13-15 years.

5. Khaled was technically homeless, having in the days before the homicide been displaced from his council residence due to bail conditions applied for the safety of his girlfriend following a domestic abuse offence. He was a frequent user of Class A (cocaine, crack cocaine) and Class B (cannabis) drugs.

6. There is no information to show that Khaled had any previous personal relationship with the perpetrator, Michael, before the day of the homicide. It is assumed any prior contact would be based purely on the business of transacting drugs, the frequency of which is unknown.

Michael

7. The perpetrator, Michael, is an 18-year-old man, who whilst known to police and partner agencies has no previous convictions. He is the youngest of 4 siblings and was diagnosed with attention deficit hyperactivity disorder (ADHD) when he was 14-yrs-old. Michael has special educational needs (social, emotional, health). He attended a mainstream school, receiving fifteen fixed-term exclusions for assaults, bullying, damage and 'other'. He was subsequently permanently excluded and schooled at a pupil referral unit.

8. Michael and his family first came to Sandwell Children's Trust (SCT) notice in 2009, initially with concerns of physical chastisement by the father to an elder sibling, behavioral issues of the same sibling (Sept 2012), risk associated to Michael's father's prison release following a 67-month sentence for robbery (Oct 2017), father's physical chastisement of elder sibling (2019) and domestic abuse by the same sibling on his mother (June 2020).

9. During their involvement with the family, assessments were routinely made by SCT. Michael rarely engaged and when he did, he made

no disclosures and was never considered to be at risk. He is not the direct focus of SCT attention until June 2022, following an assault which is detailed later.

10. When Michael moved into 'exempt accommodation service' housing in April 2023, his father did so at the same time. His father was a daily Class A and Class B drug user, declaring to the service provider that he used methadone for his depression and anxiety, and heroin, crack cocaine and cannabis for recreation.

11. Michael describes his father as his 'Drug Dad', referring to his want and need for drugs and putting that before his family or fatherly responsibilities. He states that he loves his father and is fully aware of his addiction. Michael states that he chose to avoid Class A drugs, preferring cannabis which he would use to calm his anger issues.

12. Michael has been estranged from his mother for many months, citing her lack of understanding or care for his needs or wants.

Agency Timeline:

13. As stated previously, there is no meaningful intersectionality between the lives of Michael and Khaled prior to the incident of the homicide. The timelines for them will be presented separately.

Michael

14. From Nov 2018 Michael attended Sandwell Community School (SCS), a Pupil Referral Unit, having been permanently excluded from his previous school. His behaviour at SCS gave rise to 41 various incidents of: assault on peer, assault on staff, aggressive behaviour, damage to school, bullying or theft. Following an incident Michael would receive mentoring to explore his behaviour and how he could have handled or expressed himself differently in situations.

15. During his time at SCS, Michael refused to take his ADHD medication, a decision supported by his parents. Contact was made by SCS staff with Child and Adolescent Mental Health Services (CAMHS) to see if this decision could be overridden, as it was clear to SCS staff that his behaviour was deteriorating. It is the case that parents have the right to stop their children from taking medication and (with exceptions) it cannot be overridden.

See Improving Systems and Practice below.

16. In November 2019 Michael made a make-shift weapon, a broken plastic plate and using the serrated edge, caused bleeding to another student. The school police liaison officers were informed. The student did not want to make a formal complaint. In the subsequent reflective session about the incident Michael said it was 'banter' and could not see what the issue was. This was of concern to SCS staff and he was subsequently referred to the school counsellor to explore his way of thinking and why he feels violence is the only way to express himself. Michael refused to engage with the counsellor.

17. Michael was 'voluntarily' interviewed by police in 2019 for having a bladed article on school premises. The matter was filed with no further action against him. His account in interview was plausible in that he had taken the knife from another student and then handed it to the teacher. The latter part of this statement where he handed the knife to the teacher was corroborated by the teacher. Michael did not threaten or show anyone else the article. His school mentor was aware of the incident and the police officer in the case contacted the local offender manager for youth crime so he could monitor if he was connected to other similar offending.

18. Michael's physical and verbal aggression continued, believed to be linked to not taking his medication and despite numerous interventions of mentoring and revised timetabling, his behaviour did not improve and so the school found alternative provision for him. In September and October 2020, he was on placements at local builders' companies, but these were to be cancelled due to lack of engagement from Michael.

19. In April 2021 Dudley Children's Services (DCS) referred into Sandwell Children's Trust (SCT) that Michael's adult sibling had assaulted his girlfriend's mother and there was potential transferrable risk he could pose to Michael. The sibling was arrested and bailed to live with Michael and the family in Sandwell. Michael's mother did not believe the sibling posed a risk to the family or Michael**.**

20. Michael was subsequently seen by SCT on three occasions in May, June and July 2021, with an eventual outcome of no further action.

His mother minimised the elder sibling's actions in the aforementioned assault, citing self-defence. Michael presented as confident and of an age and maturity where he could remove himself from situations if needed. It was noted that he was significantly bigger than his elder sibling and he was not someone easily intimidated by others. Police were still considering matters regarding the elder sibling but no continuing role for a Social Worker in respect of Michael was identified. He had raised no worries or concerns and expressed feeling safe at home.
See Practice and Organisational Learning below.

21. Michael first came to police notice after leaving school in Sept 2021, when he is alleged to have produced a machete whilst in an argument with two others, over remarks made about a friend. No machete or other weapon was found and there were inconsistencies in accounts given to the police. Michael was a juvenile and taken home by officers and the inquiry continued for a few weeks until the alleged victim withdrew the complaint. The bladed article matters were 'filed', with no further action taken against Michael.

22. In June 2022, Michael was arrested for a domestic abuse incident involving his ex-girlfriend. It is reported he entered the property through the unlocked front door, ran upstairs and produced a large vodka bottle, hitting his ex-girlfriend's current boyfriend over the head, multiple times with it. The bottle smashed over the boyfriend's head. In trying to protect her boyfriend, some of the glass has collaterally hit Michael's ex-girlfriend to her head. The boyfriend had a small open wound behind his left ear and a large swelling to the area, the ex-girlfriend had a small open wound to the top of her head and some blood loss. Michael fled the scene.

23. Both complainants failed to engage with the investigation and Michael adopted a 'no comment' response when interviewed. The matter was subsequently filed with no further action taken against him.

24. A Domestic Abuse Risk Assessment (DARA) was completed with the ex-girlfriend, who was graded 'high risk'. She was listed for Domestic Abuse Screening (DAS) and referred to a Multi-Agency Risk Assessment Conference (MARAC) and appropriate measures were put in place.

25. Michael's mother minimised the incident and declined to consent to any further involvement or support from Sandwell Children's Trust or Early Help. There were no immediate safeguarding concerns for Michael identified, which would have been needed to support parental consent being overridden for the threshold for a multi-agency strategy meeting to be met. The contact was therefore closed.

26. In October 2022, a 'Clare's Law' Application (Domestic Violence Disclosure Scheme) was received by WMP from Michael's sister, who was concerned that he was in a relationship with a girlfriend who assaulted him. WMP held no relevant information to share with the sister and advice was given.

