Birmingham City Council

Offensive Weapon Homicide Review Report- BOWHR002

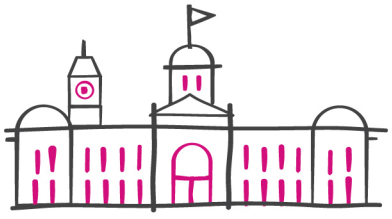
Relevant review partners (being the police and local authorities in England and Wales, integrated care boards in England and local health boards in Wales) are required by Part 2 of the Police, Crime, Sentencing and Courts Act 2022 to arrange a review into a person's death in certain circumstances.

This is where the person was aged 18 or over and that the death, or the events surrounding it, involved the use of an offensive weapon. These are known as Offensive Weapons Homicide Reviews (OWHRs).

The reviews are being piloted for a period of 18 months from 1 April 2023 in three areas:

1. London (in Barnet, Brent, Harrow, Lambeth and Southwark).
2. West Midlands (in Birmingham and Coventry); and
3. South Wales.

This report satisfies the criteria for a report completion under the terms of the pilot.



OWHR Draft Review Report (England)

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

- Birmingham Community Safety Partnership (BCSP)
- West Midlands Police (WMP)
- Local Authority (Birmingham City Council)
- Integrated Care Board (ICB).

Case Reference Number:

BOWHR002

Pseudonyms

The use of pseudonyms[1], is the normal convention to protect the anonymity of individuals and/or families. In this review report, the victims' mother chose the pseudonym for herself and her son. The Chair/Author chose the pseudonyms for each of the perpetrators, having confirmed with the victim's mother that they held no personal impact on her. Sterling's partner selected her own pseudonym. The Home Office (HO) define the term perpetrator for Offensive Weapon Homicide Reviews (OWHR's). The term 'perpetrator' is attributed to a person who has been charged with an offence related to the homicide, not necessarily one who has been convicted.

Table 1

Pseudonyms	**Relationship to Victim/perpetrators**	Age at time of incident	Source material for this report / comment
Sterling	Victim		Police summary/IMR's
Beatrice	Sterling's mother	49 years	Interview with author
Stacey	Sterling's partner	22 years	Interview with author
Sarah	Sterling's former partner	34 years	Written answers via a bespoke questionnaire
Greg	Perpetrator 1	20 years	Police summary/ IMR's
Mark	Perpetrator 2	19 years	Police summary/ IMR's
Danny	Perpetrator 3	17 years	Police summary/ IMR's

Date of incident which led to the Review:

April 2023

[1] A fictitious name used to disguise the identity and protect anonymity of individual concerned.

Date of death where applicable:
As above

Review's start date (commissioned): 20/06/2023

Review completion date (approved and signed off): 23/07/2025

Publication date: 08/08/2025

It is important to acknowledge that the delays experienced during the course of this review were due to a combination of factors. Initially, staffing pressures within Birmingham City Council impacted the capacity to progress certain elements in a timely manner. Additional delays arose during the information-gathering phase, including ensuring the accuracy and completeness of the data provided, and confirming the appropriate agencies were represented on the panel. With the appointment of new staff, prompt and efficient progress was made. However, it is important to acknowledge staffing pressures and the significant workload of Birmingham CSP in supporting OWHR's.

The first panel meeting therefore took place on 31.08.2023 (to discuss scoping returns), and the second on 22.09.2023 (IMR[2] discussion panel). Review and feedback on the submitted IMR's was extended to 30.11.2023, to accommodate agency workloads. The third panel sat on 23.02.2024 (to discuss 1st draft of the report). The prosecution trial was initially set for 27.11.2023, later delayed to January 2024, concluding on 25.01.2024. Sentencing was postponed until 18.03.2024.

At their request, the Chair awaited contact with family (post-conviction) and also any contact with the perpetrator's families, as their legal representatives had indicated they wanted to await sentencing. There were significant delays in contact with Sarah as she was managing the obvious distress felt by the family, but particularly Sterling's son. Her contribution was received on 29.06.2024.

The Chair was unavailable and out of the country between 15.12.2023 and 19.01.2024, although this had no impact on any proposed panel meetings and/or interviews. An explanation for delays was communicated to the HO on 21.05.2024.

There were delays in agencies providing feedback to the draft versions of the report. Not all agencies have provided any feedback to this report.

The final draft of the overview report was sent to BCSP on 10th September 2024 for circulation and virtual signoff by the agencies involved. On 20th September 2024, the report was returned to the author with a request from the Home Office to follow a specific localised headed template, which was completed and returned to BCSP on the same day.

[2] Individual Management Review (IMR) is a chronology report detailing, analysing and reflecting on the actions, decisions, missed opportunities and areas of good practice within the individual organisation.

The report was due to be quality assured by the local Oversight Board on 24th October 2024. The meeting was cancelled and moved to the 3rd November 2024, which was then also cancelled. A further meeting date in December 2024 was cancelled and finally a date was agreed for 22nd January 2025. The minutes (with actions) were passed to the author on the 21st February 2025 and there were a number of actions for Oversight Board members which were not completed by them, until 3rd of June 2025. The final amended report was re-submitted to the CSP on 9th June 2025 for presentation to the HO.

Outline of circumstances resulting in the Review

OWHR's were introduced under the Police Crime Sentencing and Courts Act 2022[3]. The criteria for this Review are met under section 24(6) of the Act, which specifies the homicide of a person is a qualifying homicide if

a. The person is aged 18 or over (Sterling was over 18 years) and
b. the death, or the events surrounding it, involved the use of an offensive weapon (a knife was used in the offence).

There are three named perpetrators in this case. An alleged perpetrator can be included in a review at any age, including those aged under 18.

- **Greg** is a 20-year-old British male from Birmingham. Greg was arrested in April 2023. He was charged with Murder, Robbery and Possession of a Bladed Article in April 2023. He made his first court appearance in May 2024
- **Mark** is a 19-year-old British male from Birmingham. Mark was arrested in May 2023, when he was charged with Murder and Robbery. He made his first court appearance in May 2023.
- **Danny** is a 17-year-old British born male from Birmingham. Danny was arrested on in April 2023. He was charged with Murder, Robbery and Possession of a Bladed Article in April 2023. He made his first court appearance in May 2023.

Summary of Incident:

On a day in April 2023, in the early hours, a fatal stabbing occurred in Birmingham. Sterling was chased and stabbed multiple times, leading to fatal injuries. Sterling was pronounced deceased at the scene following unsuccessful attempts at CPR. Three alleged perpetrators fled the scene and were later arrested on suspicion of murder.

The police investigation considered the murder to be the culmination of a dispute between Sterling and Danny over the ownership of a distinctive electric bike, which Sterling had purchased for over £4,600. Prior to this, they were personally unknown to each other. In October 2022, the bike was stolen from outside a high street shop by a person unknown. Stacey reported the theft to police in November 2022, incorrectly claiming it was stolen from the back garden. No police enquiries were conducted at the actual location of the theft and there were no witnesses or identifiable lines of enquiry that police could follow. Whilst there

[3] https://www.gov.uk/government/publications/police-crime-sentencing-and-courts-bill-2021-overarching-documents/police-crime-sentencing-and-courts-act-2022-commencement-schedule

is no evidence that Danny was involved in the actual theft, the bike later appeared in his possession, when he was observed riding it by Stacey. This was not reported to police. Danny's identification was not an issue as Stacey personally knew each of the perpetrators for many years from the local area in Birmingham.

Sometime in early March 2023, accompanied by Stacey, Sterling recognised his bike, being ridden by Danny and challenged him to return it. Despite denying it to be 'stolen', Danny returned the bike to Sterling. Further details were unknown about this incident, including the exact location or time, as it remained unreported by either Sterling or Danny.

In March 2023, Danny's Youth Offending Service (YOS) Officer, reported that Danny claimed to have been a victim of a knifepoint robbery (of 'his' scooter). The offender was described as a male with a 'Rambo knife'. This alleged incident could not be corroborated or investigated as Danny refused to assist police with any enquiries and did not identify anyone concerned. He provided no details of the exact day, date, time, or location. Of note, Danny also did not present this information in evidence at his trial.

In contrast to Danny's account, in her retrospective evidence to police (and interview with the author), Stacey said Danny 'simply handed the bike over', and she believed Danny invented the knifepoint robbery account to 'protect his macho image'.

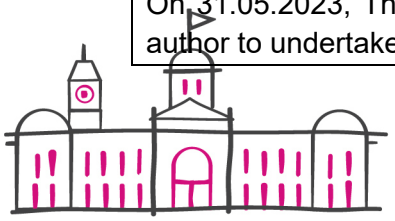
Soon after this incident, Danny made two visits to Stacey's mothers' workplace in Birmingham, demanding the bike be returned to him and making threats of retribution against Sterling in front of multiple witnesses. These threats were not reported to police or other agencies by anyone present at the time.

On the day of the murder, in the early hours, Greg, Mark and Danny, travelling in a taxi, allegedly spotted the bike 'parked' outside a shop on a High Street. Causing the taxi driver to stop, Danny confronted Sterling in the shop, before brandishing a knife and chasing Sterling on foot. This was captured on the drivers dashcam. Greg, who was also carrying a knife, joined in the chase, while Mark grabbed the bike from outside the shop. Danny struck Sterling multiple times with the knife inflicting fatal injuries on him. After the attack, the three perpetrators made off. As he lay dying, Sterling identified Danny by his street name.

A police helicopter, in the area responding to the stabbing incident, filmed the perpetrators discarding a bag before entering a block of flats. The bag was retrieved. It contained a knife which, when forensically tested, was found to have traces of Sterling's blood on it. Forensic analysis linked both the weapon and the bag to Danny and Greg, who were arrested the following day. Mark handed himself into police custody two weeks later following a public appeal.

Sterling's death was referred to BCSP by police on 26.04.2023. The RRP's steering group met on 03.05.2023 and the OWHR was then commissioned by Head of the Community Safety Team in accordance with the OWHR Statutory Guidance, as the death met the criteria defined in the statutory guidance.

On 31.05.2023, Theresa Breen was formally appointed as Independent Chair and report author to undertake the OWHR.



On 05.06.2023, BCSP formally notified the Secretary of State that the criteria had been met and an OWHR would be commenced.

An OWHR review Panel was established. The first meeting took place on 31.08.2023. The following Table (Table 1) sets out the Panel members and the organisations that they represent. The Panel acts as the local oversight process for this review. The strategic Oversight Group details are attached as an appendix.

The review panel members were drawn from the following agencies:

- West Midlands Police.
- Birmingham City Council's Housing Solutions and Support Service.
- Birmingham City Council- Community Safety Partnership Review Team.
- Birmingham City Council's Childrens Trust (Children's Social Care Representative).
- Birmingham Childrens Trust- Youth Offending Service.
- Birmingham and Solihull Integrated Care Board (BSOL ICB).
- National Probation Service.

Terms of Reference (TOR)[4] was drafted by the Independent Chair and Author and the TOR and scope of the review were approved at the first panel hearing. A redacted version of the TOR is attached.

The Chair listed six specific Key Lines of Enquiry (KLOE) which the IMR authors were asked to consider when recording their agency information, and document in their responses which included:

- **KLOE 1 - Whether family, friends or colleagues were aware of any violent or aggressive behaviour from the alleged perpetrator(s) to the victim, prior to the homicide.**

- **KLOE 2 - Whether there were any barriers experienced by the victim (or his family/ friends/colleagues) in reporting any concerns, including whether he knew how to report violence or threats should he have wanted to.**

- **KLOE 3 - Whether any of the perpetrators were known to carry offensive weapons (routinely or as a one off) and what steps had been taken to share multiagency information to prevent such usage.**

- **KLOE 4 - Whether there were opportunities for professionals to 'enquire' as to any violence /abuse linked to offensive weapons, experienced by the victim that were missed.**

[4] Redacted TOR- Attached below.

- **KLOE 5 - Whether there were opportunities for agency intervention in relation to violence/ threats regarding the victim or alleged perpetrators that was missed.**

- **KLOE 6 - The review should identify any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of offensive weapon processes and/or services.**

To focus on recent, contemporary, and relevant agency contact with the victim and perpetrators, the panel agreed the timeframe that this review should encompass would be **April 2021 to April 2023** (24 months), as suggested by the HO guidance. There was also significant multi-agency information connected to Danny over that period. However, it was further agreed that if considered pertinent and relevant the panel may also include any other periods, if agreed by the Chair.

The methodology was a review of the circumstances, a review of a number of documents including agency chronology's (scoping) / IMR's and interviews with family members, listed below. Selected IMR's[5] were received by the author on 16.10.2023, 19.10.2023[6], 22.10.2023 and 25.10.2023. They were circulated for feedback to the panel, and responses from some agencies were returned with feedback, comments and questions on 30.11.2023 to the Chair. Others were received in January and February 2024.

Contributors to the Review / Agencies submitting information following the scoping request to agencies (chronology / IMR) include:

Agency	**Contribution**
West Midlands Police (WMP)	Chronology / IMR x 1
NHS (ICB) Health Services[7]	Chronology / IMR x 4
Birmingham Children's Trust (BCT)	Chronology/ IMR x 2
Birmingham Youth Offending Service (BYOS)	IMR X 1
West Midland Ambulance Service	Chronology
Birmingham City Council (BCC) Housing	Chronology /IMR x 1
HMPPS (Probation)	IMR X 1
Birmingham City Council- Adult Social Care	Chronology
Education	School records/ Advice

Three agencies[8] provided a 'Nil' return for contact and /or engagement with the victim or perpetrators. Some other agencies did not respond to the request, and as they were not relevant to the review, they were not followed up for information.

BYOS sits within the BCT and that is resourced with staff from probation, police, education, health, and other statutory and voluntary agencies. The Forward-Thinking Birmingham

[5] WMP, Health x 3, BYOS IMR's
[6] Housing IMR
[7] NHS Birmingham and Solihull ICB- BSOL ICB.
[8] Nil IMR return from BCC- Community Safety Partnership, Housing Management Central, Ministry of Defence.

(FTB) Youth Offending Service (YOS) forms the health aspect. FTB-YOS is the offer for mental health.

BYOS had no relevant information on Sterling as he was an adult. They also had no information listed on Mark.

BCT had no specific records on Sterling. Greg and Mark were not open to BCT however they are known due to their younger siblings historically being open to BCT. As such IMRs' for Greg and Mark were not specific to them but wider familial needs.

In respect of the chronology / scoping and IMR submissions, of note, BCC's Housing Solutions and Support Service, which assesses requests for housing and homeless assistance, had limited information and was therefore confined to the chronology. There were no records of engagement with this service by Sterling, Danny, or Greg. Mark applied on four occasions to join the housing register (twice in April 2022, once in May and November 2022). Mark did not qualify to join the housing register, and his application was rejected in February 2023.

Housing information was scant. Sterling's accommodation was provided privately. It is likely that there were no independent records for the perpetrators on the register as 'tenants in their own right', due to their young age but family members may be the listed or registered occupiers. (Note. This is a challenge for the agencies when searching records and in seeking agency information).

Education records were also limited as Sterling, and two of the perpetrators (Greg and Mark) were outside of school age for the requested scoping returns. During the initial panel meeting, due to the ages of the perpetrators (17, 19 and 20 years), it was agreed that (whilst outside the agreed timeline), including a review of any recent, relevant education or school records may provide any insight into each of the perpetrators and may assist an understanding of any educational challenges or socio-economic disadvantage they may have faced. This resulted in education information being returned in respect of Danny and Greg.

Probation services only had a limited record for Sterling as he was an adult, and they had not engaged with the perpetrators due to their ages.

In addition to the IMR agency returns, interviews were conducted by the Chair with a number of individuals from various agencies. Their accounts are summarised within the body of this report.

