SAFER BRENT PARTNERSHIP OFFENSIVE WEAPON HOMICIDE REVIEW

Report into the lives and learning through service engagement with the homicide victim M

NW0002BR

This review is part of a 12 month Home Office pilot

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North West London Integrated Care System

NHS North West London

Brent

METROPOLITAN POLICE

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The Safer Brent Partnership, Offensive Weapons Homicide Review team and the Independent Reviewer would like to express their deepest regret for the loss of M's life; as well as extending their sympathy to his family, and to his friends for their loss.

The Partnership also recognises the considerable distress experienced by W, his family and those who know him.

1. Brief Outline of Homicide

1.1. On the date of his death, in July 2023, M had police contact twice earlier that day. In the late afternoon police were called in response to a bus alarm where M had been shouting at the bus driver accusing him of being racist. This was recorded as a crime. Police officers noted that M smelt strongly of alcohol. M was taken to an address believed to be his home address. This was however a previous address as M was homeless at the time of his death. Two hours later, police were called to a local supermarket as M was reported as drunk and aggressive. He told police that he had just been released from prison. Officers escorted M from the premises and dropped him at the King Edward VII Park. CCTV recorded that M had several peaceful interactions with members of the public.

1.2. It is understood that M was then provocative and offensive towards W and his friends. The group tried to move away but M followed them. It was claimed that W smashed M's vodka bottle and stabbed him twice. W has stated that he did this in self-defence.

1.3. Police were then called to reports that M was seeking help having sustained the stab injury following an incident in a local park. Initially three suspects were arrested on suspicion of murder. Following interviews and review of CCTV, no further action was taken regarding two of the suspects as it was ascertained that they had nothing to do with the incident.

1.4. The police investigation identified W as a suspect and in July 2023, he was arrested on suspicion of murder. Police confirmed that M's injuries had been inflicted by a bladed weapon. A post-mortem examination established the cause of death as blood loss following a stab wound to the armpit which proved fatal. Both men were over the age of 18 at the time. M and W were not known to each other prior to the incident. In July 2023, W was charged with murder and possession of an offensive weapon. The offensive weapon in question was a bottle that had been smashed and clearly this cannot be regulated against.

1.5. In June 2024, W was found not guilty of murder and manslaughter but guilty of possession of an offensive weapon. W was sentenced to nine months in prison but served no further time as he had been on remand for eleven months.

2. The Purpose of an Offensive Weapons Homicide Review (OWHR)

2.1. OWHRs were introduced through the Police, Crime, Sentencing and Courts Act 2022 and require the Police, Integrated Care Boards and Local Authorities in England 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.

2.2. 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.

2.3. The purpose of OWHRs is to identify any lessons that can be learnt in relation to the death, and to consider whether there is any action which should be taken to aid in preventing future homicides. The review will bring together all the relevant local partners and bodies. The review will examine their work to 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 designed to investigate the death, identify culpable parties or to be a disciplinary process.

2.4. OWHRs are currently being piloted in certain areas of London, the West Midlands and South Wales prior to a decision being made on whether they will be adopted nationally across England and Wales.

2.5. Members of the Safer Brent Partnership (which includes Metropolitan Police Service, North West London Integrated Care Board and Local Authority services), with reference to the statutory guidance, confirmed that M's death met the legal criteria for an OWHR to be completed. The OWHR Strategic Group of the Safer Brent Partnership agreed that following a final review of information gathering returns, M had links to NHS, Metropolitan Police (MPS) and Probation partners. The information gathering returns also found that W had links to the NHS, Brent Council's Children and Young People Service and the Metropolitan Police. As there was sufficient information and links for both M and W to relevant partners, the OWHR Strategic Group agreed that there could be lessons to be learnt within the scope of the Offensive Weapons Homicide Review.

2.6. Families, friends and other people who knew the parties linked to the homicide are invited to take part in the review, and to have the opportunity to speak voluntarily to the Independent Reviewer and author. Families and friends can help in providing wider context, and a level of understanding of the lives and experiences of individuals prior to the incident which would otherwise be lost.

2.7. An OWHR will normally be completed within about 12 months of the death.

2.8. This OWHR report has been anonymised in accordance with statutory guidance. The specific date of the homicide has been removed. Only the Reviewer and represented services are named. All relevant information (including names and associated review documentation) is secured by London Borough of Brent on behalf of the Safer Brent Partnership.

2.9. The following initials have been used in this review to protect the identities of the victim, the acquitted, family members and other contributing parties mentioned in the review:

2.10. Adopted initials:

Initial	Applied to
M	**Victim**
W	**Acquitted**
X & Y	**Ex partner**

2.11. In August 2023, the Safer Brent Partnership, having established that M's death met the legal criteria for an OWHR in accordance with the statutory guidance, proceeded to commission an independent OWHR.

2.12. A process for recruiting a Home Office trained OWHR Reviewer was begun, and the independent chair was appointed in November 2023.

2.13. This OWHR outlines the review process, the findings and recommendations considered by the OWHR Strategic Group in considering the lessons learnt from events prior to the homicide of M, a resident of London Borough of Brent at the time of his death.

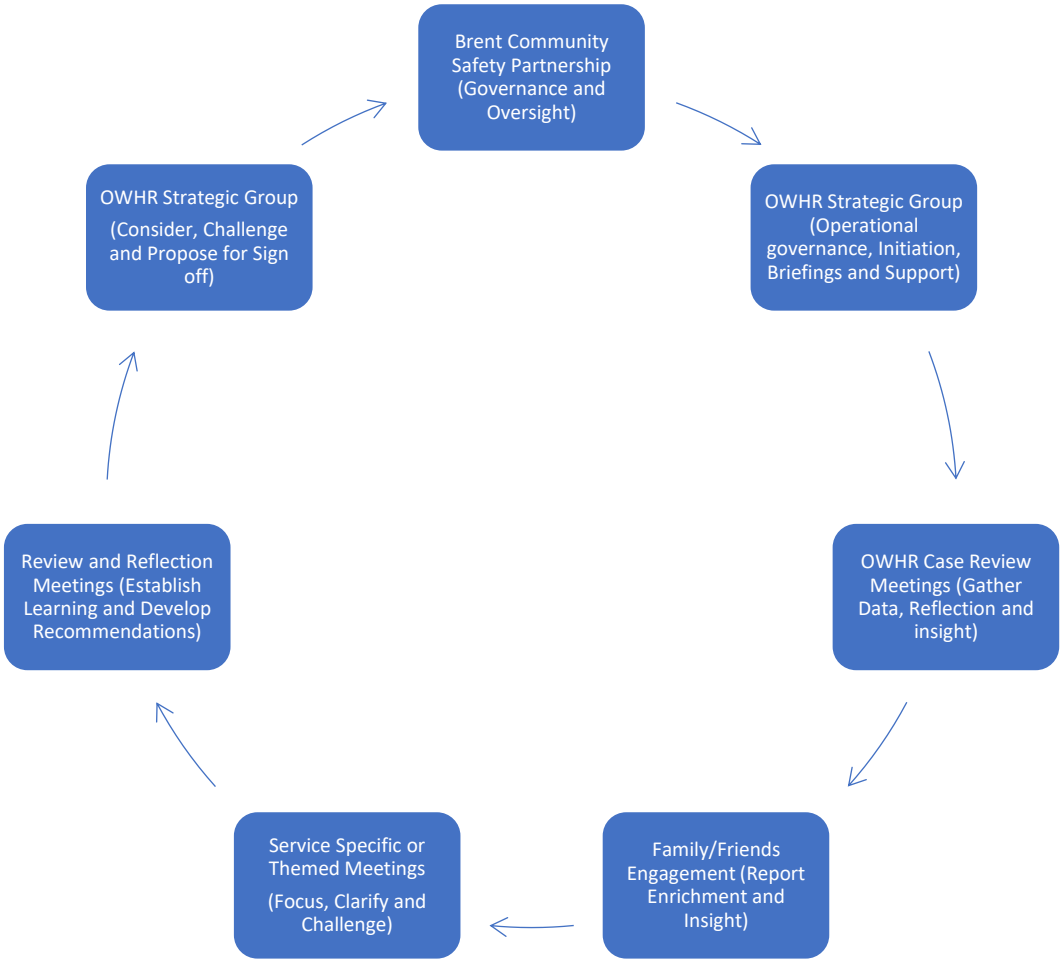
3. Governance and Structure of the Review Process

3.1. The Safer Brent Partnership is the statutorily defined forum which retain overall responsibility for local oversight and sign off the report. It has responsibility for implementation of any recommendations arising from the OWHR. The partnership delegated operational decision making and approval of reports to the Brent OWHR Strategic Group which includes a member of each statutory relevant review partner.