27. In November 2022, West Midlands Ambulance Service attended to Michael who was found unresponsive, believed due to a 'recreational' drug overdose. His girlfriend reported daily marijuana and cocaine use and an attempted hanging by him the previous week. Michael was taken to hospital, treated and referred to Mental Health Liaison Service. The referral was not accepted as Michael had not consented to assessment and there was no indication that he lacked capacity to make the decision to decline. He did opt for alternative support following discharge.
See Practice and Organisational Learning below.

28. In December 2022, Michael's General Practitioner conducted a review following the admission to hospital in November. Michael denied self-harm or attempting to hang himself, stating he was just 'playing/messing around with a string and it was a superficial injury'. He elected to speak to Improving Access to Psychological Therapies (IAPT). The Crisis team number was supplied to him and the appropriate referral was completed by the GP for 'ongoing low mood'. The referral was to later be closed due to no response or engagement from Michael.
See Practice and Organisational Learning below.

29. In February 2023, WMP respond to a call that Michael was choking his girlfriend in the park. His girlfriend was a reluctant and unwilling victim, who was taken home to her mother. A DARA was completed, with his girlfriend denying any violence from him to her. Her mother expressed a contrary view, stating Michael always hit her. His girlfriend was graded as 'high' risk due to independent witness

observation of the strangulation. The investigation proceeded based on the independent witnesses but was later closed due to lack of evidence and the girlfriend choosing not to complain or engage further. The matter was filed with no further action against Michael.

30. In April 2023, seven weeks prior to the homicide, Michael took residence at an 'exempt accommodation service' housing provision, where he was allocated a support worker with whom he had regular contact. There are no adverse reports from the service provider about his behaviour. At initial assessment he shares that he suffers with anxiety and depression, has anger issues and that he uses cannabis and alcohol on a frequent basis to keep himself calm. He self-declared that his cannabis habit cost £20-30 per day. He does not use prescribed medication and has chosen not to accept anger management support.

31. Michael is reported to 'keep himself to himself' and other than feedback for an untidy room and missing the occasional support session, his conduct is unnoteworthy.

32. Michael's welfare payments did not cover the costs for the accommodation and service, an additional £17 per week before food was required. He was selling Class A drugs, realising a disposable income upwards of £500 daily. His 'patch' was proximate to his accommodation and included the bus-stop which would become the scene of the homicide.

Khaled

33. The scope for Khaled is 2 years prior to the incident. In reviewing the timeline there are incidents of domestic abuse in the months, weeks and days leading up to his death. These are not directly relevant to his homicide but are included to provide a picture of his lifestyle and to take the opportunity to capture any learning relevant to partner agency handling of domestic abuse.

34. In January 2022, Khaled and his flat were attacked. He explained to ambulance staff that he had consumed drink and drugs with a friend who 'flipped' and assaulted him, causing a broken hand. A different account was given to police by the other party, who claimed a fallout occurred because he accused Khaled of engaging in sexual conduct with an underage female. Khaled broke his hand when he angrily punched a wall. No further action was taken due to lack of

engagement by Khaled and the absence of sufficient independent evidence.
See Practice and Organisational Learning below.

35. In April 2023 police attend Khaled's flat, responding to a reported domestic dispute taking place between him and his girlfriend. The dispute is reported to be related to the girlfriend's continuing drug use. Police attend with the outcome being a completed DARA and referrals for both parties for mental health and drugs.

36. 4 days later Khaled's girlfriend reported to WMAS that he was having a seizure. WMAS responded and hospital attendance was advised but declined by Khaled (who showed no issues with capacity). His girlfriend reported daily use of cocaine by Khaled and that there was a physical fight between them prior to seizure.

37. In May 2023, Khaled's girlfriend was found half-naked in the street, with a broken finger after an altercation with him following a dispute over money. The girlfriend chose not to cooperate, refused to go to hospital, refused to have her injuries photographed or engage with the DARA process. In interview Khaled made a full denial and in the absence of other evidence, no further action was taken. Appropriate referrals were completed, with the matter due for MARAC hearing on a date post the homicide.

38. 3 days later police are called to a domestic incident at Khaled's flat. He was taken to hospital due to drug (crack cocaine) induced symptoms and behaviour. His girlfriend made violence and sexual offence allegations but beyond this was reluctant to cooperate any further on the day. A common assault charge was authorised and Khaled was remanded into custody. Whilst he was in custody, officers re-visit his girlfriend who on this occasion allows them to view her injuries, record them and provided history regarding their relationship. She stated that the assaults were becoming a daily occurrence and were worse when Khaled was under the influence of drugs, stating he was a regular crack cocaine user. She further stated that she believed he would kill her one day, that he had told her this and he had encouraged her to leave him. She added that Khaled controlled her and was jealous. Several attempts were made by officers to encourage her to support a prosecution, but she was not inclined to take the matter further.

39. Khaled was bailed by the courts 2 days later, with a GPS 'tag' and on condition to keep away from his girlfriend. Given that his girlfriend was occupying his flat, this effectively rendered Khaled homeless.

40. The following day Khaled made a homeless application explaining he was on bail for domestic violence offences and that his partner was resident at his address. He was advised to consult with police, return with proof of tenancy and to seek out a bail hostel.
See Practice and Organisational Learning

41. 2 weeks later in June 2023, WMP receive a report that Khaled is present at his flat and therefore in breach of his bail conditions. Police were not dispatched.

42. 3 days later, one hour before Khaled's homicide, WMP receive a report from a witness hearing "Where's the money?", followed by "Ouch" and sounds of violence coming from Khaled's flat. Given the domestic abuse history and risk markers for the address, a priority response was allocated with officers arriving 40 minutes later. There was no reply at the address or from the girlfriend's telephone. The caller re-iterated their account, the premises appeared empty and the attending officers judged that there were insufficient grounds to justify forced entry. A re-visit was arranged.
See Practice and Organisational Learning below.

43. Within the next hour Khaled is killed by Michael at a nearby bus-stop. Khaled had gone to the area, in company with his girlfriend (in breach of bail conditions) to buy Class A drugs. Michael was the seller and during the transaction, an altercation has occurred resulting in Michael fatally stabbing Khaled in the chest with a knife. The knife was never recovered.

44. The subsequent post-mortem confirmed a single stab wound, about 9 cm deep. It had gone straight through Khaled's clothes into the chest, causing some damage to the rib area, and right into the heart. A moderate degree of force had been used. There were no defensive injuries.

Summary:

45. During his school years, Michael exhibited anti-social and aggressive behaviours that eventually resulted in expulsion. During his time at his subsequent placement at a pupil referral unit, he

found himself subject of 41 separate reports of aggression, bullying, theft, assault and violence. Staff describe his behaviour as 'ever worsening', apparently exacerbated by his unwillingness to take prescribed medication for his ADHD. He also had recognised special educational needs (social, emotional and health).