Pen Portrait of the Victim

At the time of his death, Sterling was a heterosexual, British male. He was of black afro Caribbean ethnicity and born in Kingston, Jamaica. He had two half siblings on his mother's side and also half siblings on his father's side (their details are unknown, and they have not participated in this review).

Sterling was brought up initially by his father and paternal grandparents in Jamaica. His father died in 1996, when Sterling was 7. Sterling moved to join his mother in south London in June 2001. Despite living in a diverse multi-cultural area, Sterling found school difficult to fit in. A move to Shropshire was challenging for Sterling, but a later move to Birmingham provided a more familiar multi-cultural demographic. His education was disturbed, as it was difficult finding a school placement for Sterling in Birmingham. After securing a short-term college placement, Sterling initially concentrated on dance/choreography before starting an electrical apprenticeship for a period but dropped out.

Sterling joined the army at 17. Shortly before the end of his basic training, Sterling discovered he had a non-cold frost injury (diagnosed medically as Raynaud's disease in 2008), impacting his hands and feet[9]. This thwarted his career ambitions, and he was medically discharged, returning to Birmingham. Raynaud's resulted in a lifelong physical impact on him, although he was not classed as disabled. Medical records show that his medical discharge from the army, did impact on his mental health and wellbeing and limited employment opportunities due to the impact of the cold and outside working on his heath. Records demonstrate he was able to access services appropriately to obtain relevant support for this medical condition.

With Sarah, Sterling conceived a son in 2007, and remaining in an on/off romantic relationship for 17 years. At the time of his death, Sterling was unmarried, but was in a relationship with his pregnant partner Stacey. Their child was born after his murder and prior to the trial in August 2023.

In terms of employment, after leaving the army, Sterling worked in a range of jobs (cleaner, loading tyres and in a factory). In his Probation assessment in 2015-16, Sterling revealed he was 'unemployed and claiming benefits on grounds of ill-health'[10]. Sterling was not working in any form of paid or unpaid employment at the time of his death. He lived on benefits, there was no reported poverty. Whilst there is no agency information concerning his income, Sterling had not indicated to anyone that he had financial insecurity.

There is information in his health records to indicate that Sterling had felt depressed and in low mood in the past (2019) because of his employment situation and health concerns, but there was no recent information. In self-disclosure to his GP and in his medical records, Sterling revealed he smoked cannabis regularly. During his involvement with the Probation service in 2015-16[11], he revealed he had 'been using cannabis regularly since the age of 14 where he would smoke with friends as he liked the feeling it gave him', and 'he had no intention of giving it up'. He also 'claimed to use cannabis as a means of pain management' for his circulation issues.

Sterling had secure housing and lived alone in a private rented flat in an urban area of Birmingham.

[9] Source Health IMR
[10] Source HMPPS (Probation) IMR
[11] Soured HMPPS (Probation) IMR

Sterling had been christened as a baby but was not religious and did not attend church although he practiced Rastafarianism and was described by Sarah as a 'passionate advocate for the religion'.

In summary, there is no evidence that socio-economic disadvantage was explicit or impacted Sterling's life, family statements indicate a supportive family environment, he attended school, and they had no requirement for financial or other support from any agency.

Cause of Death: The post-mortem was held in April 2023. The medical cause of death was recorded as, 'multiple stab wounds' with widespread sharp force injuries. The mechanism of death was 'haemorrhaging from the totality of the victim's injuries.' Defensive injuries were noted on Sterling.

The inquest in relation to the death of Sterling was opened in May 2023 and the outcome was pending at the time of writing.

The above 'Summary of Incident' describes the dispute about the electric bike ownership which appears to be the principal connection for this case, although there are no actual agency records to show Sterling or Danny as named or 'connected' individuals, prior to the murder.

The threats made by Danny prior to the murder, had also not been formally reported to any agency by anyone who was aware of or, had observed threats being made. It is important to consider that without information, WMP and other agencies could not have deduced the connection, investigated further or predicted the escalating conflict which led to the murder.

There is no known prior or existing relationship or connection between Sterling and either Mark or Greg, and only one agency[12] record that shows a 'personal' link between Mark and Greg. There are no other association links or information reports connecting the Danny, Mark or Greg as associates in agency indices.

The geographic location is important to consider in this review as the now-convicted perpetrators lived in a close geographical proximity. Sterling's murder took place on a street 5 miles south of the city centre. The scene of the murder triangulates at the centre of the (three perpetrators) home addresses, although it is closest to Mark's. Police revealed that this was an area that the perpetrators knew and frequented, although not an area that Sterling allegedly frequented at that time.

The three now- convicted perpetrators were arrested and charged. The trial was initially set for November 2023, later adjourned until January 2024. The defendants were convicted on 25.01.2024. Although sentencing was postponed until 18.03.2024 to allow for pre-sentence reports, they received the following sentences:

- Greg- Guilty of Manslaughter, Robbery and Possession of a Bladed Article. Greg was sentenced to 10 years imprisonment.

[12] Source WMP- IMR in November 2021

- Mark- Guilty of Robbery. Mark was sentenced to 6 ½ years imprisonment.
- Danny- Guilty of Murder, Robbery and Possession of a Bladed Article. Danny was given a life sentence, to serve a minimum of 25 years imprisonment.

Equality and Diversity

The nine protected characteristics under the Equality Act 2010[13] are included in this review. The author has examined any possible barriers to accessing services in addition to wider consideration as to whether service delivery was impacted.

Socioeconomic Factors such as education (low educational attainment), employment Status (unemployment), income, food insecurity, housing insecurity (inadequate housing), health (including poor mental health, loneliness, and disability) and low social mobility are considered in the main body of the report.

The Office for National Statistics explored economic inequality in the UK[14] and sought to understand regional differences. It was found that the Midlands was one of the lowest income areas and Birmingham (as well as Manchester and Nottingham) had one of the lowest household incomes in the UK.

Victim: Sterling

- Male, Aged 33 years
- Black Afro Caribbean- Jamaican
- Rastafarian
- Heterosexual
- Not registered disabled but the impact of Raynaud's on his hands and feet left him unable to bear the cold.
- Unmarried

Perpetrator 1- Greg

- Male, Aged 20 years
- Black Afro Caribbean- Montserrat
- Heterosexual
- Religion unknown
- Not registered as disabled.
- Unmarried
- There are a number of socio-economic factors evident from the available agency information which impacted Greg (covered below).

Perpetrator 2 – Mark

- Male, Aged 19 years
- Black Afro Caribbean

[13] Equality Act 2010. Equality Act 2010 (legislation.gov.uk)
[14] Office for National Statistics- Mapping inequality in the UK. May 2021

- Disability listed- ADHD[15]
- Heterosexual
- Religion unknown
- Unmarried
- There are a number of socio-economic factors evident from the available agency information which impacted Mark (covered below).

Perpetrator 3- Danny

- Male, Aged 17 years
- Black Afro Caribbean
- Disability listed- ADHD
- Heterosexual
- Religion unknown
- Unmarried
- There are a number of socio-economic factors evident from the available agency information which impacted Danny (covered below).

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

Sterling was an adult male, actively engaged in two meaningful relationships (one current and one described as an 'ex-partner'). Police records listed his mother Beatrice as his NOK, although she insisted that despite not being a blood relative, she personally recognised Sarah as his NOK. This required a sensitive approach to family engagement.

Beatrice, Stacey and Sarah were all informed by the police FLO in July 2023 that an OWHR would take place and that in their own time, the Chair would speak with them. All family members were appointed a specialist advocate to support them from the Victim Support Services (VSS) Homicide Case Team. From the outset, the FLO acted as facilitator between the Chair and Beatrice, Sarah and Stacey. The Chair was informed Beatrice was working abroad until the trial and considered that waiting until she was in the UK would be more appropriate for contact, and not to interfere with the prosecution case. Stacey was heavily pregnant and gave birth in August 2023 (a significant life event).

The Chair decided to establish all background information held, from agency scoping, to inform the timing of her decision to contact and interview the NOK, but also enable her to ask relevant questions should they be required to inform the review. The initial delay in the panel meeting taking place and receiving of IMR feedback on 30.11.2023, meant that the police investigation was in a critical pre-trial stage (due for November 2023) and the Chair made the professional judgement to wait until the trial was concluded (later postponed until January 2024) before making a direct approach to family for their contribution but maintained contact with the FLO.

[15] ADHD is legally defined as a disability under the Equality Act 2010 in the UK. Individuals with ADHD are entitled to protection against discrimination and reasonable accommodations. ADHD can have substantial and long-term adverse effects on daily activities, including education, employment, relationships, and mental health.

The Chair considered chapter 4, 'The role of the family, friends, and other networks in OWHRs' in the OWHR Statutory Guidance. Following the trial, on behalf of the Chair, on 30.01.2024, the FLO contacted each of Sterling's named family members separately, providing an introductory letter drafted by the Chair, the HO OWHR leaflet and offered flexible availability for an in-person or Teams meeting, or any other communication means (telephone/email) they preferred. Thereafter, the Chair made contact via follow-up email to arrange individual contact.

As NOK, Beatrice was provided with a personal letter and the relevant leaflets. At her request due to illness, using the medium she preferred, the Chair met Beatrice on 08.02.2024 via a Teams meeting rather than in-person. The scope and terms of reference for OWHR were shared with her, with follow emails from the Chair. Beatrice had been updated regularly.

Stacey is not a relative or family member but was Sterling's partner at the time of his death and is mother to his new baby. Stacey was provided with a personal letter and the relevant leaflets in January 2024. The Chair met Stacey on 07.02.2024 via Teams meeting, at her request. She was accompanied by her mother. Further correspondence took place via emails. The scope and terms of reference for OWHR were shared with her, with an explanation of the OWHR process. Stacey had been updated regularly and had made observations which are included in this report.

Whilst Sarah is not a blood relative, she was Sterling's long term (ex) partner and mother of his teenage son. Sarah was provided with a personal letter and the relevant leaflets on 30.01.2024, with follow emails from the Chair. Sarah felt unable to meet to discuss Sterling as she had experienced trauma connected to this event. Correspondence took place throughout February-June 2024 through the VSS advocate. Sarah supplied her information though a questionnaire.

Whilst Sterling's son was keen to be involved, it was judged that the impact and upset and trauma of asking him questions would have a disproportionate impact on him, and the author has not pursued that line of enquiry.

Contact with the Alleged Perpetrator's Family

Perpetrators family.

In order not to prejudice or compromise the police investigation, the Chair made no approach to any NOK or family members of the perpetrators during the investigation or trial process.

Contact details of any of the perpetrator's families were not easily accessible. The police do not routinely have access to contact details for family members of perpetrators. It is worthy of note that police have no legal duty to engage with family or NOK of perpetrators during a

prosecution case, unless they are operating as appropriate adults[16] for a defendant or a witness in the case. Each named perpetrator was 18 years old at the time of going to trial.

Following conviction, after liaising with the police SIO, a decision was made to communicate with the NOK or family members of the perpetrator's, through their individual legal teams. The Chair telephoned each legal representative independently explaining the request and followed up with an explanatory email. The email explained the purpose of the OWHR, attached the HO OWHR information leaflet for family members, and a request to facilitate contact with NOK.

Following sentencing, the Chair followed up the request to speak to or meet with family members via emails and further telephone calls to the respective legal teams.

Greg's legal representative had advised him about this review however they had received no authority to pass contact details on to the author.

Mark's legal representative confirmed in a telephone call and followed up by email, that he had approached Marks' mother and sisters on the authors behalf. They were unwilling to participate in this review.

Danny's legal representative was unwilling to facilitate contact with family members without a signed authority from Danny (at time of writing, that had not been obtained).

Family History and/or Contextual Information:

The College of Policing summarises specific risk factors identified through research, associated with an individual's involvement in knife crime[17]. They state that there is no statistically significant relationship ethnicity and weapon carrying (Brennan, 2018), but there is evidence that several factors may be associated with increased risk of violence and/or weapon carrying:

- Gender- males are more likely to commit serious violence and carry weapons (Home Office, 2018a; Brennan, 2018).
- Age- self-reported weapon carrying peaks around the age of 15 (Home Office, 2018a; Brennan, 2018).
- Adverse Childhood Experiences (hereafter referred to as ACE)- including abuse, neglect, parental criminality and/or substance abuse, being taken into care (Dobash and others, 2007: Hales and others, 2006; Home Office, 2018a).
- Educational attainment- school exclusion and low attainment (Hales and others, 2006; Home Office, 2018a; Ministry of Justice 2018a).

[16] Appropriate adults are called to the police station as an important safeguard, providing independent support to detainees who are: aged under 18, or maybe mentally disordered or mentally vulnerable.
[17] Understanding the causes of knife crime- First published 1 January 2019: Written by Abigail McNeill and Levin Wheller

These risk factors are considered when examining what is known about all parties concerned in this review.

Sterling- contextual.

There is limited information connected to Sterling which contributes to the learning in this case. Despite his age, Sterling's interaction with agencies was limited to mainly health related issues, although these were minimal. In addition to the pen-portrait, Sterling's previous but comparatively limited, criminal history was not considered a determining or causal factor in this case but is referenced to create an authentic picture of Sterling's life and circumstances.

From police records, Sterling was connected to 24 crime reports prior to his murder, dating back to 2003. He is a mixture of the victim and offender within the reports. Incidents of note between 2004 to 2018 include four convictions for six offences. Sterling had a reprimand for theft in 2004, a caution for possession of cannabis a class B drug in 2008 and a conditional caution for possession of cannabis a class B drug in 2018. He was sentenced to a 12-month Community Order in September 2015, concluding 12 months later, with no further Probation involvement. He was assessed as a low risk of harm, was compliant with supervision, but 'had no intention of ceasing cannabis use'.[18]

Sterling's convictions were for criminal damage in 2004, production of cannabis in 2009, possession of a bladed/sharply pointed article in public committed in 2014 and possession with intent to supply cannabis, a class B drug, causing warning markers for weapons and drugs to be placed on his record. He did not receive any custodial sentence as a result of these convictions. He entered a programme of rehabilitation. His final conviction was in 2021 for possession of cannabis and failing to provide a specimen for analysis (driving).

There were two other specific incidents prior to the agreed timeline, where Sterling came to the attention of police.

In February 2020[19]- Sterling was the suspect of a Common Assault, with a female victim who declined to support a police investigation. The matter was filed. Whilst low-level, this could be an indicator of his potential propensity towards violence but cannot be further explored due to the absence of a witness.

In January 2021[20]- Sterling was the victim of a robbery after being approached by two suspects (known to him but not identified to police), who dragged him out of his vehicle, repeatedly kicked and punched him and racially abused him. Sterling escaped in his car, but the offenders followed and rammed his car, causing him to crash. He was assaulted a second time by offenders who made off after taking Sterling's phone, car keys and house keys. Despite an independent witness present and supporting CCTV, Sterling refused to assist police at the time or subsequently. The matter was filed pending contact from him and there are then no further entries. This lack of engagement with authorities is discussed later in this report, relating to trust and confidence.

[18] Source HMPPS (Probation) IMR
[19] Source WMP
[20] Soured WMP

Greg - contextual.

There is limited information connected to Greg which contributes to the learning in this case, although several risk factors are observed (gender, age, ACE and educational attainment).

There are a number of socioeconomic factors evident from the available agency information which impacted Greg, although there is an absence of information which signals any individual intervention for Greg. Unconnected records give an insight into his poor home situation, including neglect, income and food insecurity, which tend to indicate ACE, and a range of information is available to indicate that Greg's social mobility was being impeded by the contacts he was associating with.

