

Name of Relevant Review Partners

Birmingham Community Safety Partnership and Coventry Community Safety on behalf of the relevant review partners: West Midlands Police, Coventry City Council and Coventry and Warwickshire Integrated Care Board

Case Reference Number:

OWHR004

Pseudemys

In the report the victim is referred to as Peter, a name approved by his family, perpetrator 1 is referred to as P1 and perpetrator 2 as P2

Date of incident which led to the Review:

Summer 2023

Date of death where applicable:

Summer 2023

Review's start date (commissioned): 01/10/2023

Review completion date (approved and signed off): 01/08/2025

Publication date: 26/11/2025

Completion of the report was delayed owing to challenges in scheduling a meeting with P1. The Chair arranged an in-person meeting with P1 for 29 May 2024; however, this was cancelled when P1 was relocated within the prison estate at short notice. Additional delay occurred due to difficulties arranging a subsequent meeting following the death of P1's mother.

Outline of circumstances resulting in the Review:

This OWHR was commissioned by Birmingham Community Safety Partnership in accordance with the OWHR Statutory Guidance. The criteria



for the Review are met under Section 24 Police, Crime, Sentencing and Courts Act 2022: -

- Peter's death was caused or contributed to using a weapon.
- Peter was over the age of 18 years, and his death fell within the locality of one of the three pilot areas for the OWHR.
- The initial scoping exercise identified Peter, P1 and P2 were known to several agencies and there were lessons to be learned

Notification

The Birmingham Community Partnership notified the Home Office by letter on 14 July 2023 that it was under a duty to undertake a review pursuant to section 27 of the Police, Crime, Sentencing and Courts Act 2022.

Methodology

The Review followed the core components of an OWHR set out in the statutory guidance. It was led by the Independent Chair assisted by a panel of designated professionals from each of the key agencies involved with Peter, P1 and P2.

The panel members did not have direct contact or management involvement with Peter, P1, or P2, and they were not the authors of the Individual Management Review (IMR) reports submitted by their organizations. However, there were three exceptions: the authors of the IMR for Children's Services, the Youth Justice Team, and K, who were also the panel representatives for their respective agencies.

The review process commenced with the distribution of Part A scoping questions to the relevant agencies. All the agencies responded within the designated one-month timeframe, and their information was consolidated into a single document. This document was instrumental in confirming that the criteria for an OWHR were met, identifying the members of the review panel, and formulating the Part B questions.

Requests for IMRs were then sent out, incorporating the Part B questions. Each agency compiled a comprehensive chronology of their involvement and produced IMR reports that highlighted single agency learning. The



quality of these reports varied, and some authors and key personnel were interviewed to clarify points or provide additional information.

The Review panel convened for the first time on 30 October 2023. Over the course of three additional meetings up to April 2024, panel members discussed the progress of the review and requested further clarification and additional material as needed. Minutes were recorded at all panel meetings, and all agreed actions were tracked and signed off as completed. Between meetings, additional work was carried out via email, telephone, and virtual meetings.

On 5 November 2024, the panel considered and agreed upon the draft report, subject to minor amendments. The final report was reviewed by the quality assurance team before being endorsed by the Oversight Board in March 2025, prior to submission to the Home Office

The Review Panel Members

ROLE
Independent investigator for NHS
Retired Consultant Psychiatrist
Police Force Review Team
Head of Service Delivery K
Deputy Designated Nurse for Safeguarding (NHS)
Deputy Designated Nurse Safeguarding (NHS)
Safeguarding Manager (Children's Trust)
Head of Safeguarding (NHS)
Operational Lead (Children's Trust)
Operational Lead (Youth Justice service)
Probation
Head of Safeguarding (Integrated Care Board)
Birmingham Community Safety – Review Team, OWHR

The Scope of the Review

The focus of the review is agency involvement with Peter, P1 and P2 from 1 January 2021 to June 2023 inclusive. The scope of the review has been extended beyond twenty-four months to include key events that occurred at the beginning of 2021, including interactions with the Police, Probation, Mental Health Services and Children's Services.



Agency involvement prior to 1 January 2021 is summarised save for specific and significant events which are relevant to subsequent decisions, later agency involvement, or highlight important issues.

The terms of reference

(See Appendix A for the full Terms of Reference)

The Terms of Reference were drawn up by the Chair and the Review panel, and the key Lines of enquiry were:

- To examine the processes within agencies, identify, assess and address Peter's vulnerabilities.
- To examine the measures taken to identify, assess and manage the risk of violence posed to P1 and P2.
- To examine how the agencies involved with Peter, P1 and P2 shared information and supported joint working, the quality of information shared and the effectiveness of the policies, protocols and agreements in place.
- To examine how Peter, P1 and P2 engaged with services and identify any barriers to engagement

Peter's family asked questions about his care and treatment by mental health services and the arrangements in place to safeguard him in the community which were considered by the review

Parallel reviews and investigations

Criminal Investigation

The criminal investigation and subsequent proceedings in relation to the murder of Peter ran concurrently with the conduct of this statutory review. To safeguard the integrity and fairness of the criminal justice process, and in accordance with statutory guidance and best practice, measures were implemented to ensure clear boundaries and structured information sharing between the criminal and review processes.

The Chair of the review maintained regular liaison with the Senior Investigating Officer (SIO) through the police representative on the Review Panel. At the explicit request of the SIO, no contact was initiated with P1, P2, or any individual who could be considered a potential witness in the



criminal proceedings until the conclusion of the trial. This ensured there was no risk of interference with the criminal process or contamination of evidence.

Key documents essential for the review, including the prosecution's opening statement, the post-mortem report, the victim impact statements, and the sentencing remarks of the trial judge, were shared with the review team following agreement with the police and Crown Prosecution Service. In addition, the Crown Court provided a copy of P2's pre-sentence report following a formal application for disclosure was submitted to the trial Judge.