3.2. The London Borough of Brent is the lead agency for the Partnership for OWHRs and has applied resources through the Violence and Vulnerability Coordinator - OWHR Lead role to both engage with the Home Office, the Metropolitan Police, the ICB and to support this and other active OWHRs.

3.3. Findings from this work are captured and reported to the Brent OWHR Strategic Group for consideration and challenge, before recommending consideration and approval of the final report and recommendations to the Safer Brent Partnership before submitting to the Home Office.

3.4. The Applied OWHR Process Governance Cycle:



4. Contributors to this Homicide Review

4.1. The Brent OWHR Strategic Group, comprised of experienced senior representatives that met regularly, usually on a fortnightly basis, to oversee and support active OWHRs:

OWHR Strategic Group Members
London Borough of Brent Community Safety Team
Metropolitan Police (North West Basic Command Unit)
Metropolitan Police (Specialist Crime Review Group (support role)
North West London Integrated Care Board (Lead)
North West London Integrated Care Board - Safeguarding (support role)
Brent Probation Service (non-decision-making standing member)
NHS England - Mental Health (where applicable)

4.2. The OWHR Case Review Group, comprised of largely frontline and specialist representatives from key service areas where it had been established that contact had been had with either M or W respectively:

OWHR Case Review Group Members
London Borough of Brent Community Safety Team
London Borough of Brent Youth Justice Service
Metropolitan Police (Specialist Crime Review Group)
London Borough of Brent LAC & Permanency Team
North West London Integrated Care Board - Safeguarding
Brent Probation Service
London Borough of Ealing Adult Social Care
Home Office Asylum and Human Rights Operations
Metropolitan Police Service
London North West University Healthcare NHS Trust - Safeguarding
London Borough of Brent Housing Needs Team
Central and North West London NHS Foundation Trust – Safeguarding
Brent Community Mental Health Team
Harrow Richmond Uxbridge Colleges - Harrow College Safeguarding
Ellis Practice GP
United Colleges Group Safeguarding
London Borough of Brent (OWHR Lead) – Support role

5. The scope and terms of reference of the review

5.1. The key timeline of 12 months prior to July 2023 was reviewed given that M and W were not known to each other prior to the incident, together with any relevant information prior to this. A chronology of services engagement with M and W was compiled and background information provided. Consideration was given to M and W's background, race, and ethnicity and whether this had any potential impact on services responses, including any potential biases that influenced professionals' involvement and intervention.

5.2. Consideration was given to how agencies respond to requests for housing provision for known offenders and there was an assessment of the effectiveness of the multi-agency network in the management of ongoing risks including the effectiveness of risk assessment and intervention strategies. An assessment of the effectiveness of support and services to Unaccompanied Asylum-Seeking Children, including how agencies address issues of unresolved trauma and presenting behaviours, was also considered.

5.3. A Case Review Group, of primarily practitioners and managers, met on one occasion and reviewed the draft report for comments and amendments. The report author had 1:1 discussion with 4 relevant agencies and met once with X and Y who were both ex-partners of M with whom he had birth children. Completed set questions using an agreed template and a chronology was provided by agencies known to M and W.

5.4. M and W's close family did not engage in the review.

6. Equality and Diversity

6.1. The review considered the nine protected characteristics under the Equality Act 2010[1], including examining any barriers to accessing services in addition to wider consideration as to whether service delivery was impacted.

6.2. **Age:** M was aged in his 40s at the time of his death. W was aged 18. There are no apparent barriers in accessing services for M owing to his age. W had access to services and support provided because of his previous 'Looked After Child' status in the local authority and was a Care Leaver under the Children (Leaving Care) Act 2020.

6.3. **Marriage and civil partnership:** M never married but did have relationships with X and Y. He has children with both women. His relationships with these two women were domestically abusive and he was subject to a non-molestation order regarding X. There is no evidence that M accessed support regarding his abusive and controlling behaviour.

6.4. **Race:** M was black British. He remained linked to his family with regular, almost weekly telephone and video contact with his family in the Caribbean. He has experienced racism and has made complaints to police regarding how he has been treated by other members of the public. He has reported on several occasions to have experienced institutional racism from public agencies based on his race, colour, and presentation.

6.5. W is Syrian. As a child, having left his family and parents in Syria, he experienced war and conflict in his home country and then travelled to Greece alone. This would have impacted him and he is likely to have experienced trauma and grief. This has not been well understood by professional agencies as they have been unable to engage him in any focused interventions. W originates from a diverse culture and background, bringing his own unique set of experiences. The Migration Observatory has produced a series of research papers highlighting the discrimination experienced by migrants and asylum seekers. They note that the links between public attitudes, group stereotypes, and discrimination are complex and yet minority groups who are viewed more negatively by the public also tend to experience the most discrimination[2].

6.6. **Religion or belief:** There is not sufficient information available to comment on this issue.

6.7. **Sex:** Both M and W were male. In the most recent Office for National Statistics (2023) data most homicide victims were male, making up around 7 in 10 of all victims (71%)[3].

6.8. **Socio-economic disadvantage:** M was significantly socially and economically disadvantaged at the time of his death. Following his release from prison in June 2023, he had no means of employment, housing or support and was homeless. His status as

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

[2] https://migrationobservatory.ox.ac.uk/

[3] Office for National Statistics (ONS) Homicide in England and Wales 2023

a man recently released from prison and awaiting sentencing placed him at a significant disadvantage. As he was not under any licence arrangements and as a single man, his support was limited.

6.9. W did receive support from the leaving care service and was provided with support for accommodation and services, including financially. Whilst there was no evidence of exploitation, W did appear to have access to unknown financial resources.

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

7.1. Contact was made via the Family Liaison Officer (FLO) within the Metropolitan Police to enable the involvement of M's family and ex-partners as well as W's family as appropriate. They were provided with a letter and the OWHR information leaflet. The Crown Prosecution Service (CPS) Reviewing Lawyer and Prosecution Counsel raised some concerns regarding family contact and following advice, assurances were provided to ensure this was appropriate.

7.2. The CPS Reviewing Lawyer and Prosecution Counsel were provided with the statutory guidance and having considered the matter carefully, and in all the specific circumstances of this case, the CPS did not wish to make any representations against the OWHR proceeding or raise any concerns. As no family members were witnesses in the case or are closely linked to the events that took place, this does not cause any immediate concern. The CPS did request that the report author liaise with the senior investigating officer to ensure any material obtained is reviewed for disclosure purposes if appropriate.

7.3. The CPS did request consideration be given to the publication of the review until after the conclusion of the criminal trial to ensure any material disclosed would not impact on the criminal trial.

7.4. M's close family (Mother and sister) did not wish to be involved in the review. X and Y were interviewed and provided contextual information and pen picture detail for M for the review. The FLO continued to engage them leading up to the criminal trial and the family has received support through a homicide support worker.

7.5. Consideration was given to engaging W's family in the review process and contact was made via email to W's sister. She has not responded to the request to engage in the review.

8. Family History and/or Contextual Information:

8.1. **M's Family History**

8.1.1. M was a black British man in his 40s who was described by those who knew him as a 'proud man' who always 'presented well'. They reported that he was a 'good cook', actively used the gym and was always keen to work and earn money. They reported that he always 'needed a place to call home'. He was estranged from X and Y having previously been their partner. M has children with X and Y with whom he had mostly telephone and facetime contact.

8.1.2. M had been sentenced to a 12-month Community Order for breach of a Non-Molestation Order in February 2022 following incidents of domestic abuse against X. On the 21 January 2023, M was arrested following an allegation of assault and

criminal damage by another resident at the HMO. He was charged with offences of criminal damage and grievous bodily harm and was remanded in custody. He remained on remand until the 27 July when he was released from prison pending sentencing. M had no property to return to on his release and sought housing advice via Probation services.