There is no significant medical history, and he was not known to mental health services). Greg's school records were uneventful, but he had low educational attainment causing an education psychologist intervention[21] being requested for him in 2016, due to described 'cognition and learning needs', he struggled with basic literacy skills and processing language (early literacy and numeracy skills) as he was making limited age-appropriate progress. It was noted that he did not have any special education needs in the area of health or social care. There were no more recent assessments prior to him leaving school.

Greg had limited contact with police, coming to notice for the first time in 2021 connected to possessing cannabis. He had no criminal convictions.

There were some anonymous concerns received by social workers on 31.03.2023 about a number of associates going to his address, where drugs were consumed, drinking took place and knives being seen there. BCT received that referral and, a multi-agency strategy discussion was held the same day[22]. Police, health and education attended with the social worker and team manager. There are several risk factors evident (gender, age, ACE and educational attainment), so actions agreed were for a CP[23] medical, joint S47 investigation with police and proceed to ICPC[24]. As such this was not a missed opportunity.

Mark- contextual.

There is limited agency information known about Mark prior to the murder, or specifically connected to Mark which contributes to the learning in this case, although several risk factors are observed (gender, age, ACE and educational attainment).

There are a number of socioeconomic factors evident from the available agency information which impacted Mark. Records from 2007 onwards, indicated ACE risk factors; anonymous safeguarding concerns had been raised since 2008 (alleged alcohol reliance, domestic abuse (DA) allegations and poor home environment). BCT assessed each incident reported and offered support. No further referrals were received between 2008- 2016, when DA concerns in the home were raised again.

[21] Source Education Psychologist EHCA report.
[22] Source BCT records- strategy discussion form added to the case notes and reviewed by panel member.
[23] Child Protection
[24] Initial Child Protection Conference

In May 2019, the social work team stepped the family down[25] to family support. The following needs for Mark had been identified; 'Mother is concerned that there are bigger problems affecting family relationships, such as Mark's poor school attendance, refusal to adhere to her boundaries, gang associations and involvement in criminality (theft, drug taking and dealing - Cannabis), carrying weapons (knives and batons)'. She worries that Mark does not acknowledge there are issues, wants no support and is on a path of self-destruction. ' Mark has been to several secondary schools and is currently on a managed move but attendance remains poor. Mother is facing court proceedings regarding Mark's poor school attendance - a possible fine or even prison. ' The relationship between Mother and Mark is potentially at breaking point, with Mother reporting Mark does not listen to her and she can't continue like this so doesn't want him at home if this carries on. ' Mark has a diagnosis of ADHD, but is self-medicating with Cannabis - he has stopped engaging with his Psychologist for a number of years and so they have stopped prescribing his Ritalin. BCT note that family support was provided and 'Targeted work to be completed with Mark regarding his social relationships / associations / activities, help improve school attendance, understand the risks associated with gangs' /drugs/ carrying a weapon and try to encourage him make positive use of his time. He is also to be offered support to address his Cannabis use', and 'Close liaison for schools for Mark'.

BCT records in 2019 state, 'no previous missing episodes, however there were concerns around Mark being involved with gangs and criminality'. Mark's mother withdrew consent for ongoing cooperation in October 2019 and the family were closed to the Trust.

In April 2020[26] - Mark's mother reported to police he was missing from home since the day before. The Police Locate team looked for Mark and, BCT noted that further conversations 'were required with the exploitation team' and YOS due to the previous concerns raised around gangs and criminality. Mark (now aged 17 years) returned several days later, but he refused a 'Return Home Interview', and he stated that he wasn't missing. This meant there was no further action for the Trust.

Mark was registered with a local medical partnership since 2003. He was also under the care of the community paediatric services and diagnosed with ADHD in 2013[27], following assessments due to difficulties with his behaviour and violent outbursts, although these are not expanded further in records. He commenced medication, and he was last seen by paediatrician in 2017. His ADHD presented as violent outbursts and difficulty with his behaviour. He had been on prescribed medication for some years, which he had stopped taking at the age of 18 years.

Marks' school records were uneventful and despite a diagnosis of ADHD, there are no records of any EHCP[28] or psychological reports.

[25] Step Down enables professionals from Children's Social Care, Early Help Services and a range of other partners to support the child/family intervention and plan as they move between requiring statutory, safeguarding and specialist support, and targeted and universal services and interventions.
[26] Source BCT Scoping.
[27] Source Health IMR.
[28] Education, Health and care Plan

Whilst making police enquiries at his last known address, Mark's mother had revealed to police in October/November 2021[29], that she 'had not seen him for several months, as he had left home at 16 years old, and she did not know where he was living'. It is unclear whether she shared this as a concern with any agency. Whilst Mark was now an adult (aged 18), but it is unknown whether any agency was aware of his personal living arrangements from 16 years onwards. It is unclear whether this information was shared in a multi-agency setting. It is understood that he did not have a permanent registered address, but in March 2023, he revealed to police that he was living in a room in a 5 roomed multi-occupancy house. Housing security was a concern for Mark personally, and he had applied four times during 2022 to join the housing register, but he did not qualify. It is unclear how he was funding his living arrangements.

Mark is connected to 20 crime reports on the WMP Connect system from 2016 (to the murder of Sterling in 2023). Mark has been arrested a total of four times in the WMP area. In 2018, he was found in possession of cannabis, a class B drug and received a youth caution for this. Mark does not have any convictions.

Danny- contextual.

There are extensive agency records concerning Danny, which contributes to the learning in this case and several risk factors are observed (gender, age, significant ACE and educational attainment), combined with other risks, which would suggest a vulnerability.

There are a number of socioeconomic factors evident from agency information which impacted Danny. Whilst the scope period is the previous 2 years, it is relevant to describe the records from 2007 onwards, which demonstrate ACE and associated trauma with a significant multi-agency footprint going back to early childhood[30], when Birmingham Children's Social Care (BCT)[31] became involved in his life.

Agency records describe a poor home environment, exposure to serious violence and domestic abuse (DA) allegations in the home, concerns about emotional neglect and over-chastisement of Danny. Danny experienced trauma and physical abuse and allegedly presented with challenging behaviour from a young age. It was documented that Danny had had an extremely complex relationship with his parents.

There was significant multi-agency wraparound and support for Danny from early childhood, involving child in need and child protection plans, extensive family support interventions over the years, including Multi-Systemic Therapy (MST) and Intensive Family Support (IFS).

In July 2016, prior to secondary school, Danny had an EHC, which identified he 'has Special Educational Needs which lie primarily in the area of Social, Emotional and Mental Health[32]'. Identifying he could be hostile and aggressive towards adults, it noted he struggled to talk about emotions with adults. It was also reported that Danny suffered from mixed Conduct Disorder, Attachment Disorder and ADHD[33]. He took medication for his ADHD.

[29] Source WMP IMR-V1
[30] Source Health, WMP, BCT, BYOS IMR's.
[31] Source BYOS IMR
[32] Soured EHC assessment 2016.
[33] Source BCT IMR

Danny was supported with psychotherapy sessions. In 2016[34], at a number of the psychotherapy sessions Danny stated that 'his mom doesn't like him because he is a boy' and, on another occasion, said 'what type of man will I become?', when thinking about his past and his future.

Danny repeatedly came to the attention of law enforcement, first named as an offender on a crime report[35] in 2016, where he assaulted a neighbour, demonstrating is propensity towards violence. This was dealt with by way of a community resolution. In August 2017 (age 12), Danny had a Youth Conditional Caution for Common Assault, which he successfully completed.

In October 2019[36], records highlight an initial criminal exploitation meeting took place (discussing his alleged gang membership, alleged drug dealing, criminal damage, assault, possession of knife). Danny had been missing for 2 extended periods. He was assessed as medium risk child criminal exploitation (CCE), which was not high enough risk level to go to panel.

In early December 2019, aged 14, Danny was convicted of possession of bladed/sharp pointed article in public, threaten a person with a blade and robbery, demonstrating his propensity towards violence,. He was sentenced to a 12-month Referral Order for possession of a knife, robbery and threatening a person with a blade[37]. A 3-month Parenting Order was made also. The referral order was revoked in December 2020, and he was sentenced to a detention and training Order (DTO) for Assault Occasioning Actual Bodily Harm (ABH), which he successfully completed.

Between Oct-Nov 2019 and Jan-Feb 2020, Danny was accommodated under S20 on two occasions, in a residential children's home. He then moved to live in a secure children's home (MBM) but subsequently returned home with mum and his sister but by April 2020[38], Notes from Forward Thinking Birmingham (FTB) records show that Danny was withdrawing from FTB interventions, and he had no treatment for years on ADHD and sleep disorder due to parental choice. In May 2020[39] - notes from FTB records show that mental health and the Senior Social worker reviewed Danny's decision to disengage which they judged as to close case as non-compliant. Dialectical behaviour therapy (DBT)[40] withdrawn.

Between mid-December 2020- mid-March 2021[41]: He was registered with MBM and during this time he was receiving regular input from FTB, transitions team, psychology, Empire Coaching and physical and mental health assessments. Accommodation was providing structure for him. Risk assessments were also completed. Danny told professionals he was not keen on having a Social Worker (SW) because '*they all come and go even if they promise to stay'.* He said only person that mattered to him was his probation officer (*believed*

[34] Source Health IMR
[35] Source WMP
[36] Source Health IMR
[37] Source BCT IMR
[38] Source Health IMR
[39] Source Health IMR
[40] Dialectical behaviour therapy (DBT) is *a type of talking therapy.* It's based on cognitive behavioural therapy (CBT)
[41] Source Health IMR

this meant his Youth Offending Officer) and once his order had expired, he wished to have no further involvement from authorities. The SW promised to stay and work with him, but he remarked that '*they all promise to stay but never do'*. Danny was self-aware of the issues affecting his life. He reflected on his anger issues as well as difficult relationships and being unsupported by family members to comply with support provided.

March 2021[42]: Immediately prior to the scoping period, Danny was residing at residential care accommodation under an agreement between children's services and his parents. Social care's submission details that Danny was accommodated under section 20 for a number of periods which includes: from Decem ber2020 to March 2021 and from April 2021 to June 2023 (a cumulative period of approximately 18 months prior to the murder). They described mixed behaviours during his residence, with him being aggressive at times.

March 2021[43]: A Local Risk and Vulnerability (LRSP) panel hosted by Youth Offender Services (YOS), was attended by Change, Grow Live (CGL), social worker, education mentors, restorative justice practitioner, enterprise coaching, youth crime office, noting a number of vulnerabilities. They included: self-reported allegiance to a gang and concern from his mother that he does not feel he can get out of it; concerns about criminal exploitation and missing periods; involvement in county lines activities; possession of weapons; self-harming (lacerations to his arm) and suicide attempts; excessive use of cannabis; lots of people noted coming and going from the house; disclosure that his father had an injunction against him for over-chastising of Danny.

Agency Timeline

Sterling (during scope period).

There is limited information known about Sterling by agencies during the scope period relevant to this review. In summary, he came to attention for a drink driving matter, possession of cannabis on two occasions and a common assault allegation show, so there was limited police contact.

The information concerning the carrying of a weapon is relevant. From records, there was no information or intelligence to suggest that Sterling was a routine or habitual carrier of knives or weapons. However as mentioned in 2014, during a stop check of a car he was in, cannabis, a claw hammer, a flick knife and an 8-inch knife were located within the car, for which he was prosecuted. Sterling did not come to police attention again for carrying a weapon (knife) until his death. He was in possession of a knife on the night he was murdered, described as 'a large carving knife'. Whilst there is no information that he exposed or used the knife; this information was not in agency records and not mentioned by family members in this review.

[42] Source WMP and BYOS IMR.
[43] Source Health IMR/ BCT IMR

The College of Policing summarises motivations for, and factors associated with an individual's involvement in knife crime[44]. They state, 'Evidence suggests there are three broad explanations as to why people carry knives (Brennan, 2017). These are:

- Self-protection and fear ('defensive weapon carrying') – particularly for individuals who have previously been a victim of crime (Lemos, 2004).
- self-presentation – particularly for individuals who want 'street credibility' and 'respect' (Silvestri and others, 2009).
- utility (offensive weapon carrying) – particularly for individuals who use weapons to facilitate other behaviours (Brennan, 2017) such as theft, sexual assault, injury and serious harm.

There had been 9 years between the incidents where Sterling was known to carry an offensive weapon (2014 / 2023). In hindsight, the recent threats being made towards him, could have been evidence of 'defensive weapon carrying', and a factor in his decision to carry a knife on the night of his murder.

Greg (during scope period).
There is limited information known to agencies during the scope period, which refer specifically to, or in isolation to Greg. There are unconnected reports (concerns raised through information and intelligence) but no individual interventions for him. From police records, Greg has warning markers on PNC for drugs only. He has no convictions. Greg came to police notice for Anti-Social Behaviour (noise and cannabis) on 12.05.2021[45], Possession of Cannabis on 24.10.2021[46] and again on 20.06.2022[47].

He attended hospital in November 2021[48] with an injury to his ankle. It was noted he was a college student in catering, and in October 2022[49] presented with an arm injury. According to those medical records there were no alerts, previous history of violence or aggression, gang associations or notes of him carrying offensive weapons.

The home conditions were noted on records pertaining to other family members. In December 2021[50], there were records of socioeconomic issues impacting the occupants, and in April 2022, a further referral was received from an Early Help Worker, as the house was described as 'uninhabitable'. A family assessment was carried out, and family support offered. Although a family support worker was allocated to work with the family, no specific concerns were raised about Greg.

March 2023[51]- Anonymous information was received that Greg was selling drugs at his address and a number of unidentified males were visiting there daily and smoking cannabis

[44] Abigail McNeill and Levin Wheller- Understanding the Causes of Knife Crime- First published 1 January 2019.
[45] Source WMP IMR
[46] Source WMP IMR
[47] Source WMP
[48] Source Health IMR
[49] Source Health IMR
[50] Source BCT Scoping document
[51] Source BCT Scoping document

and drinking. Uncorroborated information referred to 'a bag of money', an item which 'looked like a gun' and 'a male with a 30cm long knife, like a machete'. Whilst not specifically relating to Greg, these anonymous reports led to professional concerns (linked to his lived experience and home life) being raised on March2023. A multi-agency Strategy Discussion took place. The concerns included: child abuse in the address, significant harm and neglect, child in crime, anti-social behaviour, acute mental health, at risk of or already being sexually exploited, consistently unclean, inappropriately clothed, hungry. The outcome of which was S47 and subsequent ICPC[52] (but was not focused on Greg).

An ICPC was held April 2023[53]. The outcome was that a critical marker was placed on the address due to the report that weapons had been seen there but there is no further information about sharing intelligence connected to Greg or his associates, despite a file comment that 'the family home seems to be a haven for these people (*associates*) which is a risk of harm to '*other residents*'[54] present' and 'We are really concerned about Greg's associates'. Greg was 20 years of age at this point so any diversionary activity would have to have been led by the police.

Mark (during scope period).
Mark was an adult during the scoping period.

In August 2021[55] – Mark was stop-searched by police, after being found in company of another male who admitted he was in possession of a knife. Mark was not found in possession of a weapons, but he did have a small amount of cannabis.

Mark again came to notice in October 2021[56] – for possession of a small amount of cannabis. A follow up visit at his known address, revealed he had left home at 16 years old.

Mark again came to notice on in January 2022[57], for possession of a small amount of cannabis when in a car that drove off from police in which he was a passenger. He was detained. In the front passenger footwell a 7-inch knife was located. Mark was arrested for possession of a bladed article and possession of drugs. He denied knowledge of the knife and it was not prosecuted. He was 18 years and 8 months old at this time.

Mark came to notice on in January 2022[58] for Common Assault, and on in March 2022[59] with concerns about intruders at his address. Neither resulted in any multi-agency referrals.