NHS England Independent Investigation and Further Serious Offence Review

At the time of the offence, P1 was under the care of local Mental Health Services and was also subject to supervision by the Probation Service. These circumstances met the threshold for an independent investigation under NHS England's Serious Incident Framework (March 2015), and triggered a Further Serious Offence Review (FSOR) to assess whether there were any failings or omissions in the probation service's management of P1 during the period leading up to the offence.

An independent investigation was commissioned to examine the care and treatment provided to P1 by NHS services. To prevent duplication of effort and ensure cohesive system-wide learning, a collaborative working arrangement was established between the author of this review and those leading the NHS investigation. The Chair of the review met with the NHS Head of Investigations and the lead investigator from Niche (the organisation commissioned to undertake the NHS review) to agree terms of reference and ensure alignment of key lines of enquiry. A representative from Niche participated in all review panel meetings, and the NHS lead investigator and the Chair undertook joint meetings with Peter's family, K charity, and P1. The findings of the independent NHS investigation were finalised in December 2023 and have been integrated into the conclusions and analysis of this review.

The chair met with the author of the Further Serious Offence review to consider her terms of reference and the Independent Management Report for probation reflected the findings of the FSOR which are incorporated into this report.



Consideration of Children's Services and Safeguarding Processes

P2 was a looked after child at the time of the offence and was under the care of Children's Services. His involvement in the murder of Peter met the criteria for both a Community Safeguarding and Public Protection Incident (CSPPI) Review and a Child Safeguarding Practice Review (CSPR), under Working Together to Safeguard Children (2018).

Following consultation, the Relevant Review Partners agreed that the scope and depth of the OWHR would sufficiently encompass all the matters required under both CSPPI and CSPR frameworks. This decision was taken to avoid duplication and ensure a streamlined, multi-agency review process that captured all relevant safeguarding, risk management, and systems learning.

Confidentiality

The report has been written for publication and is anonymised in accordance with the statutory guidance. The date and location of the homicide has been removed. Only the chair is named, pseudonyms and titles have been used for the victim, the perpetrators and their family members. The review has sought to include sufficient detail from the lives of Peter, P1 and P2 to provide context and for the lessons and recommendations to be understood whilst balancing the need for confidentiality.

Background

The homicide

Peter was killed by P1 and P2 in the summer of 2023. A post-mortem examination determined that the cause of his death was a combination of significant neck compression, sharp force injuries, blunt force trauma, and underlying cardiac disease. Several of the injuries were caused by a machete, which was removed from the scene following the murder and has not been recovered. P1 and P2 were subsequently arrested and charged with murder. They were convicted in December 2023 and sentenced in February 2024. P1 was sentenced to life imprisonment with a minimum term of 30 years. P2 was sentenced to life imprisonment with a minimum term of 18 years, considering his age and personal background.



The coroner opened and adjourned an inquest into Peter's death pending the outcome of the criminal trial. Following the convictions, the coroner confirmed that the inquest would not resume, as the criminal proceedings had conclusively established the cause of death

Equality and Diversity:

The Chair and the Review Panel considered all protected characteristics as set out in Section 149 of the Equality Act 2010, with particular attention to age, disability, race, and sex.

Peter was a white male of Irish heritage, aged 73 years old at the time of his death. He had been diagnosed with Bipolar Affective Disorder and Alzheimer's Dementia, both of which are recognised disabilities under the Act.

P1 was a 43-year-old woman of dual heritage—White and Black Caribbean/Asian—and had diagnoses of bipolar disorder and Emotionally Unstable Personality Disorder, both of which may also constitute disabilities under the Act.

P2 was a 16-year-old White British young person, diagnosed with Attachment Disorder and Foetal Alcohol Syndrome (FAS). These conditions are also recognised as disabilities under the Equality Act.

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

Peter

Peter is survived by his former wife, his daughter (PD), her partner, and his grandchild. In her victim personal statement, PD described Peter as a kind, generous, and hardworking man who loved to laugh and had many friends. She wrote:

"The family have been left broken-hearted and with a sadness that doesn't compare to any loss we have ever had to endure. We hope in time that positive memories will emerge and eclipse the bad ones, and we can remember him without anger."

The timing and approach to involving Peter's family in this review were discussed in advance with the Senior Investigating Officer and the Family



Liaison Officer to ensure sensitivity to the ongoing criminal proceedings. An introductory letter was sent to the family, explaining the purpose and scope of the review. This was based on the template provided in the OWHR guidance and adapted to reflect Peter's circumstances.

The first meeting with Peter's daughter and his former wife took place in October 2023, ahead of the criminal trial. This meeting was held at their family home and supported by the Family Liaison Officer. Subsequent engagement included a virtual joint meeting with the author of the Independent NHS report and a final face-to-face meeting to discuss the final draft report. Throughout the process, the family remained engaged, asking and responding to questions, and receiving regular updates via email about the progress of the review.

The pseudonym "Peter" was chosen with the family's consent, and the review was conducted with awareness of key dates, including the criminal trial, the sentencing hearing, and the anniversary of Peter's death—which the family found particularly difficult. The Review Panel wishes to express its sincere thanks to Peter's former wife, his daughter, and her partner. Their candid and thoughtful contributions to this review have added important insight and helped shape the final report. The Panel pays tribute to their courage and resilience during what has been a deeply painful process. While this review has necessarily examined the complex challenges related to Peter's mental health, capacity, and behaviour in his final years, the Panel recognises these do not define who he was. He was a loving husband, father, and grandfather for most of his life.