46. In his homelife, Michael was exposed to adverse childhood experiences and these combined with his ADHD and possibly other undiagnosed disorders, present a range of what are widely accepted factors that will, much more likely than the general population, see him become engaged in criminal behaviour and the criminal justice system.

47. Although never charged, Michael is involved in 3 violent incidents attracting the attention of the police. This review has the benefit of hindsight and analysing the incidents collectively and sequentially, seeing them become more serious in nature. In each of the incidents there are good reasons why they were not proceeded with, and that no further action was taken. That said, this OWHR has identified a pattern of increasing levels of violence and aggression by Michael, where the partnership agencies and working arrangements were seemingly unable to at the time.

48. In late November 2022, Michael was admitted to hospital for a suspected drug overdose, which he later claimed to be accidental rather than an attempt at self-harm. Additionally, his girlfriend claimed an attempt made by him to hang himself a week earlier. Protocols meant that mental health assessments were not possible as Michael was deemed to possess sufficient capacity to opt out, which he chose to do.

49. Michael, an 18-year-old man with no previous convictions, is convicted for the manslaughter of Khaled and sentenced to 17 years imprisonment.

50. During his life Michael has had several interactions with partnership agencies; should it, or could it have been known that he could commit a homicide, or had the potential to commit such a crime and should, or could the community safety 'system' have prevented it? It follows that the primary focus for this OWHR is one of risk assessment, examining the partnership agencies capacity and

capability, individually and collectively, to understand and assess the likelihood of Michael causing serious harm to others.

Practice and organisational learning:

51. This section of the report identifies individual learning points arising from the case, including effective practice and good practice. It is confined to the terms of reference and the key lines of inquiry within them. Recommendations are summarised at the end of the report (page 39).

52. **Risk assessment**

53. **Sandwell Children's Trust**

Michael is the youngest of his siblings and has grown up with adverse childhood experiences such as his father spending time in prison and with much professional concern from various agencies for his elder brother, who has additional needs and an understanding far below his chronological age.

54. Michael has never been the subject child in the involvements the family had with Sandwell Children's Trust. He has arguably experienced increased parental and agency focus upon his older brother, with his needs only being collaterally considered in the June 2021 interaction arising from the referral relating to his older sibling.

55. The review leads SCT to question whether transferrable risks, adverse childhood experiences, 'social graces' and the cumulative impact upon Michael of his lived experiences were as robustly considered or understood as they could have been. The 2021 assessment of Michael could have been strengthened by seeking an independent view from a medical professional on whether his mother and elder sibling's account regarding risks posed should the elder sibling become violent, were valid.

56. It is not until June 2022, when approaching 18 years of age, a violent episode by Michael was made known to SCT and that the family were declining support. Given the potential transferable risks that were indicated, SCT reviewers for this OWHR believe professional curiosity could have been better demonstrated and more effort made towards encouraging the parents to consent to an assessment of Michael.

57. It is evident in hindsight that some of SCT's historic assessments would have benefitted from more visits to test out any hypothesis and achieve 'relationship-based practice'. Procedures today are improved within Sandwell, with a 'Shared Practice Model' being implemented across SCT and all relevant partner agencies, to ensure every frontline professionals is working in a strength based, trauma informed and relational way with families. Minimum standards for visiting children at regular frequencies are in place and monitored through regular performance data, with checkpoint supervision by Team Managers. Assessments are completed and reviewed, with managerial 'sign-off" and authorisation required.

Sandwell Community School (SCS)

58. During his time at SCS, Michael was demonstrating ever-worsening disruptive and violent behaviour, on one occasion using a make-shift weapon on another pupil. The use of risk assessments for Michael were good in recording incidents, but less so with regards to detail of; updates on action taken, subsequent recommendations or results. This makes any assessment as to whether the measures and interventions taken were working or not, difficult.

59. SCS have learnt from this and now ensure that following any incident with a student their risk assessment is comprehensively updated with action taken. The Safeguarding Lead and Head of Centre now regularly review risk assessments. Also, the pastoral team now meet each week to review student behaviour trends and the interventions in place, which has resulted in a reduction in violent and aggressive behaviour.

60. It is clear from the review that SCS have sought to manage Michael's aggressive behaviour, using measures such as counselling and mentoring, but these did not have the desired effect. It was known his mother would minimise his behaviour and that she was refusing to give him his ADHD medication, as she believed it made no difference. (On reflection the school believe his parents were displaying disguised compliance, by supporting him in not taking his medication). SCS accept they could have made use of school police officers and implemented a school behaviour contract or community order, and this is a lesson learned. There is nothing to indicate that had school police officers been used, it would have been effective in controlling Michael's behaviour, but it would have

demonstrated a fuller use of control measures and mitigations available to SCS.

61. There is recognition by SCS that due to Michael's non-interaction with the school counsellor they were unable to explore any trauma he may have experienced in his life or any other issue which would be worrying him. It was known that he had an older sibling who was in prison and he had a fascination with this, which could have been explored more.

62. The school now have an Alternative Provision Specialist Team (APST) in place, made up of a Speech and Language Therapist, Youth Workers, Counsellor and Family Support Worker. A key part of the team's work is to reduce violence within the school and community. Since the APST started in 2022 SCS have seen a dramatic decline in violence with students.

63. The Review has shown that SCT did not seem to be aware of the multiple school exclusions or Michael's declining behaviour whilst at SCS, indicating information sharing has not taken place and any opportunity for additional support was missed. This is seen as a gap in effective partnership working.

64. **Recommendation: Sandwell Community School and Sandwell Children's Trust to develop a protocol on the sharing of SCS's risk assessments of pupils with SCT.**

65. Effective Practice.
Following the incident in June 2022, involving the assault with the bottle, police shared this information with Sandwell Children's Trust. Screening within MASH resulted in information sharing with Education, Health, Women's Aid, Probation, Housing and Mental Health. The entry on the patient records evidences wider safeguarding in action to share matters of concern, risk and vulnerabilities, which the Review recognises as effective practice.

66. **Archiving and record-keeping**

67. **Black Country Health Foundation Trust**
The review has highlighted the importance of contemporaneous documentation. It is recognised that Mental Health Liaison Service practitioners record the contacts they have with Acute Trust treating medical team colleagues and patients in both the Acute Trust's

patient record system (Sunrise) and Mental Health Trust's patient record system (RIO). There is the opportunity on both systems to record any conversations that have taken place with health care colleagues and patients, clinical presentation, assessment, risks and vulnerabilities and care management plans. It was noted during the review that on the Sunrise system a full appraisal of the conversations MHLS had with the treating medical team was recorded, however, only an abridged version of it was recorded on RIO. The latter did not contain the conversation that took place with the treating medical team, the resulting discussion they had with Michael, nor the plan for community follow up via a GP referral to mental health services.

68. Lessons Learned:
Whilst it would not have altered the outcome of service intervention in Michael's case, it is acknowledged that with the Trust using two patient data base systems (Sunrise and RIO), it would benefit from fullness of explanation and clinical rationales being recorded in both systems, producing parity of information for both Acute and Mental Health organisations and for all clinical staff supporting patients.