8.1.3. The family history of M was provided by X and Y. Y described their relationship as 'on and off' and when they did permanently separate, M kept a connection with the children they had together. They first met in 2007. Y reports that he had 'alcohol issues' and was 'never quite sure whether he had mental ill health', which was badly affected by his alcohol intake. They reported that M had no family in the UK and his only 'family' was his ex-partners and their children. Y reports that he did not have a 'stable home', he moved between shared accommodation and was never in stable housing. They reported very positively about his work ethic and noted he had 'held down' several trade roles prior to his imprisonment. X reported that M began 'hanging around with friends who just drank alcohol' and that he was never a 'good drunk'. When they separated, she believes his drinking alcohol significantly increased. She also believes that his alcohol use impacted his mental health, and he could be aggressive and violent when drunk.

8.1.4. They both report that they were not aware of his remand into prison in January 2023. His telephone conversations with his children ceased abruptly and as a result, they reported him missing to police. Police confirmed he was 'safe and well' but did not report that he had been remanded into custody.

8.1.5. Both X and Y report M's struggles following his release from prison and not having the opportunity to live in a safe, comfortable environment. They both reported he needed 'a safe space, his own place with bathroom and toilet'. They mentioned that on his release from prison, he was given a membership to a local gym by a friend so that he could wash and shower. Y reports that he found himself in a park on the evening of the murder because he had nowhere else to go.

8.2. **W's Family History and/or Contextual Information:**

8.2.1. W was aged 18 years and 6 months at the time of the incident. He was an Unaccompanied Asylum-Seeking Child originating from Syria and had been in the care of the London Borough of Brent since 2021. He was receiving leaving care support at the time of the incident.

8.2.2. W's childhood was overshadowed by the war and conflict in Syria. In the social work assessment, he described difficult and challenging experiences in Syria which included the loss and separation of family and a disrupted education. His journey to the UK began at age 14 and included travelling to Iran by plane and then walking to Turkey. He described being beaten, assaulted and imprisoned (by police) in Turkey because he was a Syrian "refugee" without papers. W then made his way to Greece where he was assisted to apply to come to the UK under the Dublin III rule as he had family in the UK. Much of W's experiences on the journey to the UK are unknown, however Children's Social Care confirmed that many unaccompanied children experience significant harm on those journeys, including physical and sexual assault, malnutrition and sleep deprivation, and psychological trauma.

8.2.3. The United Nations Office for the Coordination of Humanitarian Affairs (OCHA) projected that in 2019, 11.7 million people in Syria required humanitarian and protection assistance[4].

8.2.4. In January 2021 the European Intake Unit of the Home Office made enquiries regarding W, an unaccompanied asylum-seeking child, joining his sister in Brent under the Dublin III Regulation. At this point, W was an asylum-seeker in Greece after fleeing Syria.

8.2.5. The Dublin III Regulation[5] is a mechanism for deciding which European Member states are responsible for deciding asylum claims. As part of the regulation Unaccompanied Asylum-Seeking Children (UASC) can apply to join UK based family whilst their asylum applications are considered' (Home Office, 26/02/2019). A request was made for a Family Assessment (FA) of the UK relative and their property to assess if the reception was appropriate.

8.2.6. In February 2021 a family assessment was completed by the London Borough of Brent. This assessment concluded that the authority was not content with the reunification with his sister in the UK as she did not have the financial means to support him.

8.2.7. The Home Office responded that as this is an Article 8.1 case (parents/siblings), the Home Office was obligated under the Dublin Regulation III to transfer W to the UK so that they may reside in the same country as their family member whilst their claim for international protection was assessed. This was regardless of whether the family member could support them or not.

8.2.8. W arrived in the UK in August 2021. He was accommodated under Section 20 of the Children Act (1989) with a plan to reside with his sister following further assessments. W was placed in semi-independent accommodation and began accessing college. Owing to his sister's financial difficulties the assessment for W to reside with her did not progress. W then remained a Looked After Child until his 18th birthday and received Leaving Care support since that date as per statutory regulations.

9. Agency Timeline

9.1. Agency Timeline M

9.1.1. M was mainly known to agencies as a suspect for offences including domestic abuse, anti-social behaviour, violence, burglary, and criminal damage. He and his ex-partner were the subject of MARAC in Harrow. An action was raised at Harrow MARAC in May 2021 for Police to review M's conviction record and history of domestic abuse to assess the suitability for a Clare's Law Disclosure to his previous partner. Intelligence checks were completed and 'both parties' were well known for domestic abuse and have a reported history together and have been to MARAC previously. This action was repeated in September 2021.

[4] https://www.unocha.org/publications/report/world/ocha-annual-report-2019

[5] https://home-affairs.ec.europa.eu/policies/migration-and-asylum/common-european-asylum-system/country-responsible-asylum-application-dublin-regulation_en

9.1.2. Between April and September 2021, M was living in a licensed 'House in Multiple Occupation' (HMO) and was reported by fellow residents for displaying 'erratic' behaviour. The landlord had initiated eviction proceedings, but this was halted owing to the C19 pandemic.

9.1.3. The Safer Neighbourhood Officer identified risk and contacted Brent Mental Health Team directly. They were informed that M was not known to their service. 5-year intelligence checks were completed by the police team in the multi-agency safeguarding hub (MASH). An Adult Come to Notice Form (ACN) was created and shared with the MASH. The police Merlin Report rated M's circumstances as Amber (Level 3 – Amber), when complex needs are likely to require longer term intervention from statutory and/or specialist services, and was shared with Adult Social Care. The police have referred to the Vulnerable Adult Framework (VAF)[6] which guided their decision making.

9.1.4. A further MERLIN Report was created and shared with MASH in May 2021 relating to possible mental health concerns.

9.1.5. In June 2021 M's ex-partner contacted police to state that M was at the door, jumping on the fence, banging on doors and damaging cars outside her home.

9.1.6. This was assessed as a Domestic Abuse Incident and information was shared with education providers and Children's Social Care (CSC). A Domestic Abuse Stalking and Harassment (DASH) risk assessment was undertaken.

9.1.7. Throughout 2021, concerns were raised about M's alcohol and possible drug use.

9.1.8. September 2021 M was evicted from the HMO.

9.1.9. October 2021 incident at a hotel and THRIVE+ risk assessment was completed by police.

9.1.10. In January 2022, police attended a domestic abuse incident and spoke with the victim, who told police that she had a one-off relationship with M during the previous month. He had since then been harassing her when drunk and on one occasion M had assaulted her by punching her, causing visible bruising to her shoulder.

9.1.11. M was arrested for Actual Bodily Harm (ABH) and interviewed. The informant further disclosed she had been sexually assaulted by M and he was further arrested on suspicion of sexual assault. The victim was unwilling to support a police investigation and the case was closed with no further action taken.

9.1.12. January 2022 M arrested for breach of non-molestation order. He was sentenced to a 12-month community order, 120 hours of unpaid work and a 15-day rehabilitation activity requirement. He was generally compliant with the unpaid work but did not engage with his probation officer. He was breached for this and received a fine. Due to the abuse towards the female probation officer, there was a change in supervising officer, and he started reporting again.

[6] When encountering a member of the public, from victims and witnesses to suspects, all Metropolitan Police personnel must carry out the VAF to identify any vulnerability. The use of VAF at the earliest stage possible will maximise any early intervention opportunities and may help prevent victimisation.

9.1.13. An OASys assessment was completed noting M was medium risk.

9.1.14. In March 2022, police were called to an alleged assault. M's behaviour appeared erratic, and demeanour appeared "strange". The informant told police he was punched in the face and sustained cuts to his mouth and head. M was arrested for ABH and Criminal Damage. The victim was unwilling to provide a statement and support a police investigation. A Risk Assessment THRIVE + was completed throughout the investigation and the case was closed with no further action taken.

9.1.15. In August 2022, police were called following a report of an allegation of criminal damage and assault by M. The victim was unwilling to provide a statement and support a police investigation. A Risk Assessment THRIVE + was completed and an Adult Come to Notice Form (ACN) was created and shared with the multi-agency safeguarding hub (MASH).