In July 2022[60]- Mark was arrested with an accomplice for Possession of a controlled drug, Class A: Cocaine with intent to supply. Mark was in possession of a burner phone that had been wiped clean of calls and messages, and a large quantity of change. The investigation was still on-going at the time of Sterling's murder.

[52] Initial Child Protection Conference
[53] Source BCT Scope.
[54] Authors italics
[55] Source WMP
[56] Source WMP
[57] Source WMP
[58] Source WMP
[59] Source WMP
[60] Source WMP

In September 2022[61] - Mark attended Queen Elizabeth Hospital (QEH) Emergency Department (ED) with his partner. This appearance demonstrates his mindset. He reported experiencing bereavement, homelessness, drugs and alcohol use and current low mood, self-harm, suicidal thoughts, was hearing voices, and reported he had no support. He was living in shared accommodation. He was discharged back to GP and advised regarding medication (to consider recommencing Ritalin and referring onto relevant pathway for appointment). FTB crisis number was provided, and he was also offered support from CGL but declined. He attended his GP the following day but as the hospital letter was not yet in the system, he was not treated. He was advised to seek emergency medical help if he felt actively suicidal. Following this an MDT was held, and case discussed with staff at the practice, a letter was sent to him, and his GP had also tried calling but no response back. (The last contact with GP was Sept 2022 for review following attendance at the QEH).

In January 2023[62], Mark was due to attend a MH appointment with Healthy Minds but did not attend and was discharged from service, but they did write to him, and advice was given on who to contact for support.

February 2023- Mark had applied on four separate occasions to join the housing register (April 2022, April 2022, May 2022 and November 2022). Mark did not qualify to join the housing register, and his application was rejected. His living arrangements are unclear from the information identified in the review.

Danny (during scope period).

During the scope period, there were also a number of reported DA incidents with Danny as both victim and offender. They are not specifically explored in this report.

May 2021[63]- Intervention and support were offered to Danny. In a FTB phone call, Danny stated he did not want counselling/ therapies/ talking interventions as (they) not helped previously and all he has now is cannabis. No further appointments were agreed but he was advised as to how he could get help in the future.

June 2021[64]- Missing Person Report was filed by a carer from his residential home. Danny had last been 'seen' at his Grandmothers address. He was assessed as medium risk due to his age (15 years old) and placed on Compact[65] with the incident log left open for an address check. He later claimed to be unable to call as he had no phone. He had attended school the following morning, staff contacted his supported living staff. The school was spoken to and confirmed Danny was safe and well. The safeguarding lead liaised with Danny's social worker and requested a mobile phone for him. This missing episode pattern was then repeated on numerous occasions.

[61] Source Health IMR
[62] Source Heath IMR
[63] Source Health IMR
[64] Soured WMP
[65] WMP system for management of missing person enquiries

June2021[66]- Danny was settled in accommodation placement but had been excluded from school for 4 weeks. Health emailed the accommodations team asking them to identify the CAMHS hub nearest or easiest for them to come for a face-to-face review. Health noted that once education and YOT have withdrawn, the only support other than accommodation team would be health. Danny was discharged from the mental health services due to his non-engagement. (If he did not wish to comply at 16 years old, it is his choice and decision to make)

Danny became a frequent and repeat missing person in the following months, failing to abide by curfews, and refused to reveal where he was when questioned, (July 2021[67], July 2021[68], August 2022[69], September2022[70], September 2022, December 2022[71], December 2022, January 2023[72], March 2023[73], March 2023[74], March 2023). Between December 2016 and April2023 (which includes some time outside of the scope period) it is of note that Danny was reported missing on 19 separate occasions, which is relevant to his vulnerability and potential chaotic nature of his lifestyle.

July 2021[75]- Danny was not engaging with medication, but also not seen by his GP. There was a review of the case as he did not respond to validation enquiries[76].

December 2021[77]- Medical review by FTB noted his ADHD but Danny was not taking medication.

June 2022[78]- Danny was the victim of domestic assault (ABH), but he declined to support a prosecution. In July 2022[79] , he was the suspect for domestic common assault, and three separate assault reports were recorded and allocated to three separate officers. None of the witnesses would make statements. The incidents were filed.

August 2022[80] **(**see October 2022)- An incident occurred, captured on a ring camera where a group of men were seen, one with a machete and another with a gun, which was held to one man's head. Despite firearms officers intervening and four of males arrested, no firearm was located. The witness later refused to make a statement. A significant comment by one suspect on arrest was 'you didn't find the gun though'.

August 2022[81] , Danny was reported for Harassment: Pursue course of conduct in breach of Sec 1 (1) which amounts to stalking and take or to make or distribute indecent photograph

[66] Source Health IMR
[67] Source WMP
[68] Source WMP
[69] Source WMP
[70] Source WMP
[71] Source WMP
[72] Source WMP
[73] Source WMP and Health IMR
[74] Source WMP and Health IMR
[75] Source Health IMR
[76] Validation- checking from mental health perspective as to how they are.
[77] Source Health IMR
[78] Source WMP/BYOS IMR
[79] Source WMP
[80] Source WMP
[81] Source WMP

or pseudo-photographs, of children. Social workers were informed. Repeated attempts (by phone and in person), to contact the victim and/or informant, were not answered and the matter was eventually filed.

September 2022[82]- GP records for Danny note a 'Child cause for concern', after receiving a letter from MASH Hereford, West Mercia Police: Risk of Harm due to County Lines involvement, drug associations and exploitation.

October 2022[83]- A male self-presented at University Hospital with two stab wounds but was also in possession of numerous knives and weapons. Danny was the suspect for that assault, which was believed to be over a £5 debt. Danny was arrested and remained in custody overnight, whilst police conducted enquiries and whilst the victim had surgery. Danny became aggravated in custody, causing damage to his cell, blanket, sink and flooding the cell, banging on his cell door. The following day, he had calmed down. He was charged with Grievous Bodily Harm (GBH), bail was refused and as there was no suitable secure juvenile accommodation, detained in police custody to be placed before the next available court. According to police records, Danny's social worker was contacted regarding secure accommodation, but did not respond to custody staff. Later the Emergency Duty Team (EDT) were contacted, and they found a placement for him. BCT confirm from their records that that EDT were aware that Danny had been arrested.

October 2022- Danny had a fight with his cousin and stabbed him. Danny was charged with GBH, and the police requested he be placed in secure accommodation at the time, due to the concerns around the risk he posed to others.

October 2022[84] – Danny (aged 17 years) was remanded to the Care of the Local Authority for offences of GBH and possession of a knife. Danny was referred to Birmingham & Solihull Mental Health Trust (BSMHT). He was evicted from current supported accommodation but declined support with finding alternative accommodation. He told them he can keep himself safe when released. Due to limited engagement, staff were unable to update risk assessment. It was concluded that there was no evidence of acute mental health concerns, and they would liaise with social services and the South Children in care team.

October 2022: Danny was identified by police as the offender with the gun in August 2022 (recorded as Possessing firearm or imitation firearm with intent to cause fear of violence).

January 2023- A strategy discussion was held in relation to concerns around Danny's multiple missing episodes leading to a report documenting concerns, information obtained, and information which was shared days later. Danny was missing from supported accommodation since December 2022 and had been given notice that his placement was due to expire.

- Danny was seeing his Youth Offending Service (YOS) worker once a week but was last spoken to mid-December 2022 where he 'self-reflected', indicating fears of reprisals if he went to prison. Danny was not engaging with had his allocated social

[82] Source health IMR
[83] Source WMP
[84] Soured Health IMR

worker or support workers, despite their attempts to contact him and he had failed to appear at court some days earlier.

- His mother claimed Danny was not missing, but 'on the run' and trying to make some money before going to prison, which she said *he* believed was inevitable. He was worried he would see previous gang associates.
- Despite referrals for emotional and mental well-being he did not like talking to professionals. He was on medication for ADHD, which was prescribed by FTB, but he had refused to take it and was using cannabis to self-medicate.
- Danny was suspected to have been involved in drug dealing and county lines previously and it was probable that was how he was earning money, thus raising his level of vulnerability.
- Health staff suspected Danny was also suffering with PTSD and had previous suicidal ideations.

Whilst the outcome of the meeting was a Section 47 single agency investigation, with several actions set for BCT, police (missing strategy) and Danny's legal team, the adequacy of the multi-agency response needs to be considered. This is a significant incident and a potential missed opportunity to proactively address the escalation in harmful behaviour, as the subsequent entries show his risky behaviour did not reduce.

January 2023[85]- Danny's mother reported to WMP, that Danny had been stabbed and was at that time a missing person. He had been sleeping rough. Danny was wanted by police for failing to attend court, so was arrested. Danny would not provide any details of the stabbing. There is no record that BCT were informed, or any referrals made. YOS (Youth Crime Officer from WMP) records also do not contain information about the stabbing. In custody, Danny was seen by the community psychiatric nurse (CPN) for Liaison and Diversion (L&D). Danny refused an assessment, stating that he did have mental health issues but felt fine at that time. He also refused support for when leaving custody. Danny was remanded to be placed before the court for the other unconnected matters. Danny appeared at Walsall Magistrates Court for Section 18 Wounding, and received a 3-year Youth Rehabilitation Order, with intensive supervision and surveillance programme attached. He also had an electronic tag fitted, with a 3-month curfew from 7am to 7pm[86] and was taken to accommodation.

January 2023[87]: (see entry 25.08.2023 re firearms incident). Police decided Danny would be arrested based on the CCTV identification. Danny received a Community Disposal and 3 Year Youth Rehabilitation Order (YRO[88]). This included a number of conditions, such as intensive supervision and surveillance, and also an electronically monitored tag with a curfew for three months (7pm – 7am). However, Danny was reported missing within hours after arrival at the accommodation in January 2023. Danny returned home at 00.09 hours days later, stated he had been at his Nan's house and had fallen asleep. He stated that he had not been involved in any criminal activity and no safeguarding concerns were raised.

[85] Source WMP
[86] Source BCT IMR
[87] Source WMP/ Source Health IMR
[88] Source BCT IMR

From January 2023, Danny resided in supported accommodation provided by Brightsky Youth Services and engaged positively with his YRO.

February 2023[89]: (see entry 25.08.2023 NFA). Danny was arrested late February 2023 by the organised crime team. His room was searched and 7 wraps of Class A drugs, believed to be cocaine were seized. In interview, Danny stated he could not remember where he was on the offence date but denied the allegations in full. He denied being the male on the CCTV or carrying a firearm. He admitted possession of the drugs (for his own personal use). Danny was released on bail until June 2023. WMP records show that a Children's Advice and Support Service (CASS[90]) referral was made by police.

March 2023[91]- Danny's YOS officer reported that Danny had been a robbery victim but that he was not willing to engage with police. They reported that 'Danny had been on his electric bike when was approached by a male with a Rambo knife'. Further details were unknown, including the exact location. Danny refused to cooperate with police. This is believed to be the incident with Sterling.

March 2023[92]- Danny was arrested following a DA incident (possession of cannabis, kidnapping) assaulting an officer in the process.

March 2023[93]- A carjacking incident occurred where the victim was robbed of his car at knifepoint. Offenders abandoned the car following a police chase. One offender disposed of a bag whilst being chased. The bag contained a burner phone, a firearm (an Ekol Tuna 8mm blank firing pistol), crack and £85 cash.

March 2023[94]- Danny was identified from CCTV for the carjacking and arrested for possession of Class A- crack cocaine; Carrying an Air Weapon or imitation Firearm in a Public Place; and Robbery (personal) after the carjacking. The CPS refused to charge in custody, so he was bailed. He was later charged and bailed until June 2023, with bail conditions not to contact victim or co-defendants (two adult co-offenders; male aged 22 years and male aged 20 years).

March 2023[95]- A strategy meeting was held due to a number of missing episodes, concerns regarding exploitation. Outcome includes, Locate Police Missing investigation to continue. Gather and review details of Danny's extended family members, friends, and ex-girlfriend. Collate address details and contact numbers. Attempts to be made to liaise with Danny's parents and grandmother to potentially arrange a meeting with him, to create a robust safety plan. He was assessed as medium risk.

[89] Source WMP IMR
[90] If there are indications that a child may be at risk of Significant Harm, the Children's Advice and Support Service (CASS) team manager may authorise whatever actions are immediately necessary to protect the child or others in the household from Significant Harm.
[91] Source WMP
[92] Source WMP
[93] Source WMP
[94] Source WMP
[95] Source BCT IMR

March 2023[96]- There are several missing episodes over previous days, so a further S47 Strategy meeting was held, and Danny was assessed as medium risk when missing[97].

- a safety plan for placement was required.
- a referral to be made to Aquarius, to explore drug dealing/drug debt and care planning for post 18.
- CIC Nurse to complete health passport prior to his 18th Birthday. Danny returned late March 2023[98].

March 2023[99]- BCT made a request for secure accommodation for Danny once he was found (to prevent him from committing further offences).

March 2023[100]- A section 47 enquiry was opened. Danny was assessed as a 'vulnerable young person with complex needs.' Professionals were worried that Danny was at risk of significant harm by unknown individuals. Risks included:

- Danny had suffered adverse childhood experiences, had a diagnosis of ADHD and experiences low mood'.[101]
- Refusal to take his melatonin medication and engages in cannabis usage to manage his emotional wellbeing.
- Danny has suffered from suicidal ideation previously and has a history of drug dealing and county lines.
- Danny was subject to a Youth Rehabilitation Order and has intensive supervision and surveillance in place.
- Recent arrests for robbery/ firearms/ drugs/ phone.

A disruption and safety planning meeting via EmpowerU was requested. A safety plan was to be formed between YOS, Duty SW and the provider to manage the risks.

April 2023[102]- Danny was reported missing by his support worker (his 19th missing episode). He was on a final warning for curfew violations. In line with WMP policy, a missing record was created, reviewed by the supervisor within the Locate Team (designated team to respond to and investigate missing persons). A THRIVE (Threat, Harm, Risk, Investigative Opportunities, Vulnerability and Engagement) assessment was completed, and actions were set to locate Danny. Danny was deemed to be at risk of criminal exploitation and gang violence; he was noted to be a regular missing person, was flagged as a suicide risk having previously attempted to hang himself at school and also had a history of self-harm. He was subsequently graded 'medium risk': 'The risk of harm to the subject or the public is assessed as likely, but not serious.' The panel noted that the risk assessment on this occasion did not reflect a full understanding of the risk posed to, and by Danny. The risk level was raised to high late April 2024 but consideration for high risk at the outset would have been preferable.

[96] Source WMP and Health IMR
[97] The risk of harm to the subject or the public is assessed as likely but not serious.
[98] Source WMP
[99] Source BCT IMR
[100] Source BCT IMR
[101] Source BCT Scoping
[102] Source WMP

April 2023[103]- A Missing and Found Briefing was held with all agencies, including BCT, police, health and education.

April 2023[104] - Danny's mother reported threats (to her) from Danny following a disagreement about his clothing, although she was unsure whether she wanted to make a formal complaint and statement. A sighting of him is recorded on his missing person log.

April 2023[105]- The YOS held a Local Risk and Safety Panel on Danny. These are multi agency meetings to discuss children who are assessed as presenting a high risk of serious harm to others, share concerns and agree a risk management plan. The Police Youth Offender Manager attended this meeting. These meetings should have been initiated earlier and this has been identified as an area of learning for YOS.

April 2023[106]- WMP records show that Danny was discussed at the Birmingham Missing Triage with Locate officers in attendance. This is a multi-agency meeting. It is not clear what the outcome of this meeting was or if any specific tasks were set. On the same day, it was identified that Danny had been removed as missing from PNC for an unknown reason[107]. This mistake was rectified.