69. MHLS now have access to Russel Hall Hospitals Electronic Patient Record system (Sunrise) with read and write access for contacts, review information and the recording of mental health treatment plans.

70. The Acute Hospital has an identified Mental Health Matron, who provides support for the oversight of complex cases, has access to clinical incidents and can access BCHFT Trust Electronic patient Records (RIO) – employed by the Acute Trust

71. There is also now a Complex, Vulnerability, Dementia and Delirium Mental Health Team based at the Acute Hospital – employed by the Acute Trust.

72. Regular forums and meetings take place between the Acute Hospital and BCHFT Teams, along with case-by-case clinical management meetings.

73. Effective Practice:
Risks in relation to Michael that were relayed and received from partner agencies were appropriately logged on the RIO system. MHLS, IAPT and L&D worked correctly within their policies and processes.

74. **Birmingham City Council Housing**
Effective Practice.
Recognising the need for improvement to record-keeping of inter-agency working, the decisions made and the supporting rationale, BCCH have ensured all Housing Needs Officers have completed; 'Effective and Factual Recording' Training,

75. **Police response to domestic abuse**
As indicated earlier in the report, the observations on domestic abuse response arise owing to the actions of the OWHR victim Khaled, towards his girlfriend. Whilst not relevant to the terms of reference for the OWHR, the review has identified some shortcomings in the performance of WMP domestic abuse response, and it is considered appropriate to report on them.

76. WMP service level agreements for response times were not met for the reported domestic abuse incident on the day of the homicide. To be clear, there is no connection or bearing on the homicide and this reported incident.

77. The delay in response was due to non-availability of resources who were committed (appropriately) to other higher priority incidents. The reported incident at Khaled's flat was correctly graded as a Priority 1, meaning officers should attend within 15 minutes of the call. Officers did not arrive until 39 minutes later. The address appeared to be empty and officers did not feel that they were in possession of sufficient information to suggest a risk to life or limb to justify forcing entry to the premises. The officers left the scene intending to return later.

78. A review of the circumstances by senior police colleagues reaches a different conclusion and that entry under Section 17, Police and Criminal Evidence Act 1984 was justifiable. After conducting house-to-house inquiries and with the lack of response from the girlfriend and no information to the contrary of the initial report, this increases concerns for her safety. On this basis the officers should have

entered the premises as there is objectively, a risk of harm to the occupant of the location.

79. For the incident 2 weeks prior, where Khaled is reported to be at his flat and therefore in breach of bail conditions, the Priority 3 Grading (P3) for response was not appropriate, given his presence there as a high-risk offender and the domestic abuse history of the couple. The call handler was aware the girlfriend was a high-risk victim and that if she was in company with Khaled, she would require safeguarding. A P2 response should have been applied and following subsequent review later, this happens. In the meantime, as a P3 and in the context of many other P1 incidents, the log and therefore any planned response were subsequently closed without resourcing the incident, without conducting a safeguarding check on the girlfriend or considering locating and arresting Khaled.

80. The redesignation and reopening of the log to P2 should have seen a response within 60 minutes. This did not happen, again due to resources being deployed to higher priority incidents. In total, 39 hours elapse from when the call is first received to when a supervisor reviews and subsequently closes the log, re-assessing the risk to low, relying on the reasonable, albeit false, premise that the GPS Tag Khaled was wearing would have indicated his presence at the flat.

81. Senior police colleagues have reviewed the incident and accept that the rationale provided is not sufficient to justify the closing of the log with no further police action. The reliability of the GPS tag should have been explored within the first few hours of the incident and used as an option to confirm Khaled's location, along with pro-active steps to safeguard the girlfriend.

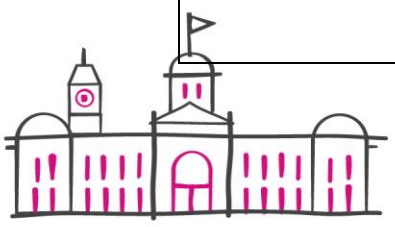
82. The issues found relate to the assessment of risk and prioritising the appropriate police response. It is noted that these issues are already known to WMP senior management and that there are action plans; Operations Vanguard and Willowbay, to address performance in these areas**.** Given the focus of the OWHR and that the issues reported pre-date the introduction of Operations Vanguard and Willowbay, it is not considered necessary to formalise further recommendations. The reporting of findings is made to reinforce the need for the extant action plans and for improvement in the areas identified.

83. WMP senior management are aware of what needs to be done to improve the quality of investigations and deliver a better service. The main areas of focus through Operation Vanguard are, response attendance times, the use of investigation plans, reducing delays to investigations, exploitation of investigative opportunities, the general effectiveness of investigations, the use of victim contracts and the service given to victims in line with Victim Codes of Practice, the way crimes are finalised and the overall effectiveness of supervision.

84. During the last 12 months, West Midlands Police has moved to a new operating model and has been working to improve call handling, dispatch and response times and performance has improved in these areas. Operation Vanguard aims to improve the quality of investigations which is currently a force priority. Changes in April 2023 now mean that local teams investigate a broader range of neighbourhood crimes, with the Public Protection Unit and Force Criminal Investigation Department investigating complex and organised crime. This is reportedly having a positive impact on outcomes.

85. Additionally, following engagement with His Majesty's Inspector of Constabulary and Fire Service, WMP have responded with a 'rapid improvement plan', Operation Willowbay, addressing MARAC procedures, 'backlogs' and multi-agency safeguarding.

86. The issue of dynamic risk assessments by officers and staff, and their knowledge of powers and policy is also addressed under Operation Vanguard with the assistance of Qualitative Assurance Thematic Testing (QATT). The data from QATT is used to give insight to the investigation quality and the support given to victims. The reviews in QATT focus on key areas that HMICFRS and this review identify as needing improvement. It informs and improves supervisor reviews, so they can identify if officers and staff require additional learning due to gaps in knowledge when attending incidents. If officers are missing key points in the investigation, supervisors will now be able to see this. The approach is complemented through officer's continued professional development.



87. **Police response to assault on Khaled, Jan 2022**
Khaled was the victim of an assault in January 2022, where an appropriate police response was provided. There is a missed opportunity in that the account given by the perpetrator together with knowledge of Khaled's offending history, should have given rise to safeguarding concerns for the juvenile allegedly involved in underage sexual activity with him. As a minimum, there should have at been a referral made via the MASH, there is no record of such. The new QATT process under Operation Vanguard is intended to reduce such delivery failures in the future.

88. **Conditional bail following Khaled's release from court custody**
Khaled was charged with a domestic abuse related assault and remanded into custody by police, then appeared in court late May 2023. He was subsequently bailed with conditions not to contact his girlfriend either directly or indirectly or go within a mile of his home address, where his girlfriend was residing. He made application to the courts to return to his home address, this was correctly refused. He then made application for emergency accommodation, BCCH were unable to assist him as he had no proof of displacement from his tenancy address. He was advised to seek this from WMP, which he never did. A combination of Khaled's lack of follow up to police and the bail conditions imposed, effectively rendered him homeless. This was his official status at the time of the homicide.