9.1.16. In September 2022, Ealing Adult Social Care Advice and Referral Centre (ARC) received two police reports and notification of a pre-assessment checklist rated Green. ARC is the front door service into adult social care. All initial external referrals, police reports and Merlin's are sent to an inbox which is screened and forwarded to the relevant departments, external agencies including voluntary organisations for onward actions.

9.1.17. These reports were screened and forwarded to the mental health department for their attention seven months later in April 2023. Green graded referrals are identified as the lowest priority.

9.1.18. In September 2022 a DASH risk assessment was completed as M was constantly telephoning previous partner.

9.1.19. In September 2022 he reported he was having problems with his neighbour who attacked and provoked him. He claimed he had reported this to police.

9.1.20. M was subject to statutory probation supervision between February 2022 and February 2023.

9.1.21. In October 2022 he reported he had lost his job as a supervisor, and he was struggling financially. Referrals were made to employment, training and education advisors and he attended 3 sessions and secured new employment.

9.1.22. In December 2022 he reported someone had been kicking his door, he reported this to police, requesting assistance to find alternative accommodation.

9.1.23. M was seen by the Liaison and Diversion service[7] at Acton Custody Centre in December 2022. M was described as violent and aggressive on arrest for criminal damage. His aggression was possibly due to intoxication from substances. No further contact with mental health services were recorded on clinical systems.

[7] Liaison and Diversion (L&D) services identify people who have mental health, learning disability, substance misuse or other vulnerabilities when they first come into contact with the criminal justice system as suspects, defendants or offenders.

9.1.24. January 2023 M was arrested and charged with GBH and affray against his neighbour and appeared in court. He pleaded guilty and was remanded in custody until June 2023 when he was bailed by the court.

9.1.25. The community order had expired so he was no longer subject to statutory probation supervision.

9.1.26. M was homeless at the point of his discharge from prison.

9.1.27. In July 2023, M attended Ealing Probation Office asking for assistance with Housing as he had been bailed and was homeless. Ealing Probation Office referred to the London Borough of Ealing Housing Team.

9.1.28. M was advised a 'duty to refer' under homelessness legislation had been made in 2022 to the local authority homelessness/housing options team[8].

9.1.29. Probation completed a 'StreetLink'[9] referral and gave M a list of landlords who accept people who have been on probation.

9.2. **Agency Timeline W**

9.2.1. In 2020 W was an unaccompanied asylum-seeking child in Greece after fleeing Syria.

9.2.2. In December 2020 the European Intake Unit within the Home Office received a formal request from Greece for W joining his sister in Brent under Dublin Regulation III.

9.2.3. In August 2021, W was accommodated in semi-independent accommodation following 'Pan London transfer allocation[10]'. He arrived in the UK in August 2021. He was allocated a social worker and became subject to Looked After Child processes.

9.2.4. W started college in September 2021.

9.2.5. February 2022 W was reported as a missing child.

9.2.6. In March 2022, Police were contacted stating there was a group of approximately ten males arguing with each other. A CCTV operator within the control room was concerned the argument appeared to be escalating into a fight. W had assaulted a fellow college pupil by punching him in the head.

9.2.7. As part of the investigation, W's college told police that he had been suspended pending the outcome of a disciplinary hearing. He was interviewed under caution, in the presence of a solicitor, appropriate adult and interpreter. W admitted

[8] The Homelessness Reduction Act 2017 significantly reformed England's homelessness legislation by placing duties on local housing authorities to intervene at earlier stages to prevent homelessness in their areas, and to provide homelessness services to all those who are eligible.

[9] StreetLink is a platform that connects people rough sleeping in England and Wales to support provided by local authorities and charities.

[10] CP6. Children and Families Moving Across Local Authority Boundaries

assault. W was referred to the Youth Justice Service (YJS). In April 2022 he was assessed as being suitable for case disposal by YJS Triage by means of a Community Resolution Order. W engaged in the assessment process.

9.2.8. Youth Justice Service was involved, and he was assigned 1:1 support. Offers of emotional support and anger management were declined.

9.2.9. In May 2022, an intervention plan was shared with W, his social worker and placement staff. Interventions included mental health screening, an offending consequences group work session with the police, and a session with his case manager about decision making. He was suspended from college after threatening another pupil.

9.2.10. In June 2022, W attended his mental health screening appointment. His mental health worker (an NHS Youth Justice and Liaison Worker) identified the presence of trauma. W said he was not ready to receive any support. Mental health screening was shared with YJS and Brent's Children and Young People Service. He declined the offer for further contact and the case was closed to YJS.

9.2.11. References in direct work with W that when he gets angry, he 'loses control of himself'. W declined culturally appropriate support offered by the YJS.

9.2.12. W had a series of missing episodes and return home interviews were offered. Friends of W report he gets 'angry' at the placement.

9.2.13. References in case records to W presenting as both 'calm and angry'.

9.2.14. Police National Computer checks were conducted by the Home Office in June 2023 and no match was found with no indication he was known to police.

9.2.15. In August 2022, he started a new college placement. This college were not aware of his previous exclusion.

9.2.16. W declined therapeutic support offered and reported as having 'limited indicators of violence' as reported by the YJS. W received no therapeutic support for his past trauma before coming to the UK.

9.2.17. In November 2022, YJS confirmed to W that the case was closed to YJS.

9.2.18. Just 8 weeks until W was 18, no Personal Advisor had been allocated and there was no joint working with the Leaving Care Service.

9.2.19. In January 2023, a new Personal Advisor was appointed. W was deemed to have settled in well and was enjoying a new college placement.

9.2.20. He changed placements in March 2023, following a fire at the placement.

9.2.21. W's first Home Office interview was attempted in June 2023 but was cancelled due to technical issues with an interpreter.

9.2.22. The Home Office conducted Police National Computer checks in June 2023 and no match was found suggesting he was not known to police at the time.

9.2.23. In July, he attended his Home Office interview. W was granted Asylum on 06 July 2023 and Asylum grant paperwork was sent to W's legal representation on 07 July 2023.

9.2.24. Incident on 17 July 2023

10. Practice and organisational learning: M

10.1. M's ethnicity and cultural background

10.1.1. There were several references in the history, documents, and discussions that M had experienced racist abuse, at work, at home and in the community. Very little is referenced in the documents regarding M's ethnic and cultural background, and experiences and how this may have influenced practice or support. Given M's consistent concerns about how others responded to him and how he then responded in turn, this issue does not seem to be reflected in risk assessments, reports of his lived experience and any intervention work. It is important for agencies to reflect on the impact of not referencing or considering how his race and ethnicity was reflected in his agency contact and how it framed much of his response to others. The police had 'considered' a referral to CATCH on the day of the incident following M's concerns about being racially abused. However, this referral was not made. CATCH is a group of charities working to end hate crime providing advocacy services for people facing hate crime in London. It offers specialist advice and help to people targeted with violence, abuse or harassment because of their race, religion, disability, sexuality, or gender identity.

10.1.2. Whilst several reports exist repeating the same issues, the Black British Voices Survey published in 2023 highlighted amongst other significant issues, that there remains 'extremely high levels of distrust and discrimination still felt deeply across Black British communities when it comes to systems such as health, education and criminal justice'[11]. The report concludes that 'much more needs to be done to overcome unacceptably high levels of racial discrimination and the failure to adequately acknowledge the depth and complexity of the causes of racial injustice remains a major contributory factor to its continuation'. Agencies could go some way in addressing this by reflecting and considering this crucial factor more in their assessments and interventions.

10.2. Police responses to M

10.2.1. There are no formal referrals to the Metropolitan Police Service (MPS) from partner agencies during the period defined within the terms of reference regarding M. The interaction is directly between officers and M.

10.2.2. M was known to the Metropolitan Police predominantly as an offender and for concerns over his presenting mental health. Scoping from January 2018 indicates 20 crime reports, 9 Merlin referrals and 7 custody reports. He was mainly known as a suspect for offences including domestic related abuse, harassment, and malicious communications. He was also known for anti-social behaviour, violence against others, burglary, and criminal damage and most of these reports detail that he was drunk or intoxicated.

[11] The Black British Voices Project September 2023. University of Cambridge.