April 2023[108] - Missing Person ongoing. Officers located Danny at an identified address. It was confirmed he was there voluntarily with a female. Danny was allowed to go outside the address to smoke a cigarette, at which point he made off and was lost by the officers in attendance. It was recorded that there were no criminal offences to record and there had been no reason to arrest him.

April 2023- (connected to events of March 2023). Danny had been positively identified during an ID parade. The firearm and drugs were submitted for analysis and enquiries were still on-going. His PMP was later updated reflecting his arrest in March 2023 for robbery. These details were shared with partner agencies.

April 2023[109]- Missing Person ongoing. The fact Danny had absconded was subject of further discussion during multi-agency meetings and consideration given to placing him in secure accommodation once located. Refreshed phone data analysis was requested, and additional address checks requested.

April 2023[110]- A strategy meeting was held regarding Danny's missing episodes. In respect to being missing, he was assessed as medium risk. However, YOT SW noted that from YOT perspective, which looks into other areas, Danny was considered to be at a higher risk to himself and others. During this meeting, it was noted that there was a level of professional concern as to the length of time Danny had been missing for. At this point, Danny had not been seen since March 2023.

Of note, 12 Missing and Found Briefings held between early and late March 2023 and Danny's missing report was subject of several reviews as per WMP policy. Throughout his missing episodes, at times, some of the tasks set went unactioned owing to the fact there were several other 'high risk' missing persons records that required resourcing. As he was graded medium risk, any high-risk cases would always initially take precedence over

medium risk cases. Five addresses were prioritised for visits based on the results of data analysis on his phone. During this meeting, it was shared by his ASW that Danny had on occasion answered the phone but on learning it was her on the phone, would hand the phone to others and would not engage. Family had reported they had not heard from Danny. Danny was said to be in breach of his curfew and was to be returned to his original accommodation when found, but on reaching 18 years of age, he would require different accommodation which had not been decided. The phone work remained on going but Danny was still a missing person when Sterling was murdered.

Effective Practice and Learning.

Three separate offenders were involved in the incident which led to Sterling's murder, although playing different roles.

As the main perpetrator, there were a large number of agency interactions with Danny which ultimately were not successful in diverting him away from serious crime and harm against others. The multitude of incidents in which he was involved, were considered seemingly in various forums independently. There are various multi-agency meetings which take place - Strategy Discussions, Disruption Planning meetings, Local Risk & Safety Planning etc and the panel considered the challenge of how, as a system, these are all brought together when risks are escalating and, to make sure that there are some key single points of contact who hold the information from various sources of intelligence etc.

In this case, a Local Risk and Safety Panel (LRSP) was held in March 2021 to share information about risks connected to Danny. Following this, strategy discussions concerning his missing episodes were routinely held.

However, despite various multi-agency meetings (which may all have a different focus) taking place over the following 3 years, it was not until April 2023, when the YOS held a further LRSP on Danny where the totality of the concerns and escalating issues (arrests/ firearms/ knife and other violent offences/missing episodes) raised in relation to him were considered by a multi-agency panel. The delays inevitably impacted the ability for risks, to him and others to be adequately assessed and addressed as a partnership. This had identified some learning going forward.

On occasion, the lack of a multi-agency meeting and the need to better co-ordinate the different meetings and information sharing meant the totality of the safeguarding challenges were not always known to all involved agencies. It is not documented in a single location that all relevant intelligence and information was shared to understand the comprehensive

[103] Source BCT IMR
[104] Source WMP
[105] Source BYOS
[106] Source WMP
[107] Source WMP
[108] Source WMP
[109] Source WMP
[110] Source BCT IMR and WMP IMR

risk picture. The link between vulnerability and repeated missing person episodes should be prioritised through a consistent partnership delivery approach.

Police : In this review, the dominant theme regarding Danny's vulnerability is shown through his increasing missing persons episodes and the increase in risky behaviour. Although he was in local authority care, Danny was a frequent missing person, with a total of 19 missing episodes from 2020 and he was a missing person at the time of his arrest for murder. He was reported missing four times in March 2023 and once in early April 2023. Danny had an identified and escalating history of vulnerability.

Whilst finding Danny after he was reported missing was the primary responsibility of police, once found it is down to the local authority to ensure that he placed in a location suitable for his needs where his risk of further missing episodes would decrease. Demand and resource challenges were quoted as having impact on police ability to service missing person enquiries. Also, the challenge of local authority 'accepting' that Danny was 'staying with family' appeared to reduce the urgency of Danny's situation, and the prioritisation of searches for him.

Examining the detail of where Danny was allegedly found, he appeared to frequently be with his family members- grandmother/great grandmother/uncle who all refused to give their addresses. It is unclear why Danny was 'accommodated' rather than living permanently with family. When he went missing and stayed with family, there were no obvious concerns raised by social care. This creates a conflict or dilemma for agencies and raises the question about whether sufficient work was completed with him and them, to enable him to return permanently to family.

The family reluctance to cooperate with authorities supports the assertion about community culture and barriers to reporting, which was a KLOE 2 in the TOR. That is specifically addressed below (addressing TOR). The lack of comprehensive detail on the debrief reports (where he had been/ who he was with), added little value to the overall risk picture for Danny. Timely and meaningful updates on reports are important.

In dealing with his missing episodes, the police IMR demonstrated on multiple occasions, officers were committed to other enquiries and unable to service the missing calls. Enquiries consisted of ringing his phone number, which Danny would mainly not answer. Other 'high-risk cases' were prioritised over Danny. The lack of documented detail in understanding the cause of his missing episodes and the absence of contextual factors impacting Danny, which could only come from a missing return interview. This is a constant challenge in terms of young people engaging with a return home interview, to explain their vulnerabilities and reasoning for going missing. This is an area where young people could be reached and influenced but it is unclear what more could be done, especially system wide to reach them.

The national standard to adhere to missing person risk assessment are governed by the College of Policing and is part of WMP policy. WMP own their own policy (Attached as an appendix 1).

WMP policy dictates that missing return interviews are:

** Required for children and the vulnerable in society.*
** All children who are under the care and support of Local Authorities are subject of return home interviews conducted by the Local Authorities themselves.*
There is an expectation of a prevention interview being completed.
** A prevention interview must be undertaken by WMP to identify any ongoing risk or factors which may have contributed to the person going missing in an attempt to prevent the person going missing again (generally completed by support workers at Danny's accommodation).*
** Prevention interviews must be carried out in all high-risk cases but must also be considered for no apparent risk (absent), low and medium cases.*
** A prevention interview must take place as soon as practicable after the person has been found.*

Prevention interviews were rarely completed in Danny's case, (and if they were, they are not documented), and agency records do not always explain a) the rationale for non-completion or b) whether they were actually offered. The absence of this information leads to an incomplete picture of risk through the voice of the missing person. This is learning for all agencies who interact with young people as there is limited information on which to understand the contextual factors impacting Danny or assess Danny's vulnerability or likely future / repeated missing behaviour.

Entries on records show that when Danny was 'found' with family members or at their addresses, he was deemed to be 'safeguarded', but this creates a dilemma in ongoing risk assessment. The ongoing missing locate records showed that family addresses were possible addresses but were not always the locations that he was found at. He would routinely re-appear, often when it suited him, with no explanation as to where he had been. Whilst it cannot be stated that the murder could have been prevented if Danny had been located before the murder, it is obvious that the incomplete picture in his return or prevention interview history (of why he was frequently missing) did not assist in locating him before the murder.
Danny's case was discussed at Birmingham Missing Triage with Locate officers in attendance (a multi-agency meeting) in April 2023 but it is unclear what the outcome of this meeting was or if any specific tasks were set. On the same day, it was identified that Danny had been removed as missing from PNC for an unknown reason. This mistake was rectified although the opportunity to have found him in the interim cannot be assessed.

In April 2023, Danny was also found at an address but absconded from the scene. Although there were no criminal offences to record or arrest to be made, this behaviour should have triggered a significant and meaningful effort to trace him.

WMP would not have made any connection between Danny's frequent missing episodes and his ongoing conflict with Sterling, as there had been no reports to any agency. Additionally, whilst police followed all recommended policy and practice, WMP recognised the speed of effective decision making and associated rationale, led to missing persons prevention interviews not taking place. None of the agencies engaged could have foreseen the actual potential for the murder.

There is a range of (additional) learning which covers investigations/ missing person enquiries/ information sharing. Neither Sterling nor Danny had cooperated with police.

Community intelligence was not passed to police which could have allowed a risk assessment to have been conducted. Police therefore lacked the information to understand the threat, risk, or harm that existed. Danny refused to cooperate with information about the alleged robbery which could have identified the associations. Without information -CCTV or other witnesses, even with the accurate information about the real location of the electric bike theft, it is unlikely that officers would have been able to trace the electric bike and connect the associations.

The WMP IMR author noted some specific investigative challenges that multiple and often conflicting accounts could appear on crime reports and non-crime incidents, relating to the quality of CCTV or ring doorbell footage, which often led to incidents not being correctly interpreted or investigated. Poor quality CCTV and lack of witness corroboration meant that some allegations were not proceeded with. WMP have noted learning (below) for the police.

In January 2023, it was good practice to have a multi-agency meeting about Danny, to share information and formulate a plan how to move forward with his care. It was an unusual step for his solicitors to take part, but excellent practice to work with them to locate and safeguard him. While WMP had charged Danny for offences and he was due in court, this multi-agency meeting shows that at that time, services were working together for Danny's best interests.

WMP noted learning for the force:

- When receiving crime reports to investigate, it is essential that officers read all the contents and view all relevant documentation.
- When filing incidents, factually correct information should be used in the rationale.
- All relevant CCTV should be obtained and viewed.
- All missing person episodes should be subject of a debrief, including details of the missing persons attitude, appearance etc if they will not engage.
- Prevent interviews should be captured where appropriate and if not, the rationale of why not should be included within the missing person report.
- All missing person reports should be updated in a timely fashion, with accurate information, clearly naming where the person was found, who with and the contact details of the location found and the person with. It should be made clear who family members are, how they can be contacted and where they live.
- Where warrants are issued by the courts and allocated to officers, arrest attempts should be completed as soon as practicable.
- If a missing person is wanted for any other reason, including for an outstanding warrant, this should be made clear within their compact record.
- When suspects of crimes are identified from CCTV, the arrest of that person should be made promptly.

Probation: Due to their ages, there was no information connected to Greg, Mark or Danny held by Probation. Sterling had limited contact with services. The Probation Service had been not involved with Sterling since September 2016, some 5 years prior to the period covered by this review. There was no indication in the probation case management records that Sterling was personally violent or aggressive or, had or may have been subjected to

violent or aggressive behaviour. In this review, there is some identified effective practice or learning for Probation.

Sterling had been managed as 'low risk'. He was offered 17 appointments and attended 10 of those appointments. 3 of the failures to report were deemed unacceptable. Enforcement action should have taken place. The requirements of contract with the Ministry of Justice mandated that Staffordshire and West Midlands CRC should have considered enforcement action. Records show that this was not considered. Whilst this was not a contributory factor in Sterling's death, learning from this case regarding enforcement action would enable future offenders to be more appropriately monitored and managed, and lead to a better understanding of their non-compliance.

Housing: There is limited housing information held regarding Sterling and the perpetrators. Sterling was in private rented housing having been supported by the Royal British Legion. It had been understood that they had provided his accommodation, however it later emerged that they are a service who support and aid ex-military with a contribution towards deposits or rent. They held no information to inform learning in this this review.

There was no separate or independent housing information held on any of the perpetrators. Occupancy records are all held in the names of adults at the various premises. Unless the occupants come to the attention of agencies (council/ police social services) who then share the information, there is no single repository for the information. Whilst not currently mandated, consideration could be given to recording the names of all occupants in a premises, to understand the demographic makeup. It will also allow for effective sharing of information between agencies, particularly where multi-agency discussion may be required. This would allow for data collection on occupants including issues such as overcrowding (Census data in Birmingham indicated that almost 10% of homes in the area suffer from overcrowding), and potential socioeconomic vulnerability.

The impact of housing security has previously been referred to. Each of the perpetrators was experiencing challenges with their housing and living situations. Greg lived in an impoverished home with his mother and multiple siblings. Little detail was recorded save to say that there was poverty in the home. Kody was experiencing housing insecurity, having left home at aged 16 years, and he had repeatedly but unsuccessfully applied for housing. Danny was in supported accommodation from the local authority but had indicated his desire to live alone and have his own premises.

In this review, there is no specific identified effective practice or learning for Housing

Health

Danny presented with a problematic health background. In his case, referrals to mental health services were made via a number of routes such as Urgent Care Team, community services and also via police when he was detained in custody. There have been numerous assessments by a number of professionals including mental health, medical staff, nurse practitioners, youth workers, transitions team, he also had input from psychotherapists. They have completed various assessments such as risk, exploitation screening, lateral

checks, physical and mental health assessments, he was also offered Dialectical Behavioural Therapy (DBT). Depending on the outcome of these assessments would then determine the action to be taken. It was also clear from review of the records and speaking with Safeguarding Team at the Birmingham, Women & Childrens Hospital (BWCH) that staff understood the actions to take, who to involve and if referral to other services was required. However, due to his non-engagement, compliance with care and treatment this did prove quite challenging, they also identified that his mom had also impacted on decisions being made especially around ADHD medication and access to DBT.

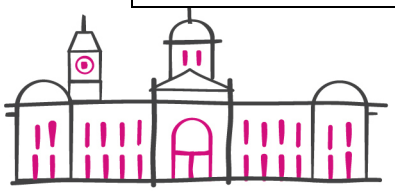
It is important to note that he was only registered with some of the GPs for a short period and they would have had limited opportunity to assess him directly, he was however coded on their system as risk of CCE/CSE and information had been shared regarding the Strategy discussion.

Staff do have access to a variety of policies and procedures such as the Safeguarding Adult and Children's policies. Safeguarding training is also provided which would cover vulnerabilities and who is at risk of harm, abuse this would also include those at risk of CSE/CCE too. Practitioners will also be aware of the indicators but as identified by the safeguarding team at BWCH they are also reliant on the person being open, honest and transparent, but also other colleagues, professionals to share information with them, an alert is noted within their records and following the Strategy meeting March 2023, it is noted was in possession of a firearm.

It was evident from the review that early on in his childhood Danny had experienced trauma due to DA and noted that his homelife was very unstable, chaotic, with a lack of consistency. Across Health there is a growing awareness and understanding of the impact of Adverse Childhood Experiences (ACEs) which is used to describe a wide range of stressful or traumatic experiences that children can be exposed to whilst growing up. ACEs range from experiences that directly harm a child (such as suffering physical, verbal or sexual abuse, and physical or emotional neglect) to those that affect the environment in which a child grows up (including parental separation, domestic violence, mental illness, alcohol abuse, drug use or incarceration).

Danny had access to many different services such as Primary Care/GP, community paediatrics, mental health, children's services & psychotherapy. Although services were readily available for him, he was known to disengage especially around managing his ADHD and substance misuse, the continuity of care can also be difficult to maintain/achieve given the changing locations and the duration he stays in that particular setting/home etc. We were aware that he was accessing services provided by other agencies such as Change, Grow, Live (CGL), enterprise coaching, youth services, social services/local authority, there was also a support worker allocated to him. Staff were aware of his vulnerabilities and Health were linking in with other agencies to understand the risk and did attend a number of risk and vulnerability panel meetings. It is recorded that he did have a support worker allocated to him.