Perpetrator involvement

Engagement with Adult 1

P1 was invited to participate in the review process following the conclusion of the criminal trial. A letter outlining the purpose, scope, and importance of the review was sent to her via her probation officer, in line with standard engagement protocols. P1 agreed to participate and took part in a joint remote meeting on 9 July 2024 with the Chair of the review and the author of the Independent NHS report. During this meeting, P1 was given the opportunity to share her perspective on the events leading up to the murder and her experiences with services. Her views and reflections have been considered by the Panel and are reflected in the findings and analysis contained within the report. The Review Panel acknowledges the value of her contribution and would like to thank P1 for her engagement in what may



have been a challenging process. Her input has assisted the review in developing a more comprehensive understanding of the circumstances that preceded the homicide.

Engagement with P2

P2 was remanded to a secure adolescent psychiatric hospital after his arrest following a decline in his mental health. The professionals working with P2 felt he should not be approached, and the Review Panel accepted their view. The pre-sentence report reflects P1's views around the murder and provides some insight into his view of services and barriers to engagement but key information from his perspective is missing.

Engagement with Wider Family

The Independent chair met with P2's grandmother at a venue local to her home. She provided useful background information about P2's early childhood, his experience of education and involvement with agencies. This information has been incorporated into the Review. The Review would like to thank her for taking the time to meet with the Chair at a time when she was still processing the outcome of the criminal trial.

Family declined involvement ☒

P1's sister did not respond to two text messages inviting her to contact the Independent Chair. The family had recently experienced the bereavement of their mother, and it is acknowledged that the timing of the approach may have contributed to the lack of response.

Family history and contextual information

Peter

Peter spent most of his adult life living with his wife and daughter, providing a stable and loving home. His family recall a happy life together, supported by Peter's long career as a paint sprayer. He was proud of his daughter and grandson, and until the onset of illness in 2018, he was closely involved in their lives. In 2018, Peter was diagnosed with bipolar affective disorder (BPAD). His presenting symptoms included manic episodes, grandiose ideas, and delusional beliefs, all of which were notably exacerbated by alcohol use. During this period, he also exhibited disinhibited and sexualised behaviour towards females, which had not been observed prior to 2018. Due to the severity of his mental state, Peter was initially detained



under Section 2 of the Mental Health Act 1983 (MHA) for assessment and was subsequently transferred to Section 3 for treatment. Peter's family disputed the diagnosis of bi-polar affective disorder, they thought his symptoms were more consistent with dementia. While Alzheimer's dementia was considered as a differential diagnosis at the time, it was not formally diagnosed until 2022.

In July 2019, Peter was convicted of harassing a female acquaintance. He was sentenced to an 18-month Community Order and supervised by probation from July 2019 to February 2021. Although this period largely falls outside the scope of the review, it raises important learning points regarding inter-agency communication, which are explored in a later section. The Community Order included a Mental Health Treatment Requirement, mandating 24-hour supported accommodation and ongoing treatment and a Rehabilitation Activity Requirement. Four key sentencing objectives were identified; to engage in offender-focused work to reduce re-offending, to participate in victim empathy sessions, to secure long-term accommodation and to address alcohol misuse, which was a contributing factor to Peter's offending and closely linked to his mental health. At the start of the scoping period Peter was living in a secure hospital subject to the community order supervised by a Community Rehabilitation Company.

Perpetrator 1 [P1]

At the time of the murder, P1 was 43 years old. She reported having two adult sons (though only one is referenced in official records). Her mother was White Irish, and her father was said to be Black Caribbean, though records identify him as Asian from Pakistan. She was raised primarily by her mother and had two sisters, to whom she was reportedly close. Both her parents have passed away—her father in 2022 and her mother in June 2024. P1 reported she had worked as a dental nurse, carer, and restaurant supervisor but during the scoping period she was unemployed and in receipt of health-related benefits.

P1 is an unreliable historian, it has not been possible to verify many of her accounts. She described experiencing sexual and physical abuse during her childhood and adolescence. If accurate, these experiences may explain some of the difficulties she encountered as an adult. Her criminal history began at age 17, by the time of the murder, she had 16 recorded convictions for 42 offences, including affray, drunk and disorderly conduct, theft, drug possession, and drink driving. Prior to her murder conviction, there were no recorded convictions for serious violence, although she



claimed to have committed several serious assaults, including a stabbing. P1 had police markers for weapons, violence, mental health, and alcohol misuse. Sanctions included prison and community sentences, there is no record of any specific weapons-awareness interventions. P1 was involved in multiple domestic violence investigations. In most, she was listed as the victim, having experienced serious assaults by partners. In some cases, she was listed as the perpetrator. During the review period, she was both perpetrator and victim in incidents involving her then partner, P2's maternal uncle.

P1 first involvement with mental health services was in 2016 when she was aged 35. She was diagnosed with Emotionally Unstable Personality Disorder and Bipolar Disorder, thought to be secondary to her long-standing alcohol addiction. P1's chronic alcohol misuse significantly impacted her behaviour, relationships, and mental health. By 2021, there was an established pattern of alcohol use followed by a deterioration in her mental health and aggression and volatility. The trial judge noted that she had been aggressive to neighbours and violent in the months preceding the murder—behaviours that became fully apparent during the police investigation. P1 had a long-standing relationship with P2's family, the families lived in the same area. P1 was a contemporary of P2's mother and had been in a relationship with his maternal uncle until shortly before the murder and had known P2 since he was a baby.

Perpetrator 2 (P2)

P2 was 16 years and 9 months old at the time he murdered Peter. His early life was marked by significant adversity. He was exposed to maternal substance misuse during pregnancy and was placed in the care of his maternal grandmother at six months due to his parents' chronic alcohol misuse, mental health issues, and domestic violence. P2's siblings were known to Children's Services and were either accommodated or adopted. He had no relationship with his father and only limited contact with his mother and siblings. He experienced multiple bereavements, including the murder of a great uncle. These factors negatively influenced his development.