10.2.3. Some of M's behaviour caused police officers' serious concern. The Safer Neighbourhood Team were proactive in contacting Brent Mental Health Team directly. This did not result in any action. The Safer Neighbourhood Team[12] also made referrals to the MASH, noting that M had complex needs that might require longer-term intervention. There were no direct referrals to mental health services. Several MERLIN reports were submitted to the MASH following significant concerns over M's mental health, erratic and aggressive behaviour and in relation to his daughter following domestic incidents between M and his ex-partner.

10.2.4. When in custody, M was subject to the standard risk assessment for all suspects who are booked into a custody suite. The questions are comprehensive and at no time identified any vulnerabilities or issues that would assist in assessing M as a specific risk. Following M's arrest in January 2023, it was noted that he showed signs of being intoxicated. A Risk Assessment was completed resulting in M being subject to regular observation and checks every 30 minutes. When he was charged a 'pre-release risk assessment' was undertaken to determine bail or remand. This assessment noted increased risk given the seriousness of the charges and living in the 'house in multiple occupation' (HMO) with the victim. He was refused bail and was remanded in custody.

10.2.5. The MPS decision making, and assessment tool known as THRIVE+[13] was undertaken with M in relation to all police investigations.

10.2.6. The MPS has a "vulnerability and protection of adults at risk" policy. It utilises the vulnerability assessment framework (VAF) along with other risk assessment and decision-making tools to inform the actions of officers and staff. A corner stone of the policy is information sharing via the MERLIN system, which occurred. The vulnerability assessment framework (VAF) policy is part of an overarching organisational requirement to help identify any vulnerability from a member of the public, especially any vulnerable victims, witnesses or suspects. The VAF is a tool to assist MPS police and staff in identifying vulnerability in members of the public they encounter. The purpose of applying the VAF at the earliest stage is to maximise opportunities for early intervention to prevent someone becoming a victim or suspect at a later stage. The process of identification will raise any risks for police to consider and act upon, either alone or with partner agencies. This policy only relates to adults at risk.

10.2.7. In February 2023, the MPS introduced an additional vulnerability checklist, which must be completed by all officers who have arrested any young person under the age of 18. The purpose of the checklist is to ensure that victims of child exploitation/ vulnerable children are identified and that a proactive approach is taken to safeguard young people from harm.

10.2.8. The police MERLIN reports were shared with the multi-agency safeguarding hub (MASH) including an Adult Come to Notice. They rated the February 2023

[12] Brent Safer Neighbourhoods Team (SNT) is a group of Met police officers dedicated to serving the local community. The team is made up of officers based in Brent supported by additional officers from the wider area. They work closely with local authorities, community leaders and residents to decide policing priorities for the area.

[13] The College of Policing approach to recognising vulnerability-related risk, based on the concept that vulnerabilities are features of individuals, and that harm, or the risk of harm, occurs when relevant vulnerabilities interact with the individual's situation.

referral for M as Amber (Level 3[14]) for when someone with complex needs is likely to require longer term interventions from statutory and/or specialist services. In April 2021 and in September 2022 M's vulnerability was rated as Green. Ealing Adult Social Care, following screening, also rated this referral as Green and therefore low priority. It then took seven months to refer M onto mental health services as the summary of the report suggested a decline in his mental health. It was assumed that the worker interpreted M's behaviour as needing specialist mental health support.

10.2.9. There did not appear any significant change in M's circumstances between April 2021 and September 2022, to shift the vulnerability and risk levels. It is not clear whether either Adult Social Care or the MPS had taken into consideration the previous referral that rated M as Amber.

10.2.10. The was no follow up contact made by officers in the MPS regarding those MERLIN referrals as capacity prevents this. Once the information is shared with partner agencies involving vulnerable adults, this is the end of the interaction. This is different to the referral pathway for children where there is more in-depth activity.

10.2.11. The GREEN rated assessment from Adult Social Care led to a significant delay in a referral to mental health services and by the time information was sent, M's circumstances were not subject to further assessment to reflect any updates. Mental health services have no records of a referral being received. This delay, confusion, and differences of opinion regarding risk and need resulted in no assessment or interventions being provided to M. The honest reflections by Ealing Adult Social Care that more enquiry was needed, and referrals made suggest that M's risks and needs had indeed not been given due attention. Given this is likely to be the case for other adults, the partnership could consider implementing a mechanism for how agencies adopt a more in depth and coordinated approach for dealing with high risk vulnerable adults such as the Community MARAC in Brent, including holding similar multi-agency vulnerability panels for adults as they do for children and young people.

10.2.12. From the 31 October 2023, the MPS introduced 'right care, right person' (RCRP) which is designed to ensure that the right help, by the right professional is given to those in need. At the centre of the RCRP approach is a threshold to assist police in making decisions about how police respond to a mental health related incident. MPS control room staff have been applying the new approach to assess all health incidents and to support this, health and care professionals are auditing current policies and processes to ensure that those experiencing a health crisis are identified and supported effectively.

10.3. **National Probation Service**

10.3.1. M was convicted of a breach of a non-molestation order and was sentenced to a Community Order on 13th January 2022, which was supervised by the Probation Service. His case was allocated to the Ealing Probation Office. He was required to complete two requirements during the Community Order, a Rehabilitation Activity requirement and an Unpaid Work requirement. M was assessed initially at Court, by a Court Probation Officer, who completed the Pre-Sentence report. Following sentencing, an OASys assessment was completed

[14] The Merlin system was created as a vehicle for police officers to deal with vulnerability. This allowed the recording and sharing of concerns with partners in order to effectively safeguard members of the public.

by the allocated Probation Officer. M was assessed as posing a medium risk of serious harm to known adults (victim of the offence client X) and to the children.

10.3.2. To calculate the likelihood of reoffending, the Probation Service has access to several risk predictors, each designed to calculate the risk of one of five types of reoffending. In respect of the risk assessment tools, M was assessed with a low probability of proven reoffending within 2 years, a low probability of proven non-violent reoffending within 2 years and a medium probability of proven violent-type reoffending within 2 years with a low risk of serious recidivism.

10.3.3. There were some quality issues with the OASys assessment, specifically regarding the Risk Management Plan which was not entirely relevant to M's case or circumstances. It had also been completed without the full details of M's children, leaving safeguarding insufficiently addressed and a full picture of potential risk towards identifiable children unclear. Although, appropriate safeguarding checks were completed, information was received from Brent Children and Young People Service detailing some previous incidents of concern between M and his ex-partner and their children resulting in children's social care involvement. The details of the assessments highlight alcohol misuse and erratic behaviour being displayed by M over several years. His children were previously subject to child protection and child in need planning. M had a history of causing disturbances, being under the influence of alcohol and causing damage to property.

10.3.4. There were no further updates or reviews of this initial risk assessment which indicates that practitioners managing the case did not consider a different assessment was required or that there were any significant changes to M's situation during the period of supervision.

10.3.5. Formal arrangements are in place across London to send information and intelligence requests to both Children's Social Care and the Metropolitan Police to assist Probation Officers in the gathering of information to support risk assessment and risk management. Both were completed for M appropriately and vital information was obtained that provided a wider view of his behaviours and the impact of alcohol misuse on his potential to be violent.

10.3.6. M was not a MAPPA eligible case and therefore this arrangement was not an option for the Probation Officer. However, a referral to MARAC[15] could have been considered had there been an increase in the risk posed to the victim at any stage. Information was known that M had previously threatened his ex-partner with a hammer. A community MARAC referral may have been appropriate in consideration of the reported dispute with the neighbour, but this was not completed. However, his intimidating and controlling behaviour towards his allocated Probation Officer, who was female, should have warranted a review of the risk assessment and consideration given to risk of harm towards staff, which was initially assessed as low. This allocated Probation Officer had requested that M's case be re-allocated. His compliance with his Order initially was poor. M was breached for non-attendance and for his behaviour during appointments and he appeared at Court yet was given a further opportunity to comply with the Order. His case was re-allocated to a male Probation Officer and there were no further concerns noted about his behaviour in supervision. At the point of reallocation,

[15] Multi-Agency Risk Assessment Conference

there was not sufficient evidence of management oversight which would have enhanced decision making and direction of the case management. His behaviour, both in relation to the index offence and towards the Probation Officer should have focused professional interventions on his behaviour towards women.

10.3.7. The Rehabilitative Activity Requirement of the Order was not sufficiently implemented or delivered. The Probation Service notes that there is a lack of 'professional curiosity' in the case records exploring more details around employment, substance and/or alcohol use and his children's safeguarding.