There have been numerous assessments by a number of professionals including mental health, medical staff, nurse practitioners, youth workers, transitions team, he also had input



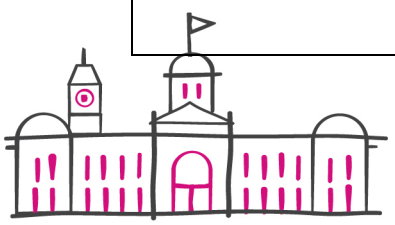
from psychotherapists, then depending on the outcome of these assessments would determine the action required. However as per previous comments it was proving challenging for those involved due to him not engaging and location/setting changing. He was also being monitored and reviewed regularly by Health and other partner agencies via the risk and vulnerability meetings, Strat discussions and follow up appointments.

Audits are undertaken regularly across the health system, but they are not necessarily about a particular individual, as focus tends to be clinical, quality, research based and can also be following a serious incident. The Safeguarding teams also carry out a number of audits that can arise from various reviews such as Domestic Homicide & Safeguarding adult/Children reviews.

There is evidence that information has been shared across Health and with other partners. Risks, alerts and safeguarding Strat discussion have been noted by GP, FTB staff and from the other agencies too. There is reference to Empower U having contact with him however no evidence that information as to their involvement or of the outcomes has been shared with any staff within Health. West Mercia Police also shared information across boundaries due to his involvement with County Lines.

Following discussions with GP's it has been recognised that their knowledge and understanding for managing violence, aggression, offensive weapons is limited/varied and would benefit from more guidance as to how it can be managed in practice but also who to refer too and what agencies are available that they can signpost victims and perpetrators to. They have also had a recent presentation from a member of the exploitation group (MAACE) at their GP safeguarding forum and found this very useful and informative. They were also reminded that there are Force Intelligence Bureau (FIB forms) that are an effective way of sharing concerns with police colleagues if they become aware of any concerning activity that either a patient tells them, or they see happening by their GP surgery/locality.

- Continue to raise awareness of Trauma Informed Practice and impact of ACE's.
- Continue to work in partnership with the Birmingham Community Safety Partnership, Violence Reduction Board and implementation of the Serious Violence Duty
- Cascade and share learning from this OWHR across Health
- Continue to work in partnership regarding Transitions especially for those children in care where it is known that there are previous/ongoing safeguarding concerns.
- GPs would like more guidance/resources on how to manage those that have a history, disclosure of violence, aggression or carrying weapons. Which agencies to refer and contact details. They will also check coding system to see if it can be flagged re Offensive Weapons
- Continue to Promote and raise awareness of the BSAB guidance re how to manage those that disengage and Risk Enablement
- Raise awareness of the FIB forms
- Raise awareness of the Veteran Friendly GP practices



BYOS

BYOS noted that Danny switched between engagement and non-engagement during their dealings with him. completed an Internal Learning Review on the overall management of Danny, which concluded on the 10.08.2023. That Internal Learning Review is part of the Serious Incident Process. Effective Practice was noted. It was apparent that the social worker and other professionals made sustained attempts to work collaboratively with Danny and his mother, following the Child Protection plan being created in 2019. Unfortunately, this was met with superficial engagement from Danny's mother and disguised compliance.

Danny seemed to present well during interactions with professionals, including his social worker (noted SW visit September 2022), in which he was able to articulate that he was doing well and had the intention of completing his pathway plan exploring suitable accommodation options post 18. He also shared that he wanted to improve his life skills and independent living skills. His time at Empire Coaching and Barton Moss seemed to help him to develop positive routines, structure and consistency within his life.

Danny had shared several times that he had suicidal thoughts, that he wanted to harm or even kill himself. During the CP plan period (August 2019), it was noted that Danny had been found carrying a knife. When Danny was 14 years old, it was noted that he had locked himself in his bedroom with a knife. He was said to have been a young carer for his sister but more worryingly, he was said to have class A drugs in his possession whilst in school. There is no further reference to this or whether there had been efforts made by BCT to explore this further, e.g., where had he obtained the knife, was this something he did regularly and the reason for doing so (perhaps self-protection?). This was an early opportunity missed.

It is apparent from the case files that Danny's mother had made efforts to parent him appropriately but when her efforts failed to generate positive results, she resorted to inappropriate physical chastisement of Danny. Although this was acknowledged by all professionals, no specific work was undertaken with his mother and Danny around the impact of this on him. It is noted several times in casefiles that Danny had low self-worth, self-esteem and that he shared that he wanted to kill himself. However, it was not possible to locate any specific interventions identified to address this or support Danny. It is possible that Danny declined support or intervention work, however.

It is shared that Danny's mother 'did not seem to engage' meaningfully in the CP plan and this was felt to be potentially due to her previous experiences with social workers. It was recorded that Danny had eight social workers between December 2019 and April 2023. The number of changes in social worker did not assist the building of a trusting and supportive relationship between Danny, his mother and the trust.

The Trust could have been more curious about Danny's reported access to weapons and how he was able to gain access to knives and firearms, so easily. The limited engagement of Danny and his mother with professionals had a significant impact upon the effectiveness

of any planned intervention work around this but there is no clear evidence that the trust made significant efforts to explore this fully.

The PSR and breach report are both very thorough and trauma informed.

The contacts on Care Director (Appropriate Adult service) from March 2023 when YOS provided an Appropriate Adult in Police Custody are thorough and all relevant information is fed back to the allocated YOS case manager. This is an excellent example of how YOS providing an AA service works well.

ISS Team going above and beyond- There is clear evidence of the ISS team providing sessions that are tailored to Danny and his needs (i.e. cooking sessions, helping him pay Court fines) and them going above and beyond to arrange Education, chase updates and request IT equipment.

There is evidence of YOS staff demonstrating a good response to critical incidents such as missing episodes, disclosure of risk/safeguarding information and Danny being in Police custody following an arrest. There is also clear management oversight following incidents with actions to be taken as a response.

BCT

Whilst the review panel considered the below content to be an area of learning, the local oversight board panel member considered this to be an identified theme within effective practice.

The theme that has emerged around the number of SW that this YP had over his young life is one of multiple social workers , whilst a SW is one of many professionals who will have been known to the YP , he himself identified that the changes in SW's impacted on him trusting the system and people who were there to help. The issue of how children social care systems are set up , alongside national retention and recruitment of social workers can mean that the child and family experience several different social workers over time.

This is not helpful in creating a trusting relationship and is something that is a challenge for children services across the country. There is an ambition to limit this issue for children and families and work being undertaken through the National Reforms will support this. BCT have a transformational programme at the core of this programme is the desire to limit the number of social care staff that children and families have and to identify a lead professional, who may not be a social worker, to walk alongside the family as they are offered services and support

The limited engagement of Danny and his mother with professionals had a significant impact upon the effectiveness of any planned intervention work around this. It was apparent that the social worker and other professionals made sustained attempts to work collaboratively with Danny and his mother, following the Child Protection plan being created in 2019. Unfortunately, this was met with superficial engagement from Danny's mother and disguised compliance.

Danny was a complex young man who engaged intermittently with services. The rationale about non-engagement is not totally understood. Danny seemed to present well during interactions with professionals, including his social worker (noted SW visit September 2022), in which he was able to articulate that he was doing well and had the intention of completing his pathway plan exploring suitable accommodation options post 18. He also shared that he wanted to improve his life skills and independent living skills. His time at Empire Coaching and Barton Moss seemed to help him to develop positive routines, structure and consistency within his life.

Danny's many complex risk behaviours were explored with him. Danny had shared several times that he had suicidal thoughts, that he wanted to harm or even kill himself. These incidents were referred to MH and to GP services for support. During the CP plan period (August 2019), it was noted that Danny had been found carrying a knife. When Danny was 14 years old, it was noted that he had locked himself in his bedroom with a knife. He was said to have been a young carer for his sister but more worryingly, he was said to have class A drugs in his possession whilst in school. There are no further details about this or whether there had been efforts made by BCT to explore this further, so this suggests an early opportunity missed.

Recorded incidents of inappropriate physical chastisement of Danny by his mother, did not lead to any specific work around the impact of this on him. A specific intervention addressing low self-worth or self-esteem could have led to a more comprehensive understanding of Danny's beliefs.

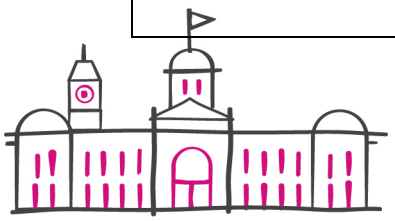
Danny had eight social workers between December 2019 and April 2023. The number of changes in social worker did not assist the building of a trusting and supportive relationship between Danny, his mother and the trust. The continuity of support is a critical factor in ensuring trust in authority and support figures.

Overall, throughout the review, the importance of information sharing was discussed. Whilst there are some sharing protocols and agreements between some agencies, there was a lack of consistency and information and intelligence sharing protocols across the multi-agency footprint.

Addressing Terms of Reference- the following evidence, from agency IMR's addresses the individual TOR questions.

KLOE 1- Whether family, friends or colleagues were aware of any violent or aggressive behaviour from the alleged perpetrator(s) to the victim, prior to the homicide.

Stacey knew each of the perpetrators. Whilst Greg and Mark were apparent strangers to Sterling, there was a history of conflict between Sterling and Danny regarding the ownership of the electric bike. This information was known by Sterling's partner, and commonly known to an (unidentified) number of witnesses who had observed Danny making verbal threats towards Sterling in a public place. These threats went unreported to authorities.



Stacey was prepared to give evidence at court, but others, who she knew to be witnesses to the threats made, refused to do so. It is unclear why, but the possibility of the threat of retaliation is a real fear in communities.

There is limited information held by agencies about Greg or Marks' pre-disposition towards violence. Neither were known as prolific offenders. Greg was known to police as an offender for low level, non-violent matters. He had come to attention for anti-social behaviour and two incidents connected to cannabis possession, where he received community resolutions.

Mark's offending history is previously documented. He was also found with cannabis and under investigation for possession with intent to supply cocaine at the time of the murder. There is a police record, that Mark was in company of a male who was carrying a knife in August 2021. Mark was not prosecuted. Mark was later arrested in January 2022, when a 7inch knife and drugs were found in a car in which he was a passenger. He was again not prosecuted.

Danny had a previously documented propensity towards violence and aggression. With arrests and convictions for weapons and Danny also displayed violence and aggression to police on arrest.

Danny was known not just as an offender but also a victim of violence. He was reportedly stabbed in March 2023 and whilst there was no injury recorded on his custody record, it had been confirmed by his grandmother and mother. As the victim of a violent crime with a weapon, the possible escalation of risk and vulnerability this demonstrated in his lifestyle, should have been identified and a referral made because of the type of offence. It is unclear from any agency record whether this vulnerability was noted.

KLOE 2- Whether there were any barriers experienced by the victim (or his family/ friends/colleagues) in reporting any concerns, including whether he knew how to report violence or threats should he have wanted to.

The review found no actual barriers to reporting concerns. Police and other agencies have robust reporting mechanisms for reporting concerns, should victims or witnesses choose to do so. Whilst conducting the review, it became apparent that a reluctance, resistance, or reticence to report the threats made by Danny to authorities were not connected to any organisational barriers within the agencies.

His family revealed that Sterling was aware of 'how' to report concerns (as he was able to report the 'theft' of his electric bike), but the barriers he faced appear more closely linked to culture of not cooperating with police. As Stacey explained, 'it just isn't the done thing'. Danny's IRO asserted that 'social dynamics within the community gave the impression that trusting professionals and police was frowned upon'. Reporting crime (or snitching) carries a lot of negativities in some communities. Additionally, the fear of repercussions of being seen as a whistle-blower or informant inhibits cooperation.

When he had been the victim of carjacking in January 2021, despite an independent witness and supporting CCTV, Sterling refused to assist police at the time or subsequently and the two suspects (known to him but not identified to police), were never traced.

This goes beyond suspicion of the police or, a trust and confidence issue. As witnesses to this case revealed, it appears that Sterling (and the multiple unidentified witnesses to the verbal threats made by Danny), did not readily cooperate with authorities, or potentially recognise the gravity or risk associated with those threats.

In respect of independent witnesses, any number of reasons could explain the lack of reporting of any concerns. They may have considered that others would/could have reported matters. They may have believed they were no obligated to get involved- a sense of disinterest could also conceal a fear of retaliation. Sterling's hesitance appears to be linked to the long-standing culture of non-cooperation with authorities.

And whilst it is now known that Sterling was carrying a knife at the time of his murder, there is no actual information that Sterling personally feared Danny. Instead, the opposite appears true, he confronted him to get his electric bike back.

Academic debate has focused on lack of reporting to police as being fear based, where a code of silence is promoted through implicit or explicit threats, physical violence or retribution in other ways such as damage. A real concern is the apparent lack of trust in authorities. This is particularly prevalent in youth culture connected to knife crime. Crimestoppers Research[111] revealed that 'less than one fifth of children and young people who experience violent crime actually go on to report this to the police (ONS, 2014).

There are a number of reasons why young people may decide not to report a crime, some of these reasons include; Fear of repercussions, Joint enterprise: concerns around if they share too much information they may be associated with the crime/incident, Distrust of police/authority figures, or they don't have a safe place/person to report this information to, Not sure if what they have seen constitutes a crime, They experience higher rates of crime so become desensitised to it.'

In Danny's case, there appeared to be a barrier linked to his suspicions of professionals[112] and he had approximately eight social workers during the time he was in care. He shared that he did not trust social workers as they did not help him and in the months before the murder, has refused to engage consistently with his social workers and his personal advisor. The consistency in support may have aggravated Danny's feelings of mistrust.

In Greg's case, anonymous information was received about access to knives and drugs at his address. This information was problematic for the source in reporting the concerns and created some tension on how to best protect the vulnerable source. However, when shared appropriately with police through the Social Worker, the information was managed and enabled a warning marker to be placed on the address.

[111] Reporting Crime- Snitching and the Bystander Approach
[112] BCT IMR

KLOE 3- Whether any of the perpetrators were known to carry offensive weapons (routinely or as a one off) and what steps had been taken to share multiagency information to prevent such usage.

There is no intelligence or information that either Greg or Mike 'carried' weapons, either routinely or as a one-off.

One anonymous report to social workers suggested that a knife, gun and drugs had been seen at Greg's address, and the information indicates that this was shared with police and a warning marker placed on the address. To protect the source, no other proactive work was done with Greg. No details of associates were contained on the report, and this is a missed opportunity to understand the associations and how Greg, and others may be being exploited, or descending into risky behaviour.

On two occasions, Mark had been in the company of others who carried or were in possession of knives, but he was not charged. There is no record this information was shared with other partners.

There was intelligence and information in the police systems to indicate that Danny did carry a variety of offensive weapons. Danny was the perpetrator of violence, including the stabbing of another young person in the past. In December 2019, Danny was charged with being in possession of a bladed item and robbery.

On 05.08.2022, Danny was identified on CCTV as being involved in an incident where a firearm and machete were seen. The items were not found, and he was not prosecuted. Later, BCT case notes indicate in October 2022, Danny had a fight with his cousin and stabbed him. Danny was charged with GBH and the police requested he be placed in secure accommodation at the time, due to the concerns around the risk he posed to others.

In March 2023, Danny was involved in a carjacking where the victim was dragged from his car at knife point and his car was stolen. The information was shared in a strategy discussion on in March 2023 and in a Local Risk and Safety panel in April 2023. Although this is a positive multi-agency engagement, it is recognised now that multi-agency meeting should have taken place much earlier when the escalation in his risky and volatile behaviour may have been addressed. These incidents are clear demonstrations of his propensity towards violence.

BCT held a strategy meeting on in March 2023, where it was noted that Danny had received extensive support to address his offending behaviour whilst part of his Intensive Supervision and Surveillance Programme for 6 months[113]. He was under electronic curfew for 3 months 7:00pm to 7:00am daily. Initially he coped well with the curfew, but he struggled to comply with the requirements consistently. Danny's compliance in ISS sessions was good and he attended all sessions. Danny should have been in receipt of 20 to 25 hours of support each week. However, due to budget and resource issues, he was only provided with 12 hours of

[113] Source BCT IMR

weekly support. The support included Danny seeing a tutor. In addition, it was noted that Danny attended the following sessions:

- Knife awareness.
- Reparation work.
- Sessions with YOT SW's.