89. There is no suggestion that his homeless status has any bearing on the homicide, for example by placing Khaled as a victim to homicide because he was in the wrong place at the wrong time. It is a matter of fact, settled in the subsequent court trial, that he was in the location to buy drugs; a transaction that would occur there regardless of his residential status. Nevertheless, the partnership agencies, albeit properly motivated to safeguard a domestic abuse victim, did render him homeless, seemingly offering him little support and that requires attention.

90. This is a lesson learnt for West Midlands Police and Birmingham City Council Housing Management, that at the point of police consideration of bail conditions and the potential exclusion of individuals from their tenancies, improved engagement between them is required, in particular, understanding the consequences to the client (the potential for homelessness) and the appropriate

support to be provided. WMP and BCCH have committed to developing joint-working protocols and procedures for such instances.

91. **Recommendation: West Midlands Police and Birmingham City Council Housing to finalise joint-working protocols when considering conditions attached to bail for BCCH tenants.**

92. The review identified an issue pertaining to Khaled's bail conditions and the use of a GPS tag to monitor his compliance with the prescribed exclusion zone. Owing to a breakdown in communication between the Courts and the tagging company, the GPS tag was never fitted to Khaled. WMP were not made aware and believing it had been fitted, officers relied upon a false premise to assume Khaled was complying with his conditions. WMP have consequently updated procedures to include assurance checks with the tagging company and no other recommendation for action is required.

Improving Systems and Practice (National, Regional and Local):

93. To promote the learning from this case the review identified the following actions and anticipated improvement outcomes. Recommendations are summarised at the end of the report (pages 40 and 41).

94. **Withholding consent**
A theme for Michael is his non-engagement with support and services offered by partnership agencies, a position adopted by his parents (his mother in particular) whilst he was a child and young person and repeated by him as an adult. His parents engaged to a degree but did not consent to all siblings being assessed, with them feeling the issues concerned the elder sibling only.

Examples:

95. <u>Sandwell Children's Trust</u>
Early Help interventions were offered to the family, strategy meetings, referrals and statutory assessments completed, however no statutory 'Child in Need' Plans were ever implemented. The case file shows this was considered but parental consent was not forthcoming and therefore could not be progressed (unless threshold is met to escalate to an Initial Child Protection Conference which it wasn't).

96. Integrated Care Board

It is recorded on Michael's patient records at Russell's Hall Hospital (RHH) database system, that a discussion took place between the Mental Health Liaison Service and the treating medical team at RHH who proposed referring him for an assessment by MHLS. It was established that consent for referral to MHLS had not been sought from Michael. Subsequently, the treating medical team discussed this with him, where he declined an assessment by MHLS but agreed to a referral to community mental health support. The treating medical team notified his GP of this who made the referral to IAPT.

97. Michael was never formally referred to MHLS and any conversation between the treating medical team and MHLS does not constitute a referral. In such cases, where a referral has not been made to MHLS, but where the treating medical team believe that further support from mental health services would be prudent and the patient is consenting to this, it is the acute hospital's responsibility to inform the GP and request that a referral is made, which was done. In the case where a formal referral is made to MHLS and the person declines to see them at that point, MHLS would notify the GP accordingly and ask that any further mental health referrals be generated by the GP.

98. The MHLS Operational Policy (2022) – which has since been reviewed and ratified in September 2023 notes that; '*MHLS is a consenting service, however in cases where the person does not give consent then 'Best Interests' would be considered*.' In respect to Michael, 'Best Interests' were not enacted as there was no indication that he lacked capacity in respect to his decision to decline the assessment; indeed, he opted for alternative support following discharge.

99. The same day as the GP referral was received by IAPT, two calls were made to Michael. There was no response to either call. A letter to 'participate in an assessment' appointment was sent to him on 14 December 2023 with a final response date of 30 December 2022 noted within that letter. The letter informed him that the telephone consultation was aimed at establishing if talking therapies was appropriate for him, with options if it would benefit him for onward referral to another service. The letter explained that he could

seek further information on the types of treatment available via IAPT services; and also signposted him to online self-help resources. On 30 December in the absence of contact from Michael, he was discharged unseen by IAPT services with a letter to GP noting the same.

100. The instances of non-consenting and non-engagement with services should be viewed as missed opportunities to support Michael. Free will and self-determination are of course fundamental rights, but there are occasions in Michael's life, where the choice not to engage has been professionally assessed as potentially harmful to him and, or others, but it has not been possible to override Michael's or his mother's agency.

101. The thresholds for agencies to override consent are seen as proportionate and there is no need or desire to recommend changes to them. Accepting that the current protocols are to be worked within, but that Michael and his mother before him were able to decline support, the review highlights the need for greater awareness raising and education for parents and guardians, as to the extent of support and services provided by the partnership, which should see an improvement in take up of partnership provision. The delivery of awareness raising for parents and guardians, will also allow for the opportunity for trust to be built and will likely lead to a better take up and consenting to partnership agency support.

102. **Recommendation: Birmingham Community Safety Partnership to develop (or review their existing) communication strategy and delivery plan, to raise awareness of the full breadth of support and services provided by the Partnership.**

103. It is recognised that regardless of partnership efforts, there will be adults and parents of children who will not engage or consent to assistance from support services. It is therefore necessary for the partnership 'system' to be attuned to non-engaged individuals and families. Best endeavours should be made to monitoring and detecting vulnerability and potential risk to individuals, with a view to responding appropriately when required.

104. **Recommendation: Birmingham Community Safety Partnership agencies to include within their respective continuous professional development programmes, the need for frontline staff to maintain enhanced vigilance and monitoring of non-engaged families.**

105. **Neurodiversity and criminality**

It is known that children with ADHD and conduct disorder (CD) have more difficult lives and poorer outcomes than children with ADHD alone.[5] Having ADHD along with a coexisting disruptive behaviour disorder (such as oppositional defiant disorder (ODD) or conduct disorder (CD)) can complicate diagnosis and treatment, and worsen the prognosis. Even though many children with ADHD ultimately adjust, some (especially those with an associated conduct or oppositional defiant disorder) are more likely to drop out of school, have fewer years of overall education, have less job satisfaction and fare less well as adults.

106. It is not known if Michael had a coexisting disruptive behaviour disorder to his ADHD. There is no information to show that he was ever assessed for them. During his school years he demonstrates behaviours that would prima facie place him on the continuum of oppositional defiant disorder and as he gets older, he demonstrates worsening behaviours characteristic of conduct disorder.

107. Neurodiversity in the criminal justice system was subject of a call for evidence and subsequent reporting in 2021[6], with a view to understanding what was currently known and being done and to make recommendations for further action from government. The resulting action plan[7] is in train and regularly updated[8] and clear progress is being made. However, the focus is very much upon those entering and passing through the criminal justice system, with prevention work addressing re-offenders, rather than those such as Michael, yet to 'enter' the system.