10.3.8. M is provided with monthly appointments with the Probation Officer but there is no structured intervention work completed as designed in the sentence plan. There was insufficient action taken regarding M's alcohol misuse which appears to be a significant risk factor. A referral to a local substance misuse treatment provider could have been completed to support M in this area of need.

10.3.9. M went on to complete all the unpaid work hours by August 2022.

10.3.10. In September 2022, following M reporting contact with police, a police intelligence check was completed by his Probation Officer. The police intelligence check revealed several occasions when police had been called to incidents involving M at his home address including altercations with a neighbour and evidence of violent behaviours. M is reported to be heavily intoxicated. Information is also provided of an alleged further offence against the victim of the index offence. There is an insufficient response to this information by the Probation Officer. It is not raised with the Senior Probation Officer and no action is taken to increase the frequency of reporting or to liaise with police relating to potential new charges or consider a referral to MARAC and children's social care.

10.3.11. In contrast, the Probation Officer did make a referral for Education, Training and Employment support for M in October 2022 when M reported losing his employment 'due to his boss being racist.' This information adds to M's concerns about how he was being treated as a black man.

10.3.12. In December 2022, M reported that he wanted to move out of his current accommodation due to an ongoing dispute with his neighbour. The Probation Officer completed a Duty to Refer in response to this. It is not clear if this was sent to Brent or Ealing Local Authority.

10.3.13. M had been remanded in custody in January 2023, one month prior to the Community Order expiring and therefore there was no formal supervision or contact with M in the 6 months prior to him being killed.

10.3.14. There was no obvious consideration to intersectionality in the management of M's case by the National Probation Service. While the equality and monitoring form had been completed there was no evidence of additional discussion or consideration given to this during his supervision appointments.

10.3.15. While there were some gaps in the management of his case during 2022 when the Community Order was running, it is difficult to determine that these had a direct bearing on his circumstances in July 2023 or the circumstances around the event that lead to his death.

10.3.16. There are noted areas for improvement in the management of M's case from the National Probation Service focusing on the delivery and implementation of the Community Order plan. Additionally, the practitioner could have sought advice and guidance from a manager to provide direction on the case. It notes that evidence of management oversight could also have been improved. Yet this does address the reasons why these events occurred as they did. The review author has requested agencies consider the context in which practitioners were working at the time and the influences on practice such as leadership, culture, and organisational challenges, unfortunately these have not been considered.

10.3.17. The reasons as to why action, activity, and interventions, particularly referrals to address M's alcohol or substance misuse, were not undertaken remains unclear.

10.3.18. The Community Order expired whilst M was in prison and therefore there were no formal supervision arrangements on his release.

10.3.19. M did seek support from Ealing Probation Service, yet the notes made at the time do not indicate that any referrals were made. M was signposted to the local authority to obtain housing assistance and was also provided with details of 'Streetlink'.

10.3.20. The lack of support and services to M on his release appears to have caused him some distress, with an apparent expectation that he would be self-sufficient to seek housing and support services as required. His release from prison and subsequent lack of accommodation and support network potentially led to M's further decline into further alcohol use and, consequentially aggressive and abusive behaviour towards others. Whilst the outcome could not have been predicted for M and no agency could have prevented his death, support services to adults on release from prison are crucial to rehabilitation back into the community. Resettlement support for those being released from prison following a period of remand should be like that of someone who is released after completing a prison sentence. However, following the reunification of the Probation Service in 2022 and subsequent changes in the delivery of resettlement services, remand prisoners were not included in new contracts with accommodation support agencies. The prison estate is tasked with supporting offenders leaving prison with advice regarding housing and available support services, yet it is not clear how effective these arrangements are for those offenders leaving prison with no licence conditions in place.

10.3.21. Following the 'reunification of the Probation Service in June 2021 which brought the formerly privately contracted community rehabilitation companies (CRC) to an end, the delivery of Probation Services was adjusting to significant change. There had also been chronic staff shortages that have existed across the organisation since this time with a national prioritisation framework being introduced in response. This ultimately could have been a factor in the quality of the work completed in M's case. Since this time, the London Probation Service has implemented a quality improvement programme that was rolled out for all practitioners in 2023 and has implemented a new auditing framework that is carried out monthly.

10.3.22. Prisoners on remand can have access to their own GP but this would be at a cost to the prisoner. Healthcare staff in the prison estate should make sure

relevant services in the community are told about an offender's health needs and when they are being released. However, M's GP received no information from the prison regarding his status or release date. M's GP felt strongly that there should be some exchange of information, access to prison health records or the provision of health summaries provided to community GPs from healthcare in prison. Representatives from the prison service have responded noting that prisoner's data is transmitted through System One to all healthcare practitioners within the prison and before their release, any medical issues the prisoner expresses during an evaluation are emphasised in the records and appropriate referrals made. After release, prisoner records are passed on to their registered GP. Data may be exchanged if the prisoner grants permission, however, if the prisoner withdraws consent, information can no longer be shared. Where there is a significant risk of harm to either the prisoner or others, sharing information should be considered. Relevant to M's circumstances, being homeless can make it difficult to connect individuals with a GP or get them the necessary referrals and support in the community. Lack of knowledge about how GPs can help and reluctance to seek appointments or provide complete medical information can also hinder proper care for homeless individuals upon their release.

10.4. **Police Intelligence Checks**

10.4.1. In both M and W's circumstances, there was a gap in knowledge from both the National Probation Service and the Home Office regarding police involvement.

10.4.2. In M's case, his Probation Officer was not aware of significant arrests and criminal activity whilst M remained on a Community Order. It is not clear as to why this would be the case and the issue was further complicated by a lack of follow up by the allocated Probation Officer. It is understood that a criteria is applied and checks can only be carried out every 6-months by practitioners. Probation practitioners are not pro-actively supplied with arrest incidents of those subject to community disposals unless the subject is an integrated offender management nominal or if the investigating officer contacts the practitioner to assist in enquiries. The MPS have reviewed M's full Police National Computer (PNC) record. There is no information marker advising that M was an integrated offender nominal and subject to offender management.

10.4.3. It is understood that the Metropolitan Police Service and National Probation Service information sharing agreement states that information needs to be requested using a specific form (known as V11). This is the only acceptable method of request and anything outside of this criterion would be rejected. This is because of the volume of demand from the National Probation Service and the level of resourcing within the Metropolitan Police Service to provide such information. The timeframe for searches will cover the preceding six months unless a clear rationale is provided.

10.4.4. It is recorded that the connectivity of disparate MPS IT systems will be of great benefit. The custody recording system for the MPS changed in 2023 and is now recorded on 'CONNECT'. CONNECT is an integrated IT system that combines the various disparate MPS systems into one. It creates one record for each nominal and then links all the new reports to that file. The result being that each piece of information inputted about that one person will be visible to any officer dealing with them, enabling a more complete intelligence picture and risk assessment. CONNECT can generate management plans for integrated

offender management and the system allows officers to generate this plan with a new alert system to alert officers to 'real time' events linked to the individual.

10.5. **Alcohol and Substance Misuse**

10.5.1. There is evidence throughout agencies involvement with M which suggests his behaviour was linked to the use of alcohol or substances. There were opportunities to address this issue with him, particularly through the mandated Community Order. It is unclear as to why these referrals were not made. It is noted that M himself denied alcohol use, but it was evident that this added to his risk. M did eventually comply with the Community Order, and this could have been addressed at that time. It remains unclear as to why these approaches were not made other than M's apparent reluctance to engage.

10.6. **Mental Health**

10.6.1. Mental health services had one contact with M via Liaison and Diversion in November 2022 in the Custody Centre where he had been taken after displaying significant violence and aggression during arrest and booking. He was believed to be under the influence of an unknown substance. M declined a full assessment, declined any current or active plans or thoughts of self-harm or suicide, and had no signs of acute mental illness that would warrant diversion to the acute care pathway into health services. He could therefore proceed along the criminal justice pathway. M's behaviour in custody was at odds with some of his behaviour in the community and whilst assessments must consider current mental health presentation, it appears not to consider the history of presentation and chronology of previous referrals.