It was also noted in three subsequent Strategy meetings and discussion that Danny had been missing for long periods, he was at higher risk of harm to himself and others and that he had been known to present with violent, aggressive and harmful behaviour. It was also noted in the Strategy meeting dated April 2023 that Danny had been missing for a significant period of time and as such, professionals were unsure of the level of harm he was exposed to.

In March 2023, BCT made a request for secure accommodation in respect of Danny once he was found. This demonstrates an attempt by the Trust to seek to protect Danny by identifying suitable accommodation capable of keeping him safe and helping him to stabilise and reduce his offending behaviour. The Trust would have needed to secure a suitable court order alongside this accommodation but due to the demand for such provision, it appears a suitable offer was not received by the Trust. This option had the potential to protect and safeguard Danny and perhaps prevent him from committing any further offences (for the period of time he would have been in custody).

KLOE 4- Whether there were opportunities for professionals to 'enquire' as to any violence /abuse linked to offensive weapons, experienced by the victim that were missed.

Sterling had limited engagement with services. Although he had reported to police being the victim of a carjacking, there appeared to be no connection to this being associated with offensive weapons. Apart from that one incident, there was no information or intelligence in the agency records concerning Sterling as a victim of violent crime. Through Stacey, Sterling had reported his bike theft from his garden. He had not reported the threats of violence. As previously stated, the lack of reporting meant that agencies were unable to enquire with him or assess or reduce the potential risks to Sterling.

Danny engaged with some work around knife crime on his YRO, but a lot of the sessions completed prior to the murder were around relationship building and life skills. In the pre-sentence report for the sentencing hearing in January 2023, part of the proposed work included, '*Knife Crime Programme: Work exploring and challenging Danny's views on the need to use / carry blades in public, whilst increasing his awareness of the serious and wide-ranging harm they can cause'.* It appeared that more work on knife crime was going to start just prior to him going missing

There do not appear to have been any barriers in place that would prevent any of the perpetrators or their families from reporting any concerns they had linked to violence or threats.

KLOE 6- Whether there were opportunities for agency intervention in relation to violence/ threats regarding the victim or alleged perpetrators that was missed.

This specific TOR question goes to the heart of the discussion about preventability. The bike would have had identifiable features (serial numbers or marks). And whilst Sterling had reported the theft of the bike, no obvious connection was made between the theft, and the later alleged theft/robbery of Danny's electric bike, as Danny refused to supply details. Whilst police use sophisticated analysis tools in crime prevention, in this case, police were hindered by the lack of information they were given and there was no analysis which could have identified the electric bike as being involved in both incidents.

The prosecution evidence revealed that the threats of violence were unreported. Agencies were unaware of the conflict Sterling was engaged in, or the threats made towards him, so the submitted IMR's show no opportunity for agencies to intervene personally for Sterling in relation to violence or those threats.

There was no information held that prior to the murder, either Greg or Mark were aware of or, party to the specific conflict between Sterling or Danny. Whilst there was some limited agency interaction with them both, neither had come to the attention of police for violence or aggression.

Whilst the 'Sterling / Danny' animosity was unknown to professionals, Danny's history and propensity towards violence was more explicit.

From police records, Danny had markers for firearms, weapons, violent, escaper, mental health, suicidal, self-harm, and drugs. Danny was connected to 82 investigations in WMP from 2005 to 2023 and had been arrested on fourteen occasions. In the recent history, Danny had three convictions for five offences from 2019 to 2022.

Danny had a demonstrable involvement in violent offending and had received certain sentences as a result. He was known to BYOS since 2017 (August 2017 – Youth Conditional Caution, December 2019 – 12 months Referral Order, December 2020 – Referral Order was revoked, and he was resentenced to a 6-month Detention and Training Order).

After being remanded without bail for the GBH in 2022, Danny was sentenced in January 2023 to a supervision requirement - 36 months of supervision beginning with 25 hours per week of supervision. He was given a youth rehabilitation order until January 2026, compensation £75, activity requirement for 3 months with electronic tagging – and to remain at specified address between 7pm to 7am daily.

Danny had presented with significant concerning behaviour at different times, which in March 2021, led to Danny being discussed at the Local Risk and Vulnerability panel (LRVP) hosted by BYOS. Notes from FTB records showed a history of violence and aggression, assaults and threatening with a knife. In attendance at the meeting were: Change, Grow Live (CGL), social worker, education mentors, restorative justice practitioner, enterprise coaching, youth crime office. The recorded information describes the significant vulnerabilities Danny faced at this time.

The psychologist noted that Danny 'is highly anxious, fearful of men which Danny puts down to relationship with father. The placement at Barton Moss has been most stable period of time he has experienced in his life. Danny believes that in the next year he will either die or go to prison. There are concerns that part time education and no certain placement and returning to volatile placement with his mother back at home will bring about instability. It was recognised that risk is serious, and vulnerability means that a wraparound service is required'.

Enterprise coaching noted they had previously worked with Danny and feel he is suppressing his potential for life due to accumulative life experience. Education wise, they will pick him up and take him to the placement. Need to also consider activities to keep him entertained for weekends as these are flashpoints as well as Fridays as in past he was easily drawn into delinquent/gang contact when things are poor at home.

FTB noted Danny would transition to the Oaklands centre to the YOS and look to have emotionally informed work, planning handover meeting for following wk. Noted risk to others and very high risk for retaliation by Danny as he introduced a friend to gangs who was then killed this year.

It was noted that Danny's relationship with his father has also been extremely detrimental to his emotional development. As well as witnessing his father be emotionally and physically violent to his mother as a toddler, Danny then had minimal contact with his father from the age of 2 to 11 years old due to him being incarcerated. Danny is recorded as becoming increasingly keen to see his dad in the latter years of his stay in custody. Upon his fathers' release into the community, Danny had short episodes living with him, but the arrangement always ended with claims of physical chastisement.

BYOS assessed that as a result of both parents' inconsistent care, Danny is thought to have Disrupted Attachment Disorder. Danny has consistently presented these behaviours in home and education settings. Danny was diagnosed with Attention-Deficit Hyperactivity Disorder (ADHD). He has difficulty controlling impulses and regulating heightened emotions. He has previously trialled medication but did not enjoy the way it made him feel. At the time of the murder, he was opting out of medical treatment.

Danny had an extremely fractured education history. He attended four different primary schools and four different alternative secondary provisions, as well as having over 2 years of home tuition; attendance was inconsistent, and he often presented with frustration and aggression to teachers and other pupils[114]. Social care records indicate historic self-harm and suicide attempts in education settings. This information was challenged by YOS SW[115] who stated that as far as he was aware, Danny had never expressed suicidal ideation, but he did talk about struggles with his mental health just prior to going missing whilst in a breach meeting.

[114] Source EHC assessment in 2016.
[115] YOS IMR

NSPCC[116] have provided some insight into criminal exploitation and why young people join gangs, which helps to understand some of the vulnerabilities that Danny was experiencing. NSPCC suggest that young people experience:

- Peer pressure and wanting to fit in with friends.
- They want to feel protected.
- They want to gain status and feel powerful.
- They have been excluded from school and don't feel they have a future.

Whilst there is no evidence that he was in a gang, his family life and interactions show high levels of vulnerability, a lack of consistent role model (including male role models), and Danny had expressed his fears through anger and conflict.

BYOS noted his lack of attachment to his immediate family had increased his level of susceptibility to negative influences and manipulation from older peers and adults from his local community who were linked to criminality and gang activity. It is thought that from his pre-teens, he sought the support and comradery of this group in the absence of a positive male role model at home.

Danny admitted to long-term cannabis use. He maintained a positive view of the drug and its effects and has little motivation to reduce his use currently. He states he enjoys its effects, and it is suspected he is self-medicating his ADHD.

Danny's worrying behaviour continued following the March 2021 LRVP meeting and he was discussed at a number of additional multi-agency meetings where intervention attempts were. made to support and guide Danny. However, during the review, BCT observed that were several opportunities missed with regard to general intervention and support for Danny, which include:

- December 2020 – March 2021. During his period in Barton Moss, secure accommodation.
- April 2021 – January 2022. Whilst in placement at Empire Coaching Danny was stable, engaging with staff in his semi supported accommodation. He was consistently engaging with education and had made the difficult decision to separate himself from his gang affiliated peers.
- January 2022 – October 2022. Danny was attending education, mentoring program, having regular family time with his father, grandmother and paternal aunt. He talked about his future aspirations and what he wanted to do with his life.

Between December 2020 and October 2022, Danny was at his most stable and had access to support services that he could engage with. Following this time, Danny began to reassociate with negative peers and go missing frequently.

In May 2020, Danny had revealed that he had a significant mistrust of authority. BCT reported that Danny was very suspicious of professionals as he had approximately eight social workers during the time he was in care. This inconsistency in support is a significant

[116] Criminal Exploitation and gangs- NSPCC

factor in determining the effectiveness in developing a relationship for a child or young person. (*This will lead to a Recommendation: Consistency of support for a Young Person)*.

Danny shared that he did not trust social workers as they did not help him. BCT note[117], 'Danny's mistrust of social workers and professionals in general, meant that he was only likely to engage with people who he trusted and had developed a positive working relationship with. He could be quite demanding and when he did not get his own way, this often resulted in him becoming verbally aggressive and abusive to staff members. In the months prior to the murder, had refused to engage consistently with his social workers and his personal advisor'.

The BCT IMR author further noted that the most opportune time to engage and work with Danny would have been during the three periods between December 2020 and October 2022, as he was settled at Empire Coaching, was in a safe environment and had a consistent routine. He had already developed positive working relationships with staff and was consistently engaging in education and talking about his future aspirations. Danny had access to many professionals who he could talk to or seek advice and support from.

Following this period in his life, from January 2023 onwards, Danny had already begun to deteriorate in terms of his behaviour, his anxiety levels were high, he was regularly going missing, and he prioritised associating with his peers over any other activity. Danny had developed a mistrust of professionals and the 'pull' of his peers plus his chaotic lifestyle, meant that he was unlikely to significantly recognise any advice or assistance offered to him.

Whilst the connection to Sterling was unknown, Danny had come to the attention of agencies on a number of occasions from December 2022 onwards. At this time, and for several periods after and later, on the day of the murder, Danny was reported as a missing person (he was known to be a frequent missing person), and all agency records also show there was intelligence that he was being exploited, and had potential links to gangs, drugs and weapons. This should have been a significant agency opportunity for a multi-agency assessment. This did not happen.

On four dates in December 2022, despite being in breach of court bail and tag conditions, police were unable to adequately resource enquiries to trace Danny, despite having an address he was believed to have been at. The multitude of risk concerns about Danny had been documented in a report following a strategy discussion about Danny in January 2023. The outcome of the meeting was a Section 47 single agency investigation, with several actions set for BCT and Danny's legal team. Danny was eventually traced in mid-January 2023 at his grandmother's address when he was arrested for failing to appear at court for a serious assault.

The most striking missed opportunity safeguard Danny and the public and apply appropriate interventions for him was on that date when Danny was arrested, and it was revealed he had been stabbed. Although no significant injury was noted, and despite their reservations about authorities, it was worrying enough for his own family members (mother and

[117] Source BCT IMR

grandmother) to disclose to police. This incident warranted a crime number, but Danny's reluctance to engage with police seemed to negate any other enquiries taking place. Unusually, there was no record in his custody record that BCT or his social worker were informed by police, or any other referrals made, so the multi-agency assessment of the risk was missed. This should have been completed, especially as Danny was still a child (17 years). Although he refused to co-operate and was also arrested for another offence on that day, consideration for Danny as the victim of a violent crime with an offensive weapon and the possible escalation this demonstrated, could have been a turning point for assessing his vulnerability and fear and understanding his reality.

The strategy discussion in January 2023 had highlighted his many significant and varied risks (lack of contact with his social worker, risk of exploitation, gangs, deteriorating mental health, frequent missing episodes, self-medicating with cannabis, refusal to take prescribed ADHD medication, suspected of drug dealing and county lines). Health had indicated concern that Danny was suffering from PTSD and previous suicidal ideation.

The chaotic nature of Danny's missing episodes demonstrate the lack of clear structure in his life and consistent or supportive interventions to address these. The review highlighted that WMP have a policy for missing persons. The policy acknowledges that police **and** partners should:

** Understand the underlying reasons for the missing episode.*
** Gather information to assist in their location should they go missing again.*
** Seek to appropriately safeguard and support the individual.*
** Prevent future missing episodes where possible.*

It is unclear whether that policy considers the impact of the increase and the frequency of missing episodes. And whilst the circumstances of each missing episode should be considered in isolation, the cumulative impact of a child missing person, vulnerable and exploitable could/ should have signalled a need to consider a raising of his risk level to high rather than medium.

Danny had grown up in a home lacking in male adult role models, with a complex relationship with his mother. He had been engaged in the care system. His regular and frequent coming to notice appeared to mask the vulnerability he was experiencing. Danny was neurodiverse but Danny also appeared streetwise and resilient. Academic research is starting to recognise the challenge of adultification bias of young men, predominantly black youths, in child protection and safeguarding[118], particularly those who present as confident, aggressive, and self-reliant can mask the fears that they are experiencing, and at time of writing, Danny's concerns and vulnerabilities are still not explicitly understood.

From January 2023 onwards, whilst Danny had access to many professionals who he could talk to or seek advice and support from, Danny had already begun to deteriorate in terms of his behaviour, his anxiety levels were high, he was regularly going missing, and he prioritised associating with his peers over any other activity.

[118] Adultification bias within child protection and safeguarding - Jahnine Davis 06/2022

By this point in his life, Danny had developed a mistrust of professionals and the 'pull' of his peers plus his chaotic lifestyle, meant that he was unlikely to significantly take on board any advice or assistance offered to him.

Looking specifically at Greg, BCT record that information shared by the police at the ICPC (October 2020) sets out that Greg and his family were the subject of threats made by letter, that seemed to be aimed at Greg. It is not clear from the records what action was taken about this, and whether there was an opportunity to identify that Greg may have been involved in gang-related behaviour and consider what support could be put in place both for him and the family. Despite this, BCT hold no records that indicate that he was involved in violent or threatening behaviour before Sterling was killed, nor do BCT records hold evidence of any relationship between Greg, Danny or Sterling.

Overall, in summary, each agency could have been more curious about Greg, Mark and Danny's reported access to and possession of, or use of weapons, including intelligence and information regarding knives and firearms.

As a pilot, the OWHR process and services are new and create an extra layer of requirements from already stretched services. It was unclear as to the extent of the HO communications regarding the pilot or how far they had been circulated or understood. Violence Reduction Partnerships now have the responsibility for embedding awareness and training of OWHR processes and associated services. Should the polit be extended, for this process to be effective long-term, all service providers within the partnership need to be provided with the necessary training to understand the legislation, processes and support required to effectively deliver an OWHR, and importantly, the consequences of not doing so. Awareness raising is sufficient for a pilot, however, there is no substitute for actual training, where all staff concerned have the confidence and knowledge to deliver effectively in their roles.

Whilst the increase in offensive weapon offences, the challenge remains difficult for agencies to address, without a more widely understood shared strategic picture of effective services and interventions, and more importantly, those that are ineffective. The 'what works approach' draws on academic research. Paradoxically, the fact that an OWHR is in progress may suggest that intervention policies are not effective, however there may be significant intervention opportunities. Therefore, at the appropriate time, HO analysis should be circulated which identifies some of the thematic challenges facing agencies currently dealing with OWHR's to include details of any successful safeguarding, intervention, and enforcement policies.