P2's grandmother described early concerns with P2's communication, concentration, and aggression. These behaviours intensified at secondary school. In 2019, P2 was diagnosed with autism spectrum disorder (ASD) by the Community Paediatrics Child and Family Neurodevelopment Team. A



referral for Foetal Alcohol Spectrum Disorder (FASD) was made but rejected. Following his conviction P2 was diagnosed with an attachment disorder. By 2020 P2 had disengaged from education and was involved in anti-social behaviour and criminality. At the time of the murder, he was living in a residential home in the care of his local authority having been deemed to be at risk of criminal exploitation and beyond the control of his grandmother.

This section considers the Individual Management Reviews (IMRs) and Information Reports completed by the individual agencies and the panel's contribution to their analysis, focusing on the response of agencies to the presenting issues, the effectiveness of information sharing between agencies, why decisions were made, and actions taken or not taken.

The Panel have attempted to view the case and its circumstances as it would have been seen by individuals at the time not with the benefit of hindsight and has set the findings of the review in the context of any internal or external factors that were impacting on delivery of services and professional practice during the period covered by the review.

Peter

The integrated chronology for Peter is provided at **Appendix B**. What follows is a summary of key events relevant to the key lines of enquiry to examine the processes within the agencies involved with Peter to identify, assess and address Peter's vulnerabilities. At the outset of 2021, Peter was residing in a secure rehabilitation unit under the care of mental health services. His bipolar disorder was in remission, he had abstained from alcohol for a year, and he was compliant with medication, and a discharge plan was being considered. Despite clinical stability, concerns persisted about his ongoing sexually disinhibited behaviour. Peter was under the Community Order imposed in 2019, supervised by a Community Rehabilitation Company. Due to COVID-19, the Community Rehabilitation Company supervising Peter had implemented an Exceptional Delivery Model, which significantly reduced face-to-face supervision. This meant no work was done during 2020 to address Peter's offending behaviour, his inappropriate sexual behaviour or his alcohol misuse. The Community



Rehabilitation Companies were managing high caseloads and Peter would have been seen as a low priority because he was living in a care home.

There was limited contact between mental health services and probation throughout the duration of the community order. Probation was excluded from discharge planning and unaware of all the concerns around Peter's behaviour until shortly before the community order ended. In January 2021, Peter's psychiatrist wrote to probation to request MAPPA (Multi Agency Public Protection Arrangements) and housing support due to risk concerns. The letter highlighted Peter's behaviour on, and off the ward, which presented a risk to Peter himself and to others. Probation requested more information, but no follow-up occurred, and the Community Order expired in February 2021 without further action or involvement from mental health services. Regular communication between probation and mental health services might have highlighted the need for a multi-agency meeting to manage the risk to and from Peter and the need for specific work around his behaviour before his community order ended. This was a missed opportunity and represented a breakdown in multi-agency communication. Later in 2021, Peter's behaviour deteriorated, prompting police involvement and a revised discharge plan. He was moved to a secure ward and underwent several capacity and risk assessments. While capacity assessment outcomes varied, by October 2021, he was deemed to lack capacity for major decisions and insight into his behaviours. In November 2021, Peter was transferred to a residential care home that supported individuals with dementia. The risk management plan in place was to work with Peter on his behaviour and if he was deemed to be a risk to himself or others, to apply for Deprivation of Liberty Safeguards. In May 2022, Deprivation of Liberty Safeguards were used to restrict Peter's access to the community following incidents in the local area. These safeguards were discharged after Peter was reassessed as having capacity to make decisions, including decisions about where he lived. His treating team concluded that while his behaviour was problematic, it stemmed from personal choice rather than mental impairment.

In June 2022 his care co-ordinator convened a legal planning meeting to clarify whether his sexualised behaviour could be considered as part of a capacity assessment. The minutes of the meeting, nor the outcome are reflected in the notes but the meeting concluded the most recent capacity assessments (which excluded consideration of his sexualised behaviour) and deemed he had capacity were in line with legal guidance and there was



no power to detain Peter in the care home against his wishes. Following the decision of the legal planning meeting a discharge plan for Peter was put in place. A psychological assessment was commissioned to assess Peter's capacity to consent to sexual relationships, but the psychologist was not asked to advise on a risk management strategy to manage Peter's behaviour. The expert's opinion might have been useful in discharge planning. In September 2022, Peter was diagnosed with Alzheimer's dementia, this diagnosis did not alter the discharge plan or the capacity determinations. The test for capacity starts from a presumption of capacity which is not displaced because a person is choosing to make a dangerous or unwise decision. This principle is challenging for professionals trying to safeguard and for families trying to keep their loved ones safe. Peter's family felt that he would be at risk in the community and should be cared for in a dementia home. However, Peter was strongly motivated to live independently free from professional oversight. The discharge plan was implemented. Peter was allocated supported accommodation and discharged from the care home in November 2022 onto Section 117 aftercare support. As part of his aftercare package Peter had 8 hours care a week split over seven days to oversee his medication, monitor his mental health and his alcohol use. Peter's family remained actively involved, supporting his transition despite their concerns.

Between January and May 2023, Peter's care was reviewed twice. Although concerns about self-neglect and risk persisted, these did not prompt a review of his care plan, and no changes were made to it. The incidents in the community were recorded by police but not formally shared with mental health services via a referral. The care coordinator had supported Peter throughout his transition from inpatient care to community care and he continued to be the point of contact for the section 117 aftercare for a further six months post discharge to oversee his move into the community. In May Peter's case was handed over to the Section 117 team, ending direct coordination from his care coordinator. In the weeks leading to his death Peter was in contact with P1 and she had visited him at his flat on at least one occasion. Peter did not speak about this relationship to his family, his GP or support workers.