10.6.2. It is documented he had no input from Mental Health Services and was not known to Central and North West London NHS Foundation Trust which includes the Brent Community Mental Health Team that sits within Central and North West London NHS Foundation Trust. Despite references to referrals to mental health services from Adult Social Care and the MPS Safer Neighbourhood Team.

10.6.3. It is unclear whether it was viewed that M's sometimes erratic and at times bizarre behaviour was because of alcohol or substance misuse or an underlying mental health problem. Certainly, the MPS had several concerns about his presentation prompting referrals to the MASH on at least 9 occasions. This did not result in any formal assessments or interventions from mental health services.

10.7. **MASH**

10.7.1. Based on the current number of referrals received daily and the process of managing risk based on red alerts given high priority followed by amber and green given least priority, it is recorded that the team worked to the team's protocol. The aim of the team is to reduce the waiting time for green graded cases however this is an aspiration and is yet to be achieved.

10.7.2. The referral to mental health was considered an appropriate action based on the information provided by the police and their assessment of his mental health deterioration. However, Ealing Adult Social Care note that on reflection there are areas for improvement.

10.7.3. Ealing Adult Social Care believe that the assessor analysing the initial information could have contacted M to establish his situation. This conversation

could have enquired about any changes and any family involved for additional support; this would have helped assess his mental capacity. It was also felt that a referral should have been made to the designated safeguarding team who would have made additional checks in line with Pan London criteria. Contact should have been made with the GP and mental health services to raise concerns about M's mental and physical health. There could have also been a referral to drug and alcohol services to establish if M was known to them for intervention. There are no clear reasons why these actions did not take place. Ealing Adult Social Care further advise that had M not engaged in a discussion, contact could have been made with housing and police to assess risks and develop appropriate plans.

10.7.4. Ealing Adult Social Care have identified three lessons learnt from the analysis of M's situation:

- All referrals received require a call to the service user to establish their wishes and preferences.
- Closed cases with no service engagement require auditing to ensure appropriate action is taken and referrals made.
- All referrals sent to other services must be followed up for confirmation of acceptance.

10.8. **Housing**

10.8.1. M made four applications as a homeless person to Brent Housing between June 2018 and September 2021. His assessments were conducted over the telephone. The correct procedures were followed in all four homeless applications, and although he did not engage in two of the applications, the outcome of the other applications was that he secured accommodation to end his homelessness.

10.8.2. In December 2022 M approached Ealing Housing Solutions alleging anti-social behaviour and racial abuse from another tenant. He was given an appointment but at the appointment he did not want to provide identification and there was no further contact from him. It was subsequently established he had gone into custody in January 2023.

10.8.3. Following his release from prison, M approached Ealing Housing Solutions again, which is recorded as being on 26 June 2023. M reported to the Housing Solutions team that he could not return to his accommodation due to having been in prison for 6 months and that he needed to collect his items under police supervision.

10.8.4. On 3 July 2023 M was issued a Section184 non-priority decision under the Housing Act and referred to Single Homeless Prevention Service (SHPS) for help to secure private rented accommodation as part of the Council's Relief duties.

10.8.5. Ealing Housing Solutions records indicate he had an appointment to view a privately rented property in Brent on 13 July 2023 and that he accepted this appointment. However, Ealing Housing Solutions were awaiting the landlord's consent for this appointment to proceed. During this time M was also being assisted by St Mungo's Homeless charity.

10.9. **Cross borough intelligence**

10.9.1. M had community links in both the London Boroughs of Brent and Ealing, and he was engaged with services from both authority areas. Information regarding agency contact only emerged because of the enquiries into this review. This information could assist in the assessment of need and risk. It warrants consideration as to how this could be achieved for vulnerable adults.

10.10. **Practice and organisational learning: W**

10.10.1. W's ethnicity and cultural background

10.10.2. W is a Syrian national with leave to remain in the UK following his successful asylum application. He is a practicing Muslim. There are references to his background and possible lived experiences in Syria. W was offered support and therapeutic interventions to address his lived trauma, but agencies were not able to engage him in this intervention. During the initial health assessment, the doctor did not identify any specific emotional or behavioural needs but advised that this issue required ongoing monitoring. Given W's background of coming to the UK from a war inflicted zone, it is apparent that engagement with young people is needed at the earliest opportunity. Whilst the Home Office or the Foreign Office have no operational responsibilities for these children, advice and guidance should be made available to local authorities regarding the possible experiences of children and young people from countries where conflict and war are prevalent. This information is more likely to be available to government and non-government agencies which would support local authorities in culturally sensitive interventions.

10.10.3. The UNICEF Refugee and Migrant Children via Mixed Migration Routes in Europe Accompanied, Unaccompanied and Separated trend report from January to December 2022[13] highlighted almost half of the children and young adults (47%) reported war and conflict as the primary reason for leaving their country of origin. The reasons cited related to safety and security, violent family disputes, domestic violence, discrimination, religion, sexuality, and gender. Among their most pressing needs, young migrants and refugees reported food, accommodation/shelter, cash assistance, medical assistance, clothing and the possibility to continue the journey.

10.10.4. It is noted that the question of therapeutic input was raised with W in subsequent conversations and 'care experienced review meetings', yet agencies continued to fail to engage him with references to 'no requirement for formal therapy'. It is important for agencies to understand how UASC may view statutory or voluntary interventions from the perspective of their lived experience in their home country. No further culturally sensitive interventions are noted yet W was invited to Eid celebrations by his then PA. No further work or resources were made available to W to support him being part of the community and there was no evidence that a culturally appropriate mentor was considered. W was referred to mental health support by his college but it was not specifically culturally sensitive and he refused engagement.

10.10.5. It is 'believed' that the social worker offered W access to the charity 'Young Roots' for culturally appropriate support but he declined. The social worker's manager also noted that W continued to have a relationship with family members

in the UK which may have met his needs for cultural support over and above what local agencies could have provided.

10.10.6. The Youth Justice Service note that W might have benefitted from a referral to the Brent Pathfinder for Overrepresented Children at the time, a wellbeing counselling service specifically for Black, Asian and Minority Ethnic heritage children. This was an Early Help managed early intervention which ceased to operate when external funding ended in April 2024.

10.10.7. Early Help provision, including culturally appropriate early intervention opportunities for UASC and Looked After Children more broadly, should be expanded where resources permit. Community groups should also be supported to develop and implement local offers. The extent and effectiveness to which partnerships do this would improve public safety and divert young people from future harmful behaviour. It would also protect children from the serious contextual safeguarding risks which make them vulnerable to criminal exploitation.

10.11. **Children's Social Care**

10.11.1. Throughout working with W, there were concerns around unresolved past trauma, delays in processing his asylum claims and not attending medical appointments. From August 2021 to February 2022, W had settled well. He was well settled in his placement and attending college. He had regular contact with his family locally. He was presenting as 'positive' in his mood.

10.11.2. During February 2022, some concerning behaviour started to arise. W was returning to placement past his curfew and subsequently was suspended from college on two occasions, once for a physical attack and once for verbal threats. During this time practitioners had several meetings with W and the placement met with W to hear his views in relation to missing episodes. He was able to voice some concerns around his placement. Direct work, emotional support and anger management was discussed with W during several visits.

10.11.3. W was open about his anger and how he managed it. He acknowledged he can feel strong anger, at times he has broken items or assaulted others. He said this has been a pattern of behaviour since childhood. W did not see the need for support and presented as 'dismissive' of anger management strategies.

10.11.4. In September 2022, W was regularly going missing from his placement, staying out overnight and refusing to provide any information as to his whereabouts. Whilst there were conversations with W regarding anger management strategies, at no point was there a re-assessment of W's needs and risks given this shift in his engagement and risk.

10.11.5. There was no joint work undertaken for his transition post 18 to the Leaving Care Service and no Personal Advisor (PA) was allocated. This lack of joint working and care planning for W at a key transition was significant, particularly as his behaviour had deteriorated and his engagement lessened. A new PA was allocated 3 weeks after his 18th birthday, so no transition planning had taken place, but his social worker and PA began working together in late January 2023.

10.11.6. The Leaving Care Team PA provided a good level of checking in support to W and supported him well following the fire at the placement. There was delay in W

receiving allowances for new clothes. This affected his college attendance as he refused to attend in the same clothes.