[5] https://chadd.org/about-adhd/disruptive-behavior-disorders/
[6] https://www.justiceinspectorates.gov.uk/cjji/wp-content/uploads/sites/2/2021/07/Neurodiversity-evidence-review-web-2021.pdf
[7] https://assets.publishing.service.gov.uk/media/62bd9c26e90e075f2ac6045d/MoJ_Neurodiversity_Action_Plan_30_06_2022__001_.pdf
[8] https://assets.publishing.service.gov.uk/media/63d002438fa8f53fe8067133/MoJ_Neurodiversity_Action_Plan_Six_Month_Final__edit_.pdf

108. Professor Amanda Kirby in her 2021 paper for HMI Probation, 'Neurodiversity – a whole-child approach for youth justice'[9], provides commentary and insight which is highly relevant to Michael's (and others like him) circumstances, describing how early diagnosis for children and subsequent tailored effective support, will deliver positive outcomes.

109. Professor Kirby's conclusion[10] to her paper, forms the basis of the recommended action that will follow.

110. "By taking an inclusive approach to service delivery and design we can engage more people in an accessible manner…To aid interpretation and the achievement of shared goals for each child, there is a need for a common language and understanding. It is important that that there is adequate and high-quality training relating to neurodiversity which includes an understanding of co-occurrence that may be present and the intertwined relationship with childhood adversity and trauma. Staff need to have practical tools to support each child, with screening tools required at the point of engagement.[11] To fully meet the needs of the children, these tools need to be accessible and take a child-centred rather than a label-led or narrow siloed approach."

111. Given there is strong academic research showing the link between young people such as Michael and the increased likelihood of them offending, it seems a logical step to make the exploration of options for prevention and diversion at an earlier stage in their life the basis for a recommendation. Whilst the Home Office are supportive of the recommended action it is considered better that the Home Office do not lead it, as there could be risks involved in terms of stigmatising this group, which could do harm, the opposite of the intended outcome.

112. **Recommendation: Department for Health and Social Care and Department of Education to engage with neurodiversity subject matter experts, to develop a strategy for the early screening and assessment of children and young people who**

[9] https://www.justiceinspectorates.gov.uk/hmiprobation/wp-content/uploads/sites/5/2021/07/Neurodiversity-AI.pdf
[10] Page 10
[11] Similar recommendations in relation to adults within the CJS are found at: https://www.justiceinspectorates.gov.uk/hmiprobation/wp-content/uploads/sites/5/2021/07/Neurodiversity-AI.pdf

are presenting neurodivergent traits, with the aim of identifying areas for additional support provision and reducing the likelihood of negative outcomes for those individuals in the future.

113. The Royal College of Psychology paper, 'Blame it on the Brain: Exploring ADHD as a Criminogenic Factor'[12] describes how neurodiverse young people with ADHD, are so much more likely (estimated to be 5 times higher than the average population) to find themselves involved with the criminal justice system. The paper presents how the situation worsens with the presence of comorbidity to other disorders and adverse childhood experiences. Professor Kirby's research also shows a disproportionate number of neurodivergent people entering the criminal justice system.

114. The Home Office, Ministry of Justice and Department for Health and Social Care have previously worked together exploring links to mental health and serious violence/homicide. It would be helpful to better understood how the current evidence base interacts with neurodiversity, to identify whether there are interventions known to work, or more likely to be effective, which could be adapted for those who are neurodiverse. It follows that this information/learning should then be made accessible to frontline practitioners working with children and young people who are commissioning interventions.

115. **Recommendation: Home Office, Ministry of Justice and Department for Health and Social Care to explore how the existing evidence base of 'what works to prevent serious violence', interacts with neurodiversity, including identifying or adapting appropriate interventions, and to make that information accessible to those working with children and young people, including commissioning interventions.**

[12] https://www.rcpsych.ac.uk/docs/default-source/members/faculties/forensic-psychiatry/ls---blame-it-on-the-brain--exploring-adhd-as-a-criminogenic-factor.pdf?sfvrsn=2fcee45d_2

116. **Drug dealing – County Lines[13] exploitation.**
It is a fact that Michael was involved with drugs, he was a street-seller of Class A (crack cocaine) and a user of Class B (cannabis). Police intelligence reports from 2022, show he was associated with individuals who were involved in County Lines and knife point robberies. There is no intelligence or information from this review that suggests he was affiliated to a gang.

117. Michael has never been arrested for drug related offences, though he was questioned in 2019 for having a knife in school. The partnership agencies did all they should in this instance, he already had a school mentor who appropriately dealt with the incident and continued to support him. The local offender manager for youth crime became involved to monitor if Michael was connected to or was at risk of becoming involved with similar offending. There was no indication that he was.

118. It is a reasonable assumption to make, that Michael was involved in drugs before he was 18 years old, whilst legally a child. It is not clear from the review if exploitation of Michael in a County Lines context was ever considered, it is believed not. This maybe because by June 2022 when he came to notice in his own right, professionals had assumed him to have adult capacity.

119. Where children such as Michael are 'seen' as more adult-like, assumptions can be made, including the perception that they have more agency, autonomy, and choice, than they do. It is likely that these perceptions of children will transfer into the language used to describe them, affecting the ways in which they are supported and safeguarded by professionals.[14]

120. No young person is responsible for their own exploitation. Exploiters use manipulation and grooming to coerce young people into criminal (or sexual activity). In this case there is no information to suggest direct exploitation, but it is presumed that Michael became involved with selling drugs as a child (under 18yrs), in the

[13] County Lines as defined by the National Crime Agency is where illegal drugs are transported from one area to another, often across police and local authority boundaries (although not exclusively), usually by children or vulnerable people who are coerced into it by gangs. The 'County Line' is the mobile phone line used to take the orders of drugs.
[14] https://www.childrenssociety.org.uk/sites/default/files/2022-01/Child_Exploitation%20Appropriate_Language_Guide%202022.pdf

familial context of an estranged mother and a father who was a daily Class A drug user and a recognised addict.

121. With the review's benefit of hindsight, Michael should have been identified as a vulnerable child in need of safeguarding when he came to notice in June 2022, when he was 17 years old. That said, even if he had been, once he reached 18 years safeguarding children services which potentially could have helped, would have ceased. There exists a threshold and cliff-edge, where support to a new 18-year-old stops. The child of 17 years the day before, becomes an adult and is then considered responsible and accountable for their actions; morally, ethically and legally.

122. The West Midlands Violence Reduction Strategy 2023-26[15] strategic priorities are partnership based, the first being aimed at 'prevention across the life-course' with a focus on the 'transitional cohort', which directly addresses the threshold of 'maturing' from 17 to 18 years of age. This is a welcome step to providing much needed support for young people seen as adults, when in reality they are anything but.

123. Michael is an example of the many contextual factors that can lead a young person to serious violent crime, with his life experience and circumstances reflecting most of the known serious violence contextual factors.