Perpetrator 1

An integrated chronology for P1 is provided at **Appendix C**. What follows is a summary of events to examine the response of agencies to the escalating



risks associated with her alcohol use and declining mental health in the months preceding the murder.

P1's mental health care was delivered in the community; she had a telephone consultation with a psychiatrist twice a year and was to contact the community duty team or the crisis team out of hours if she needed support between these appointments. The bi-annual appointments were undertaken by different psychiatrists within the mental health team; these appointments did not identify any risk to herself or others. The last appointment prior to the murder took place in April 2023. No concerns were identified about P1's mental health and she denied any plans to harm herself or others.

Between her review appointments, contact with mental health services in 2021 were mainly around her living arrangements and problems with neighbours. In 2022 she was reporting ongoing concerns in relation to her mental and physical health and there were several incidents when she had taken an overdose of her medication. The number of calls increased substantially following stressful events, her arrest in October 22, the death of her father and problems in her relationship with her partner. P1 often presented as angry and distressed and express suicidal ideation. during these calls, appropriate safeguarding referrals were made to the police and ambulance services to check on her wellbeing. On several occasions P1 was taken to hospital following an overdose and treated and assessed.

Police and ambulance crew frequently saw P1 intoxicated when they attended incidents at her home, but she gave accounts of her inconsistent of her drinking during formal health reviews and to professionals often claiming to be abstinent. P1's physical health was severely affected by her alcohol consumption. Her GP consultations frequently included discussions about the risks of alcohol use and its impact on the efficacy of her psychiatric medication. There was consistent communication between the GP and the mental health team, to monitor her health and her medication. In 2023 there were several calls between P1, the trust and her GP about her medication and problems accessing her medication.

At the beginning of June 2023 probation service contacted the community health duty team and advised P1's mental health was deteriorating, she had not been taking her medication and was drinking heavily, she was described as 'high risk', mental health was asked to contact P1 but this did



not happen. A few days after P1 was seen in custody by the liaison and division services, she denied suicidal ideation or plans to harm others, and no acute mental illness was identified. In the days before the murder P1 spoke to a member of the mental health trust admin team, she said she had seriously assaulted someone, had not been taking her medication and wanted to see mental health services, P1's support worker from K charity also spoke to admin on the same day to report her concerns that P1 was presenting as distressed, was not taking her medication and was expressing an intention to self-harm. A duty worker from mental health services spoke with P1 after these telephone calls; P1 repeated that she had harmed someone and felt she might hurt others but denied any intention to harm herself. In a further call to admin services P1 reiterated she was worried about hurting others, it is known at the time of these calls Peter was known to P1 and she may already have been planning to harm him. The information provided to mental health services by probation, K, and P1 herself should have prompted a review of her care and direct contact with P1, rather than simply requesting an earlier appointment with her psychiatrist.

P1 had extensive involvement with the police as both a victim and perpetrator of domestic abuse, as well as for anti-social behaviour and other criminal offences. She had a lengthy criminal record and had been subject to various disposals, including a community order for assault in 2020. This order included a 30-day Rehabilitation Activity Requirement and mandated engagement with Springboard. P1 had engaged well with Springboard and was able to address her alcohol misuse and achieve a period of relative stability during the period of the community order. P1 had experienced prolonged homelessness and lived in a series of temporary homes. During her community order, there was evidence of joint working between her probation officer and the community mental health team to secure stable housing, which was critical to improving her social circumstances and mental wellbeing. In January 2021, she was referred to K, a charity. P1 was allocated a specialist housing worker through K's gender-specific "Home of Her Own" scheme. There was regular liaison between K, mental health services, probation, housing, and police, reflecting some multi-agency coordination, the lead was taken by K, not one of the statutory agencies. During this period K had a primary point of contact within the police and this helped facilitate effective communication.



Anti-social behaviour and neighbour disputes were ongoing issues both during P1's time in temporary accommodation and after moving to permanent housing in 2022. *K* supported P1 in reporting incidents to the police and her housing association. Although P1 alleged racial abuse from neighbours, *K* noted that while racist language had been used, there was little evidence she was being targeted because of her race. In their view, P1 was both a victim and perpetrator in these incidents. Her violent behaviour, particularly when intoxicated, was consistently evident and had included violence towards her partner (P2's uncle) and others in the community.

In October 2022, P1 attempted to enter the home of a male acquaintance following an argument. She damaged his door and threatened to kill him. When police arrived, she was still abusive and threatening. She was arrested and found in possession of a hand weight concealed in a sock. P1 was charged with possession of an offensive weapon. She pleaded guilty to the weapon charge and in December 2022, she was sentenced to a 12-month community order for this offence. Conditions included a four-month electronic curfew (7pm–7am) and a 20-day Rehabilitation Activity Requirement

The approach taken to P1's sentencing in 2020 and 2022 appears to reflect the national Female Offender Strategy, which encourages community-based interventions tailored to women's needs. Under this policy, P1 would typically have been allocated a female probation officer. However, in 2022, the local probation service was operating under a 'Red Rag' Prioritisation Framework due to critical staff shortages. National standards and performance measures were suspended, and P1 was allocated a male officer (CD01), P1 denied the gender of her probation officer was an issue for her.