The formation of the West Midlands Violence Reduction Partnership (WMVRP) in 2019 has already created a platform for reform and collaboration across agencies, bringing efforts together to address violence reduction. The strategic ambition focuses on addressing the root causes of violence. Some of the benefits of this work include the recognition and understanding of some of the socioeconomic disadvantages including poverty and other inequalities.

The ambition to reduce violence, including knife crime is laid out in the recent WMVRP annual report, however it cannot be guaranteed that the report gets disseminated and read by the front-line staff and operatives, or those who proactively engage with those most vulnerable to crime involving offensive weapons. Whilst the WMVRP (strategic ambition) seeks to offer a common understanding and profile of the people and locations most vulnerable to violence, the listed priorities for the WMVRP could be more widely communicated to ensure they are understood and embedded across the partnership. They could be tested through rigorous application of a contextual safeguarding framework and a menu of tactical options (MOTO) when dealing with violent or knife crime.

This is also the area where concentrated shared decision making could be more impactive. This review has found that whilst excellent individual agency work has taken place, opportunities existed to consider risk more holistically in a multi-agency setting.

Intervention services are already present in the West Midlands, and in this review, it has found that specifically in Danny's case, he had received extensive support over the period examined. Currently in Birmingham, much of the intensive intervention to address problematic behaviours focuses on young people, those who are 'at risk of being placed in custody or care due to challenging, aggressive and anti-social presentation factors; involved in serious and/or persistent crime and anti-social behaviour; displaying aggressive or risky behaviours in the family home, school and community; with educational and behavioural difficulties and at risk of losing their educational placement; involved in substance misuse; and are absconding'. This is evident from the agency records held for Danny.

Although the review revealed limited agency information regarding Sterling, Greg or Mark which could be effectively shared in a multi-agency environment, there are opportunities for agencies to consider the value of any information connected to weapons. The presence of knives at Marks' address and Greg's associates carrying knives, Danny which may have impacted this murder.

In previous years the Birmingham Community Safety Partnership vowed, 'We will be having a key focus on continuing to provide more training, intervention and support to young people and the professionals who work with them. We will continue to develop strong partnerships that work together to address the complex root causes of violence at the earliest opportunities in the lives of young people. These partnerships will be supported to develop long term and sustainable approaches to violence prevention and reduction that really make a difference. Everyone has a role to play in violence prevention and reduction, and with so much to celebrate about the West Midlands, we will continue to provide a way for people to become actively involved in the long-lasting change our region needs, and by increasing our reach even further and bringing people together we will build a strong movement that creates a generational change and provides the conditions for our young people to flourish'.

There is a range of (additional) learning which covers investigations/ missing person enquiries/ information sharing. Neither Sterling nor Danny had cooperated with police. Community intelligence was not passed to police which could have allowed a risk assessment to have been conducted. Police therefore lacked the information to understand the threat, risk, or harm that existed. Danny refused to cooperate with information about the

alleged robbery which could have identified the associations. Without information, CCTV or other witnesses, even with the accurate information about the real location of the electric bike theft, it is unlikely that officers would have been able to trace the electric bike and connect the associations.

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

'OWHRs should act to empower professionals to explore the way their organisation and the wider system they operate in could be improved to protect people from serious violence. Innovation in investigative methods and approaches, and the ability to challenge existing narratives, practice, and policy will be required to ensure a meaningful OWHR.'[119]

This report highlights a high number of interventions by partner agencies showed an ever-increasing escalation of events, which was not viewed by partners at the time in its entirety. The following recommendations are presented, with the aim to identify ways to intervene differently, before the trigger event, to prevent similar situations happening in the future for others. The below recommendations aim to meet this purpose and the objective of OWHR's, to 'identify what can be done differently at an agency and system level to prevent future homicides and reduce serious violence' (section 1.23 of the above guidance).

Recommendation 1 – Improve missing persons policy
It is recommended that the Missing Persons policy should be reviewed and revised within the partnership to include relevant agencies who come into contact with missing young people to ensure compliance with the policy owned by the College of Policing. This action should be owned by WMP in partnership with Birmingham's Children's Trust, and Youth Offending Services, where they are involved with their services, to ensure that Return Home interviews and Prevention Interviews are conducted to the standards expected, in all cases of children under the age of 18, to understand and mitigate against the risk and vulnerability posed.

Recommendation 2 – Improve Mentoring
It is recommended that Advocacy and Mentoring Services for young people who have reported offences (or suspicion of) linked to carrying offensive weapons, should be promoted within the partnership to improve awareness and promotion of mentoring services available for young people. This action should be owned by Birmingham CSP in partnership with the Violence Reduction Partnership.

Recommendation 3 - Social Work Provision
As per the theme identified in 'effective practice', it is recommended that BCT working towards the ambition of retaining staff and having continuity in service provision.

Recommendation 4 – Public Awareness
It is recommended that Birmingham City Council (BCSP) lead the development of a local media campaign aimed at raising awareness of crime prevention measures and promoting

[119] https://www.gov.uk/government/publications/offensive-weapons-homicide-reviews/offensive-weapons-homicide-reviews-statutory-guidance-accessible-version

community safety. This initiative should focus on educating the public about available resources and the collective efforts needed to maintain a safe environment.

Recommendation 5 – National Knife Crime Awareness (linked to Recommendation 4)
It is recommended that all agencies consider the promotion, highlighting and circulation of knife crime research referred to in this report for the educational and professional benefit and awareness of staff and, include any organisations who are engaged in voluntary or statutory support where knife crime features.

Recommendation 6- Internal awareness and Learning
It is recommended that staff within partner agencies involved in this review are made aware of the specific 'learning points' identified during this review and which are contained in the body of the report at section entitled Effective Practice and Learning. This could be achieved through ongoing learning events or dissemination of written learning points.

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

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

Organisation	Yes	No	Reason
Single Competent Authority	☐	☒	Agency not needed for review.
West Midlands Police	☒	☐	Click or tap here to enter text.
NHS Birmingham and Solihull Trust/ Sandwell and Birmingham NHS Trust	☒	☐	Click or tap here to enter text.
Change Grow Live	☒	☐	
Birmingham City Housing/ Sustain Housing	☒	☐	Click or tap here to enter text.

OWHR process-

Birmingham City Council, in collaboration with relevant review partners, follows a structured Offensive Weapon Homicide Review (OWHR) process to ensure a thorough and impartial examination of each case. The process is led by Birmingham City Council as the coordinating body, working closely with the designated lead agency to facilitate a multi-agency approach. An information-sharing session is convened early in the process, involving key statutory and voluntary services including law enforcement, health, social care, education, and community safety partners. This session enables comprehensive data exchange to build a full understanding of the circumstances surrounding the incident, supporting a detailed analysis and identification of learning points aimed at preventing future occurrences

Final confidence check

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

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

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

Statements of Independence

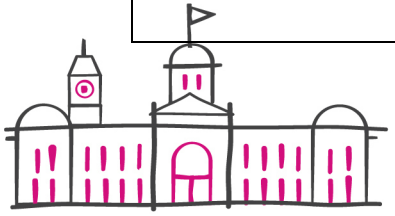
Statement of Independence by Chair:
Please read and sign the following statement. Consider the section on independence in the OWHR Statutory Guidance before completing.

Chair 1: Theresa BREEN 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:

Theresa Breen was selected as the independent Chair of the Review Panel and Author of the report. She has no connection with the relevant review partners or local oversight process for this review and has not worked for any agency involved in the review. She retired from British Policing (Metropolitan Police) in November 2018, after 30 years. As a former senior police officer, she worked across a range of policing disciplines, including Serious Organised Crime, Safeguarding and Counter Terrorism in management positions. She gained experience of reviews working extensively in partnership with other agencies and had experience of working with diverse communities. She was a trained Senior Investigating Officer (SIO) and CT SIO. Theresa worked across a number of Public Protection and Safeguarding portfolios in London and Surrey, managing and overseeing MAPPA and MARAC processes. As the police Public Protection lead in Westminster, she managed and oversaw DA services, to diverse communities. As a Borough Commander in a West London Borough, she was the core police member of the Safer and Stronger Strategy Group. Operating as 'Gold London' Theresa had overall strategic command of multiple (critical) incidents including those involving gang activity including knife crime, DA and homicide. Working in partnership, Theresa additionally led the national police implementation of the cross-agency Operational Improvement Review (OIR) recommendations following the terrorist activities across the UK in 2017/18. Theresa has not worked in the West Midlands area and has no connection with any of the agencies, RRP's or those involved in the oversight process in this review. Theresa is a trainer with experience of delivering safeguarding and equality training and has delivered the OWHR training to over 100 delegates, including Chairs, including safeguarding and, equality and diversity input. By default, she has completed the relevant HO OWHR training as one of 3 trainers.

Signature: Theresa Breen
Name: Theresa Breen
Date: 10/09/2024

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

Birmingham OWHR- 002

1. Introduction

This Offensive Weapon Homicide Review (OWHR) is commissioned by the Birmingham Community Safety Partnership in response to the death in April 2023 of 'Sterling'.

Summary of Incident:

At XX hrs in April 2023 police received reports that following a verbal altercation, three males chased and stabbed 'Sterling' at the junction of XX and XX. He was stabbed multiple times to the body and legs. On officers' arrival CPR commenced, however he was pronounced deceased.

Victim: Personal details removed.

The alleged **perpetrators** (who have been charged) are:

Danny, Greg, Mark : Personal details removed

The OWHR has been commissioned as the death meets the criteria defined in the statutory guidance as set out in section 24(1) of the Act, where a review partner considers that:

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

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

c. such other conditions specified by the Secretary of State in regulations are satisfied (see paragraphs 1.8 – 1.11 of this guidance)

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

Under section 24(6) of the Act, the homicide of a person is a qualifying homicide if:

a. the person was aged 18 or over, and

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

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

An offensive weapon is defined, for the purposes of an OWHR, in section 1 of the Prevention of Crime Act 1953 as: 'any article made or adapted for use for causing injury to the person, or intended by the person having it with him for such use by him, or by some other person.'

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

(a) one of the following has been located:

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

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

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

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

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

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

2. Chair and Membership

Theresa Breen, Independent Offensive Weapon Homicide Reviewer and Author has been appointed as Chair of the review panel and Author of the report.

Named panel members were nominated by their agencies.

3. Purpose of the Offensive Weapon Homicide Review Panel (as detailed 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.

4. Timeline and Scope
The period that this review encompasses will be **April 2021 to April2023**. However, if considered pertinent and relevant the Panel may also include any other periods, if agreed by the Chair.

5. Frequency of Meetings
Meetings will be convened at the direction of Chair. The administration and co-ordination of the Review will be undertaken by Birmingham County Council (CSP).

6. Part B 'Exploratory Questions' to be addressed by your agency including additional questions listed in Appendix 1.

Nb. The exploratory questions in this template seek to understand whether the existing policy and procedure operates in the best interests of potential victims and alleged perpetrator(s) by asking if there are any lessons to be learned from this case? Additionally, are there any necessary policy and procedural changes to be made in order to improve future outcomes and prevent offensive weapons homicides from occurring? For example, could an adjustment in policy or procedure have safeguarded and supported the victim and/or alleged perpetrator(s) better? The Areas covered are: 1. Referral and assessment, 2. Services offered, 3. Outcomes and Outputs, 4. Information sharing and 5. Potential learning.

Information request: Please complete the below section (5 areas) based on your engagement with the individual/s included in this information request. **A separate return is required for each stipulated individual listed in this request.**

Title page
a. local reference number (including initials of police force area): OWHR 002: West Midlands.

b. identification of person/s under consideration in this review c. date of death under review

d. name of your organisation, location, and lead practitioner completing this template

e. submission date of Part B – **nil returns are required**

For practitioners in contact with individuals/subject to review

1. Referral and assessment

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

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

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

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

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

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

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

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

2. Services offered

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

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

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

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

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

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

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

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

3. Outcomes and outputs

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

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

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

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

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

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

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

4. Information sharing

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

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

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

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

5. Potential learning

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

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

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

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

Relevant documentation

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

Equality and Diversity:

The Review Panel should consider and comment (where relevant) on the nine Protected Characteristics under the Equality Act 2010 (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, and sexual orientation). If you have any thoughts or observations on how any of these characteristics impact on the victim and perpetrators - please comment.

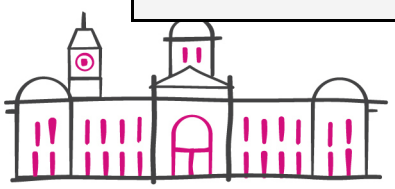
Appendix 1:

To aid the Overview Report, additional information required if not addressed in Part B Exploratory Questions:

- Whether family, friends or colleagues were aware of any violent or aggressive behaviour from the alleged perpetrator(s) to/ towards the victim, prior to the homicide.
- Whether there were any barriers experienced by the victim (or his family/ friends/colleagues) in reporting any concerns, including whether he knew how to report violence or threats should he have wanted to.
- Whether any of the perpetrators were known to carry offensive weapons (routinely or as a one off) and what steps had been taken to share multiagency information to prevent such usage.
- Whether there were opportunities for professionals to 'enquire' as to any violence /abuse linked to offensive weapons, experienced by the victim that were missed.
- Whether there were opportunities for agency intervention in relation to violence/ threats regarding the victim or alleged perpetrators that was missed.
- Whether there were any educational needs or other needs that were a barrier to accessing or receiving support.
- The review should identify any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of offensive weapon processes and/or services.
- The review will also give appropriate consideration to any equality and diversity issues that appear pertinent to the victim, alleged perpetrators e.g. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

Appendix 1

Very low risk	
There is a very low risk of harm to either the subject or the public.	Actions to locate the subject and/or gather further information should be agreed with the informant and a latest review time set to reassess the risk.
Low risk	
The risk of harm to the subject or the public is assessed as possible but minimal.	Proportionate enquiries should be carried out to ensure that the individual has not come to harm.
Medium risk	
The risk of harm to the subject or the public is assessed as likely but not serious.	This category requires an active and measured response by the police and other agencies in order to trace the missing person and support the person reporting.
High risk	
The risk of serious harm to the subject or the public is assessed as very likely.	This category almost always requires the immediate deployment of police resources – action may be delayed in exceptional circumstances, such as searching water or forested areas during hours of darkness. In many of these cases, there will also be consideration of serious crime. All of the issues that need to be addressed in those cases will need coordination with any missing person enquiry. A member of the senior management team must be involved in the examination of initial lines of enquiry and approval of appropriate staffing levels. Such cases should lead to the appointment of an investigating officer (IO) and possibly an SIO, and a police search adviser (PolSA). There should be a press/media strategy and/or close contact with outside agencies. Family support should be put in place where appropriate. The UKMPU should be notified of the case without undue delay. Children's services must also be notified immediately if the person is under 18.



Glossary of Acronyms as they appear in the report.

BCSP - Birmingham Community Safety Partnership
BCC- Birmingham City Council
OWHR - Offensive Weapon Homicide Review
CSP - Community Safety Partnership
YOS - Youth Offending Service
KLOE- Key Lines of Enquiry
IMR- Individual Management Review (chronology of events)
WMP-West Midlands Police
ICB- Integrated Health Board
BCT- Birmingham Children's Trust
BYOS- Birmingham Youth Offending Service
WMAS - West Midland Ambulance Service
HMPPS - Her Majesty's Prison and Probation Service
ASC - Adult Social Care
FTB-YOS - Forward Thinking Birmingham, Youth Offending Service
ICPC - Initial Child Protection Conference
EHCP- Education, Health and Care Plan
ACE- Adverse Childhood Experiences