124. **Recommendation: West Midlands Violence Reduction Partnership to use the observations and learning from this OWHR to support the formulation of their strategy and delivery plans for the 'transitional cohort'.**

125. **Drug Dealing – Enforcement**

The terms of reference for this review focus on how offensive weapons homicides may be prevented in the future. It is difficult to see how in the moment of the events of the day, the outcome for this homicide could have been prevented. Khaled was a habitual Class A user, whose judgment and behaviour had steadily worsened over the months preceding his death, this coinciding with his increased drug use on which he was now dependent.

[15] https://www.westmidlands-pcc.gov.uk/wp-content/uploads/2024/01/WM-VRP-Strategy-2023-26.pdf?x13642#:~:text=The%20West%20Midlands%20Violence%20Reduction,reduce%20violence%20between%202023%2D2026.

126. Selling Class A drugs to chaotic, dependant users, is inherently dangerous with a high degree of associated violence in the enforcement of debt and in the protection of territory and assets. It is common for sellers to be armed with a weapon. Michael had a knife, an offensive weapon with him and the victim did not. Khaled was intent on acquiring Class A drugs, a potentially dangerous activity and ultimately one which proved deadly to him, as disagreement escalated to violent altercation in a matter of seconds, with Khaled killed with a single wound to the chest, by a knife in the hands of Michael.

127. The direct link between drug markets and serious violence is well known, reflected in the then Government's 2021 Drug Strategy[16], Professor Dame Carol Black's independent review of drugs[17], and the 2020 Crest Advisory paper for Government, 'What is driving serious violence: drugs'[18]. Given the circumstances of Khaled's homicide, it is reasonable to assert that there is a causal link between the drug market and his violent death. It follows that any strategic or system-wide endeavour to reduce serious violence and offensive weapons homicides, must tackle County Lines and related drug markets.

128. The West Midlands Violence Reduction Strategy 2023-2026, describes a comprehensive approach for the Violence Reduction Partnership, demonstrating a clear understanding of 'serious violence duty' and a commitment to a coordinated partnership response. The introduction to the strategy states that Birmingham has the greatest proportion of under 25-year-olds in England and Wales, at 34% and that also 34% of localities within West Midlands fall within the classification of most deprived areas of the country.[19] Of the 8 'drivers of violence' listed, 'Local Drugs Supply' is first, with 'County Lines' second, with recognition that Birmingham is the highest volume and West Midlands is in the top 5 exporting areas for County Lines.[20] It goes on to state:

[16] https://www.gov.uk/government/publications/from-harm-to-hope-a-10-year-drugs-plan-to-cut-crime-and-save-lives/from-harm-to-hope-a-10-year-drugs-plan-to-cut-crime-and-save-lives
[17] https://www.gov.uk/government/collections/independent-review-of-drugs-by-professor-dame-carol-black
[18] https://64e09bbc-abdd-42c6-90a8-58992ee46e59.usrfiles.com/ugd/64e09b_932828d2bfec4fd4a2ba4831ee224dbb.pdf
[19] Paragraph 116
[20] Paragraph 119

129. *"Violence may often appear as spontaneous, unplanned and as a reaction to provocation, this is too narrow a view. Violence is often the reaction to cumulative tensions, frustrations and stress that simmer and build over time."*[21]

130. The WMVRS 23-26 is a comprehensive strategy, particularly in its understanding and planned response to local serious violence issues. There is little mention of operational policing effort in the strategy, which maybe because it is obvious and accepted as a routine deliverable by the police. Given the known links of serious violence to drug markets (with this review's findings a clear example of such) and to avoid any doubt as to its importance, police and partnership operational effort in tackling County Lines and other drug markets must be continually prioritised. Law enforcement operations against drug markets should be seen as a regular and continuing key delivery priority in any strategy to reduce serious violent crime and homicides.

131. **Recommendation: West Midlands Police to ensure continuous, comprehensive operational delivery in law enforcement and disruption activity against County Lines and other drug markets.**

132. At the national level, Professor Dame Carol Black's independent review of drugs set out the scale of the challenge on drug demand and supply and provided a range of recommendations which formed the basis of the Government's 2021 Drug Strategy 'From Harm to Hope'. In addition, the previously cited Crest Advisory Report made the following recommendations in 2020 which I draw to attention as relevant to tackling drug-related crime:

133. **Intelligence:** despite clear evidence of a relationship between drug markets and violence, too little is known about the nature and scope of those markets. The Home Office should:

- work collaboratively with universities and civil society to develop a comprehensive research programme to explore the nature of drug markets (both internationally and within the UK) and the relationship to violence

[21] Paragraph 2.1

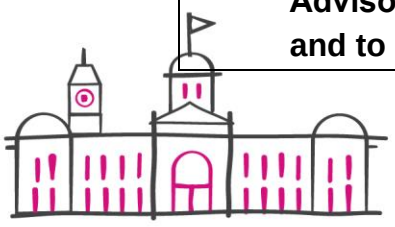
● work with Police and Crime Commissioners to ensure that a proportion of the 20,000 uplift in officers is kept back for hiring police analysts, to strengthen local intelligence of drug markets

134. **Prevention:** in order to reduce the demand for drugs, early intervention is key, but has not been systematic enough. Home Office and Department of Health should commit to:
● increasing the proportion of problematic users (primarily crack and heroin) receiving drug treatment
● a new national network of drug support workers in schools
● piloting a new and expanded Drug Intervention Programme to address the underlying causes of those whose criminality is driven by drug misuse

135. **Enforcement:** the Home Office (and PCCs) should support the police to reprioritise enforcement activity around the goal of disrupting the supply of harmful drugs into the UK, through:
● re-focusing the Strategic Priorities of the National Crime Agency (set by the home secretary) so that they explicitly include the disruption of harmful drugs markets, such as heroin and crack cocaine
● ensuring there is a targeted drugs unit within every force in England and Wales, to strengthen local intelligence around shifting drugs markets
● encouraging the police to work with the Crown Prosecution Service (CPS) to investigate low levels of detection and prosecution of drug traffickers and dealers
● making better use of existing civil orders and injunctions to limit county lines activity (including through restrictions on travel)

136. The recommendations chime with the findings of this review and are directly relevant to the strategic aims of the serious violence duty and OWHRs. Monitoring of progress against the recommendations is not readily available.