CD01 completed the pre-sentence report for the court and the Risk of Serious Harm assessment. There were serious gaps in these assessments. CD01 had no direct contact with the community mental health team, despite a note from P1's legal representative highlighting serious mental health concerns, he failed to adequately consider key factors — including P1's intoxication during the index offence, threats to kill, her self-reported weapon use, and prior assessments referencing her alcohol addiction. He did not clearly identify the categories of individuals at risk from P1 or specify the nature of the risk. P1 denied any issues in her relationship with her partner and no request was made to Police for intelligence on her current



address so domestic abuse incidents in 2021 and 2022 were not disclosed. These gaps in information, led CD01 to assess P1 as a medium risk, a high-risk rating would have been more appropriate. CD01 was an experienced probation officer and ordinarily his work would not have required management oversight. The gaps in his assessment can be attributed to his high case load given the staffing levels in the team at the time

After sentencing, P1 was allocated a female probation officer (PP1) she was a relatively inexperienced worker, this allocation was based on P1's medium-risk status. More experienced officers are generally assigned to high-risk cases. PP1 was responsible for completing the OASys risk assessment, a risk assessment tool used to assess the risks and needs specific to a person on probation and their individual circumstances. The assessment should have provided a clear analysis of the risks posed to others by P1 and the sentence plan and the risk management plan should have been formulated to address these risks. The assessment was not completed until 27 March 2023 over three months into the community order and outside the time limit prescribed by national standards. The risk assessment failed to incorporate information missed from the previous risk assessment, or capture new incidents involving P1, including an alleged assault on her partner and threats to stab him in February 2023 and her contact with him in March 2023 in breach of her bail conditions. The police do not routinely share information about arrests and call outs with probation unless the offender is considered high risk and/or subject to public protection arrangements. Probation would not have been aware of these incidents unless the officer accessed the information herself. PP1 was not aware of the incidents at the time they happened but was aware of them by the time she completed her risk assessment at the end of March. P1 denied the allegations of assault and PP1 accepted her denial without verifying the circumstances of the alleged offences with the police and she did not fully explore the nature of the relationship between P1 and her partner or complete a Spousal Assault Risk Assessment (SARA) in accordance with best practice.

PPI did not identify and or liaise with the key agencies involved with P1 and they were missing from her risk management plan, namely: the community mental health team, Change Grow Live, the police to check for recidivism, the housing association, in relation to issues around her tenancy and Children's Services. This omission meant significant risks were



unaddressed in the sentencing plan, specifically around violence to known adults, mental health and alcohol misuse and risks to children. Additionally, PP1 accepted P1's accounts of events without sufficient scrutiny, she failed to verify reports of curfew compliance or alcohol abstinence. The officer adopted a check in style approach to supervision and focussed on supporting P1's presenting needs around housing and finances rather than her presenting risks. The Officer reflected that she may have lost sight of P1's risk because she was seeing her as a vulnerable chaotic woman who had suffered trauma.

In November 2022 P1 had re-engaged with K charity and she was supported under the Women's Justice Service. The risk assessment completed by PP1 incorrectly indicated that P1 was completing rehabilitative work through K as an alternative to Springboard, a commissioned service. K provided support but no offence-focused interventions. Proper liaison with K would have clarified this and may have led to a referral to Springboard, an organisation P1 had previously engaged well with.

K charity recognised the need to address the underlying causes of P1's behaviour and referred her to Valley House for counselling, P1 to attend an appointment with them in March 2023. This was a potential turning point, as P1 had previously been reluctant to engage in therapy. P1 told the Chair she found counselling difficult because it was painful and made her feel sad, but was able to attend Valley House with support from her key worker from K. Valley House declined the referral but P1 would have met the referral criteria for the Offender Personality Disorder Pathway through probation, had her risk been assessed as high, the further serious offence review concluded a referral should still have been made based on her diagnosis and previous history. Effective liaison between probation and K might have identified the gap in services for P1 after Valley house deemed her too complex for their service.

A MARAC referral was made following P1's the alleged assault on her partner. Third-sector agencies such as K are not routinely invited to participate. At the full MARAC meeting in March 2023, the chair concluded that P1's risk was being managed through her work with K, the Valley House referral, and probation oversight. This decision was based on inaccurate information in the probation report, which overstated the role of K. The MARAC it was not aware of Valley House's decision not to offer



P1 counselling. K charity was neither present at the meeting nor provided with the minutes, therefore this information was not corrected. Efforts by K charity to raise and escalate their concerns about P1 to mental health and the police were made difficult because they did not have a named person within these agencies as a primary point of contact.

Perpetrator 2 (P2)

The integrated chronology for P2 can be found at **Appendix D** The following section provides a summary of key events, focusing on the approach taken by agencies to identify his needs, and manage his risk of violence and the effectiveness of inter-agency working and adherence to safeguarding policies throughout the period under review. Agency involvement was primarily with police, child and youth services, and health.

Diagnostic assessments for P2 and the search for a school to meet his behavioural needs took a long time and by January 2021, P2 had been out of education for 2 years. Friendships with his peers were disrupted, he spent a lot of time out in the local community associating with older males including a male who had gang affiliations, he was recorded on the police system as at risk of criminal exploitation. P2 had a limited police footprint in terms of convictions, but there was significant police intelligence around his involvement in anti-social behaviour and other criminality, including theft, burglary, threats to kill and criminal damage. These incidents did not result in a prosecution and on many occasions P2 was not spoken to, challenged, or warned about his behaviour so he was committing offences with no consequences. There were investigative failings by the police in some instances but at other times a reluctance to criminalise P2 due to his age. Agencies recognised P2 was vulnerable, but that he could also pose of risk to others, creating a tension between meeting his needs as a child and addressing his offending. P2 was made subject to a Child in Need Plan and allocated a social worker (SW) from the Horizon Team a specialist team focussing on child criminal exploitation. SW was the lead professional for P2 from January 2021 to July 2022. She had a health qualification and had the skills needed to engage with P2 and developed a positive relationship with him, albeit on his terms. During the time SW had case responsibility for P2, he was appropriately assessed as a high-risk offender and several interventions were put in place to address his behaviour and meet his needs, including engagement with the Navigation Hub, CAMHS, REACH (a resource to support emotional wellbeing), focussed work by St Giles (a



charity working with young people on violence and exploitation) and SW worked with P2's grandmother on managing risks and safety. SW co-ordinated joint working and information sharing with and between partner agencies and arranged a multi agency professionals meeting to consider P2's needs holistically and formulate an integrated care plan.