10.11.7. The PA supported W at his Home Office asylum claim interview in July 2023 and following this he was granted asylum. W was charged with the murder of M in July 2023 and remained in custody until the completion of the trial. W has been reluctant to have PA support during his time on remand.

10.12. **Youth Justice Service (YJS)**

10.12.1. W was referred to Brent Youth Justice Service via a police referral to consider an Out of Court Disposal for the offence of common assault that took place in March 2022. He had been arrested by the police following an altercation in which he punched a student from his school. The incident took place outside of his school premises. W admitted punching the victim several times after an argument. He claimed that the argument was the result of having been teased by the student previously about his height and making disrespectful remarks about Syria.

10.12.2. W was assessed by an Out of Court Disposal Case Manager using the Out of Court Disposal Rapid Assessment screening form. The form is used for all Out of Court Disposal referrals to identify a young person's needs and to manage their risk, safety and well-being. They inform decision making at the Youth Justice Service Out of Court Disposal Panel (OOCD panel) and assist in the identification of interventions and disposal conditions. W was also screened by the NHS Youth Justice Liaison & Diversion Mental Health Practitioner. The practitioner used the CAHMS young person physical and mental health screening tool. Rapid Assessments are used to gather as much information as possible.

10.12.3. W did not meet the threshold for referral to the Youth Justice Service Multi-agency Risk, Safety and Wellbeing Management Forum. He did not reoffend or undertake any actions known to the service that would cause him to be considered high risk. The offence of common assault was not serious enough to warrant multiagency oversight. He was described as remorseful and apologised to the victim.

10.12.4. The Triage Intervention was the outcome agreed by the OOCD panel. This is an informal disposal of 12 weeks intervention. It is not a criminal conviction; therefore W did not receive a statutory criminal disposal. Due to this he did not formally enter the Youth Justice system. Triage is a voluntary intervention, there are no sanctions available for non-compliance. Therefore, this information would not be available on a Police Intelligence Check. This resulted in the Home Office not having detailed information to assess W's asylum claim.

10.12.5. An intervention plan was agreed with W and this was shared with his social worker. There was limited engagement from W and the Youth Justice Service had no authority to enforce compliance. The Youth Justice Service noted that W could possibly have benefited from further mental health support such as counselling. However, this was voluntary, and W was not ready to share his trauma experiences at the time.

10.12.6. A community resolution order is a non-criminal disposal and W's attendance was entirely voluntary. He did engage with the YJS, and the NHS youth justice and liaison worker was proactive in effective handover to other agencies. The

decision to make W subject to a community resolution was procedurally correct. However, there may be a wider systems issue to consider the appropriateness of Community Resolutions for violent offences. Opportunities to work more intensively with children who have displayed violent behaviour through an enforced approach may be of benefit.

10.12.7. The Youth Justice Service have reflected that they could have worked even harder to establish the trust and relationship needed to engage W in positive activities. This might have included visiting him at his placement at agreed regular intervals and accompanying him to activities to improve his likelihood of attending. It would involve supporting him beyond the relatively short window of time that Triage Intervention was able to support him.

10.12.8. It is further noted that more access is required to well-resourced charities that can offer needs led individual support for children who arrive in the UK as unaccompanied minors.

11. Education Support

11.1. W was a student studying for a City and Guild Award in ESOL Speaking and Listening as well as Functional Skills Entry 1 Maths at his first college from September 2021 to his exclusion in June 2022. W had assaulted another pupil in March 2022 and was given a final written warning. In May 2022, W made physical threats to another pupil and was consequently excluded.

11.2. W applied for a course at his second college in September 2022 and enrolled onto the ESOL Young Foundation Pre-Entry Course. It became apparent during the review that the second college had no information regarding W's exclusion from his previous college.

11.3. A Personal Educational Progress Meeting was held with the College in December 2022 with his social worker and the 'Virtual School'[16]. The meeting was held to discuss W's progress in college and highlight any concerns. The college highlighted that more information is required at enrolment and beyond so the college are aware and can support learners when there are changes of circumstance. It was noted that often, 'we received this information late or not all'.

11.4. The college noted that they need access to key individuals quickly and efficiently, so they need full details from the local authority at the point of enrolment. The college plays a key role in the support network, and it is crucial that they are seen as part of the system supporting young people.

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

12.1. To promote the learning from this case the review identified the following actions and anticipated improvement outcomes:

1. The Safer Brent Partnership should work alongside other relevant agencies to ensure that practice guidance includes taking into account a person's ethnic and cultural

[16] A Virtual School acts as a local authority champion to bring about improvements in the education and outcomes of Looked after Children (LAC) and Young Care Leavers (YCL) and to promote their educational achievement as if they were in a single school. Our key objective is to ensure each LAC receives a high quality education which will give them a secure foundation as they move into adulthood.

background, including any experiences of discrimination and should form part of assessment and intervention practice.

2. The Safer Brent Partnership should work alongside CATCH Communities Against Hate to promote their services and support provision and ensure practitioners are aware of its service offer.
3. Adult Social Care in Brent alongside other partner agencies should consider adopting a multi-agency coordinated approach and threshold criteria for dealing with vulnerable adults who are not considered high-risk but are likely to need ongoing risk assessment and support.
4. Adult Social Care, MPS, mental health services and other agencies should ensure that the chronology of referrals or interventions undertaken, factor in the presenting assessment of need and risk. This is to ensure that current risk and planning is also based on historic context.
5. Probation Services in Ealing should seek assurances through case reviews that Community Orders and associated interventions are effective and based on the offender's identified needs and risks, including the behaviour of the offender. Identified alcohol or substance misuse should always factor in risk assessment and intervention.
6. Metropolitan Police Service and National Probation Service should review and assure that existing protocols for sharing offender information through police intelligence checks are effective.
7. His Majesty's Prison and Probation Service should consider reviewing the current arrangements for supporting offenders leaving the prison estate who are not on licence and assure themselves as to the effectiveness of those support arrangements in meeting known needs and risks. With particular reference to those who would become homeless on release.
8. The Safer Brent Partnership alongside health professionals should seek assurance that the role and functions of 'dual diagnosis' services in Brent and Ealing are well communicated in the system. It should seek assurance that practitioners are clear on referral pathways.
9. The Home Office and the Youth Justice Service should ensure existing information sharing protocols for unaccompanied asylum-seeking children are robust and enable the effective sharing of information to support decision making.
10. Brent Children's Social Care should assure itself through audit and child and young person feedback that the transition arrangements to the Leaving Care Service for unaccompanied asylum-seeking children is effective and meeting need and addressing risks in a timely way.
11. The Home Office and Brent's Children and Young People Service should ensure that a trauma informed approach is embedded into practice guidance for unaccompanied asylum-seeking children. They should ensure culturally appropriate services are commissioned to support children and young people with their trauma, including the use of culturally appropriate advocates to represent them if relevant.
12. Brent's Children and Young People Service should review their current early intervention resources for young people with anger management issues and consider whether additional resources are required to address this issue.

Dissemination

The list of recipients to receive copies of this Review Report (in line with guidance and due to the recommendations of this Report) are as follows:

Organisation	Yes	No	Reason
Brent Community Safety Team			
Metropolitan Police Borough Command Unit - Brent			
North West London Integrated Care Board – Brent			
Brent Probation			
Ealing Probation			
Brent Youth Justice Service			
Brent Looked After Children and Permanency Team			
Home Office			
Metropolitan Police Specialist Crime Review Group			
Home Office Asylum Policy Unit			
Home Office Asylum Team			
Brent Children's Safeguarding Team			
Ealing Community Safety			
Ealing Adult Social Care			
Home Office Asylum and Human Rights Operations			
London North West University Healthcare NHS Trust - Safeguarding			
London Borough of Brent Housing Needs Team			
Central and North West London NHS Foundation Trust – Safeguarding			

Brent Community Mental Health Team			
Harrow Richmond Uxbridge Colleges - Harrow College Safeguarding			
Ellis Practice GP			
United Colleges Group Safeguarding			

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 that this has been completed). ☒

Statements of Independence

Chair

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 of 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 ser 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.

Signature:

Name: **Ian Vinall**

Date: **June 2025**

To be completed by the Home office:

Please tick here to confirm thar 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 details to confirm how the alternative Chair fully meets the Competencies set out in the OWHR guidance.