137. **Recommendation: The Home Office, working with the Department of Health and Social Care and wider departments, should continue to make tackling illicit drugs a top priority and in particular draw on Professor Dame Carol Black's recommendations and the recommendations of the Crest Advisory 'What is driving serious violence: drugs, 2020' report, and to publish regular updates on progress.**



Dissemination

List of recipients who will receive copies of the Review Report (in line with guidance and due to the recommendations of this Report):

Date circulated to relevant policy leads: 08/05/2025

Organisation	Yes	No	Reason
Birmingham City Council Housing Management (BCCH)	☒	☐	Stakeholder/RRP
Birmingham Community Safety Partnership (BCSP)	☒	☐	Stakeholder/RRP
Black Country Healthcare NHS Foundation Trust (BCHFT)	☒	☐	Stakeholder/RRP
Black Country Integrated Care Board (BC ICB)	☒	☐	Stakeholder/RRP
Birmingham and Solihull Integrated Care Board (BSOL ICB)	☒	☐	Stakeholder/RRP
Sandwell Community School (SCS)	☒	☐	Stakeholder/RRP
Sandwell Children's Trust (SCT)	☒	☐	Stakeholder/RRP
West Midlands Police (WMP)	☒	☐	Stakeholder/RRP

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

Review Partners returns of OWHR Guidance Part A (Scoping) and Part B (Exploratory) Questionnaires.
Review Partner Panel – challenge assumptions and conclusions, identify further and new lines of inquiry.
Meetings with Review Partner leads.
Meeting with the victim Khaled's ex-wife, Khloe.
Meeting with the perpetrator, Michael.
Meeting with neurodiversity specialist, Professor Amanda Kirby
Violent Crime research.
Draft report – Review Panel challenge, identify further and new lines of inquiry.
Revised Draft report – Review Panel ratification.
Final Draft Report to local OWHR Strategic Oversight Group.

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: Chris McKeogh (LLB Hons, MA)

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:

Chris McKeogh is a consultant specialising in intelligence, risk and strategy. He was selected and undertook approved training to be a Home Office Offensive Weapons Homicide Review Independent Chair in January 2023.

As a former senior civil servant with the National Crime Agency and previously a senior police officer with West Midlands Police he has been a practitioner in the prevention and detection of homicide, serious violence, street gangs, serious and organised crime, exploitation and safeguarding. His law-enforcement career spans 37 years, operating at a tactical and strategic level, developing policy and procedure for the prevention and detection of crime and the protection of the public.

Whilst the Police Commander for Birmingham Central, Chris Chaired the Community Safety partnership's 'Birmingham Reducing Gang Violence' Tactical Group, leading to a secondment with the Home Office to support the development and delivery of the 'Ending Gang Youth Violence' Programme.

During his career, Chris was an experienced homicide senior investigating officer, specialist firearms commander and hostage negotiator. He was the senior police lead for the Coventry Child Abuse Investigation Unit and with the NCA, the executive lead for the National Child Exploitation Referral Bureau.

Chris is a Bachelor of Law and has a Master's degree in the Ethics of Policing and Criminal Justice.

Chris moved from West Midlands Police to the National Crime Agency in 2013. His last involvement with Birmingham Community Safety Partnership, prior to his commission for this OWHR, was 2011.

Signature: ***CMMcKeogh***
Name: Chris McKeogh
Date: 22/07/2024

Professor Amanda Kirby MBBS MRCGP PhD

Amanda is a qualified GP and has a Ph.D. relating to emerging adulthood and neurodiversity. She is an emeritus professor at the University of South Wales, an honorary professor at Cardiff University and a Visiting Professor at the Faculty of Health Sciences Trinity College, Dublin. She has extensive clinical and research experience and founded and ran a transdisciplinary clinical and research team for 20 years relating to neurodiversity.

She has initiated and run a wide variety of training programmes including a Masters in SEN programme. She is also PLOS Mental Health Section editor for Neurodiversity.

Amanda is the current chair of the ADHD Foundation in the UK and works closely with many other charities working in this area. She has been on government advisory boards (e.g., Hidden Impairment National Group) as well as advising UK and international charities in the field of neurodiversity. This includes being a patron of the Dyspraxia Association in New Zealand, and Chair of Movement Matters UK. She sits on the Professional Advisory Group for DWP relating to Disability Confident.

Amanda is the founder and CEO of Do-IT Solutions, an internationally recognised tech-for-good company that provides neurodiversity screening and web-based support tools for children and adults used in many settings including workplace, apprenticeship, school, college and university settings. She has successfully developed and delivered neuroinclusion implementation strategies for global organisations. Amanda has been voted one of the top UK HR Thinkers in 2022 and won the lifetime achievement awards at the National Diversity Awards as well as being voted in the top 50 Diversity power list. In 2023, she has been named one of: Think Women's 40 outstanding global women'; Top '33 UK Business Influencers'. Amanda has co-authored the first Neurodiversity Index Report with City and Guilds Foundation published in March 2023. She is one of the LinkedIn Top Voices and has a weekly Neurodiversity 101 newsletter with more than 140,000 followers. She has written 10 books and more than 100 research papers in the field and one of her recent books published in 2021:'Neurodiversity at Work, Drive Innovation, Performance and Productivity with a Neurodiverse Workforce' won the Business Book Awards 2022 for EDI. Her latest book in 2023 is: Neurodiversity and Education and she has a new one planned for 2024 for parents.

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. N/A

Scope/Terms of Reference

The Terms of Reference for the review were set to achieve the following Home Office OWHR strategic objectives:

a. To establish what lessons can be identified in the 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.

With the defined purpose (as specified in section 28(2) of the Act):
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.

Additionally,
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.

The scope of the review was set at 2 years prior to the incident for Khaled. For the perpetrator Michael, it was agreed it would cover his entire life (c18 years). Michael, whilst known to police had no previous convictions, was charged with murder and subsequently found guilty of manslaughter. He has had contact with partner agencies during his life and the Review Panel were keen to understand all touchpoints and interactions with the partnership system.

Recommendations

1. **Recommendation: Sandwell Community School and Sandwell Children's Trust to develop a protocol on the sharing of SCS's risk assessments of pupils with SCT (para.64)**

2. **West Midlands Police and Birmingham City Council Housing to finalise joint-working protocols when considering conditions attached to bail for BCCH tenants (para.91)**

3. **Recommendation: Birmingham Community Safety Partnership to develop (or review their existing) communication strategy and delivery plan, to raise awareness of the full breadth of support and services provided by the Partnership (para.102)**

4. **Recommendation: Birmingham Community Safety Partnership agencies to include within their respective continuous professional development programmes, the need for frontline staff to maintain enhanced vigilance and monitoring of non-engaged families (para.104)**

5. **Department for Health and Social Care and Department of Education to engage with neurodiversity subject matter experts, to develop a strategy for the early screening and assessment of children and young people who are presenting neurodivergent traits, with the aim of identifying areas for additional support provision and reducing the likelihood of negative outcomes for those individuals in the future. (para.112)**

6. **Home Office, Ministry of Justice and Department for Health and Social Care to explore how the existing evidence base of 'what works to prevent serious violence', interacts with neurodiversity, including identifying or adapting appropriate interventions, and to make that information accessible to those working with children and young people, including commissioning interventions. (para.115)**

7. **West Midlands Violence Reduction Partnership to use the observations and learning from this OWHR to support the formulation of their strategy and delivery plans for the 'transitional cohort' (para.124)**

8. **West Midlands Police to ensure continuous, comprehensive operational delivery in law enforcement and disruption activity against County Lines and other drug markets (para.131)**

9. **The Home Office, working with the Department of Health and Social Care and wider departments, should continue to make tackling illicit drugs a top priority and in particular draw on Professor Dame Carol Black's recommendations and the recommendations of the Crest Advisory 'What is driving serious violence: drugs, 2020' report, and to publish regular updates on progress (para.137)**