The police and youth justice team worked closely with SW and maternal grandmother. P2 was allocated an offender manager, who made home visits. This intervention ended after three months due to lack of engagement. P2 was also visited by officers from Operation Guardian a taskforce set up to tackle youth violence and he was referred to Right Trax and enrolled on a motorcycle maintenance course and taught basic maths and English skills. P2 initially engaged very well with this project, he had an interest in fixing bikes and enjoyed the practical aspects of the course. Between January 2021 and March 2021 positive signs were noted including a reduction in P2's missing episodes and his offending behaviour.

By the April 2021 P2 began to disengage from Right Trax, his grandmother thought he had conflict with some of the other young people who attended the programme. There was also a marked increase in missing episodes, misuse of drugs and alcohol, anti-social and criminal behaviour in the community. It is not possible to say if P2's disengagement led to an increase in negative behaviours, or the negative behaviours led to his disengagement. The police responded by listing P2 on a proactive Management Plan for his local policing area which allowed the neighbourhood community officers to monitor him, and SW undertook focused work with P2 on exploitation and requested an ADHD assessment by CAMHs and a review of his medication. P2 was prescribed melatonin to help him sleep but had complained this was not working and he was using alcohol to self-medicate. SW also made referrals to Dare to Dream, an educational mentoring resource and Positive Choices a substance misuse service for direct work and support. There was limited engagement with these interventions due in part to continuing criminality, and an increasingly hostile relationship with his grandmother.

A Multi-Agency Child Exploitation Framework meeting in September 2021 determined there was a need for more targeted action to divert P2 from criminality and a referral was made to the National Referral Mechanism NRM (a framework for identifying victims of exploitation to ensure they are getting adequate support). This referral was accepted on a



reasonable ground basis, but no final decision had been made by the time of the murder.

In October 2021 P2 was arrested for possession of an offensive weapon, he had made threats to a police officer with a baseball bat and had been drinking at the time of this offence. During his time in police custody P2 was assessed by the liaison and Division team (community mental health) but no role for them was identified. The police referred the case for a decision by the Out of Court disposal Panel (a panel of professionals including police and the youth justice team who consider assessments and make recommendations to the court), this was P2's first formal contact with Youth Justice Service.

P2 was allocated a youth offender officer who completed an assessment to inform the out of court disposal panel. The manager recalled the intelligence picture for P2 being very general from the police but specific concerns about P2 were shared by SW and information was requested from his grandmother's housing provider to gain a clearer picture of his behaviour in the community. P2 was assessed as high risk of re-offending and causing serious harm to others. P2 was sentenced to a youth conditional caution in November 2021 with conditions to attend sessions on criminal exploitation, victim awareness, empathy and weapons awareness.

All children coming into the Youth Justice Service (YJS) have an initial health screen to identify any physical or mental health needs. The health screen for P2 identified an outstanding ADHD assessment and priority was given to progressing this. The youth justice service has CAMHS workers seconded to the team, they did not undertake any direct work with P2 as he declined to engage with them around his diagnosis and he declined assistance with substance misuse, but the workers supported staff to work with P2. All staff are conversant with the research around the impact of adverse childhood experiences and were aware of P2's history and worked with him through a 'trauma informed lens'. The youth justice service operated a 'child first offender second approach' which meant identifying and responding to P2's welfare needs before addressing his criminality.

P2's grandmother was allocated a support worker, and she engaged in the peer-to-peer support. The support worker worked with her to increase her understanding of P2's diagnosis and help her recognise the signs and symptoms that he was struggling emotionally. The support worker



continued to work with his grandmother following P2's arrest and supported her through the criminal trial and following his conviction and sentence. P2's grandmother confirmed this support was very positive for her personally.

In October 2021 the Child in Need plan was stepped up to a Child Protection Plan due to escalating risks. P2 was given support in several areas, education, activities, emotional well-being and substance misuse. Further housing and parenting support was provided to his grandmother. Core group meetings were held monthly to review the plan. P2 was allocated a support worker to help him engage with the interventions and the youth conditional caution. In November and December 2021 P2 engaged in direct sessions under the Youth Conditional Caution when his support worker physically brought him to appointments at a venue close to his home. Under the order, he completed work on exploitation awareness and two sessions of the Knife Crime Prevention Programme, this programme is normally 6-8 sessions, but the sessions were broken down and adapted to take account of P2 communication and learning needs. P2 engaged in discussions and watched a video about risks to self and to others from carrying a knife, it was expected this work would be revisited with his youth offending officer during the period of the youth conditional caution. This did not happen as P2 disengaged from the service in January 2022.

During the first half of 2022 the police records for P2 included incidents of aggression, threats to harm his grandmother and her property, missing episodes and involvement in the sale of drugs. P2 was leaving home at night, stealing bikes to order and spending the money he made on clothes. A multi-agency safeguarding referral was made by the police citing serious safeguarding concerns. P2 was largely beyond the control of his grandmother and her housing association was threatening to terminate her tenancy due to his behaviour. P2 was also failing to comply with the terms of the youth conditional caution. The youth justice manager described the attempts made by his youth offending officer to get P2 to engage but these were not successful. As a last resort the case was sent back to the police for a charging decision in relation to the offensive weapon offence. The police ultimately decided there should be no further action in respect of this offence. This decision was delayed without explanation until December 2022, by this time P2 was in the care of his local authority.



In March 2022 P2 was sentenced to a nine-month referral order for criminal damage to his grandmother's property. The referral order was made without a report but his youth offending officer was in court and was able to provide the bench with background information about P2. The referral order was a high tariff for criminal damage and appropriately reflected the wider information about P2 presented to the court. If the police had made a timely charging decision, the youth court could have sentenced for the earlier offence of possession of an offensive weapon, alongside the offence of criminal damage. This might have resulted in a longer referral order, or some further focussed weapons related work being part of the order.

His youth offending officer and his support worker completed a referral contract, P2 agreed to attend work related learning, work to address substance use, engage with his youth offender officer and social worker each week, and undertake reparative work. The contract was a collaborative process with input from P2. It reflects the circumstances of the offence and the issues the young person is flagging as a concern, in P2's case, substance misuse and lack of education and training were flagged. Despite a high level on intervention May and June 2022 saw a continuation of the cycle of missing episodes, criminality, substance misuse, multiple threats to maternal grandmother, including a threat to kill and an assault on a 17-year-old girl. The police made a referral via the vulnerability persons portal for maternal grandmother, but the assault was not prosecuted, the victim was deemed too vulnerable to support a prosecution.

Information about P2's criminal behaviour was shared with children's services; a legal planning meeting was convened and the meeting approved section 20 accommodation for P2 and his grandmother consented. P2 was placed in a residential home in the North of England in July 2022. Initial reports from the residential home were positive, P2 engaged well with one-to-one support and tuition, he also engaged with 'hands on' learning two days per week at a local farm and gardening in the local community. P1 felt P2 could be himself in the residential home, he did not have to put on a front because no-one knew him, she talked to him on the telephone, and he began to talk about returning to education which she felt was a very positive sign. P1 had maintained a relationship with P2 since he was a small child, he had spent a lot of time with her and his uncle during their relationship, and they were his grandmother's primary source of support for P2 and were part of the safety plan when P2 went missing. P1 and P2's uncle asked to be considered as long-term carers for P2, however, their initial viability



assessment in February 2022 was negative. It concluded P1's history of mental illness and alcohol addiction, and the size of their accommodation meant they would not be approved as long-term carers.

P2's grandmother was very positive about his time in the residential unit; she would travel up to see P2 every few weeks supported by children's services and their relationship improved. She described the staff as 'lovely' and felt P2 was developing a good relationship with them. Children's services also supported visits by P2's girlfriend to help stabilise his placement.

P2 successfully completed his referral order whilst living in the residential placement. His youth offending officer remained involved and co-worked the case with an officer from the placement area. Both workers attended P2's looked after reviews and professional meetings and contributed to the closure plan at the end of the order. P2 engaged in work around sexual and criminal exploitation, victim awareness and online safety, but he declined work around substance misuse, but he did agree to a session with his youth offender officer on the dangers and consequences of alcohol use. The closure plan involved ongoing work around relationships and exploitation, and support for P2 in education and training and a safety plan based around P2 continuing placement in the unit. A new social worker was allocated to his case and the involvement of his youth offending officer ended at this point.

An Independent Reviewing Officer (IRO) was appointed in July 2022 to oversee P2's care plan and ensure it fully reflected his needs and that the actions and outcomes set out in the plan were consistent with the local authority's legal responsibilities. The IRO met P2 for the first time ahead of his Looked After Child Review in August 2022. She recalled he initially struggled to engage in meaningful conversation with her and wanted to focus on his own agenda, which was to return to his local area, however the IRO was able to establish a good relationship with P2, and she supported him during his trial.

Shortly after the end panel, P2's placement gave notice, citing safeguarding reasons, there had been missing episodes, P2 was climbing out of his bedroom window at night and not getting up during the day and becoming verbally demanding to staff members. The home felt they were unable to keep P2 safe. Four disruption and stability meetings were held to try and



stabilise the placement and offer support including additional staffing. The residential home refused to extend the notice period and P2 was moved to a placement in a city close to his home area in February 2023 where he remained until moving back to his home area in June 2023. All the professionals involved with P2, including his IRO, recognised a placement close to his home area was not suitable and likely to disrupt the progress he had made since July 2022, but there were very few places available at short notice. P2 perceived the breakdown of the placement as a rejection and struggled to understand why he had to leave. This was a significant transition point for him, professional relationships were disrupted and the plans for his care had to be reviewed. P2's care plan continued to be managed by his home area in line with good practice.

Between February and June 2023, the frequency and duration of P2's missing episodes increased. Initially P2 was leaving his placement to spend time with his girlfriend. The police did not consider he was at risk at her address; he was in contact with staff and sometimes answered calls from the police who were able to confirm his whereabouts, and he engaged well with the return home interviews. Consideration was therefore given to a safety plan supported by a written agreement to allow him to visit his girlfriend without being deemed missing. However, several issues led to a deterioration in P2's behaviour his relationship with his girlfriend became problematic, he was struggling with his mental health and misusing alcohol. The deterioration in his behaviour put his placement at risk. His allocated social worker supported P2 to complete a mental health application, he was offered substance misuse support, and a referral was made to Youth Promise (an organisation providing support with mental health for young people aged 16-29 who are not in education or training). The staff at the home encouraged P2 to attend appointments and activities were put in place to assist with his emotional wellbeing. P2 was allocated an intervention worker from Youth Promise, who planned to undertake light touch work and commence rapport building work with P2 until the programme began formally.

MARAC failed to flag P2 as a potentially at-risk child as no agency had provided information about their relationship even though the MARAC was convened to consider the risks P1 posed to his uncle. Probation failed to identify P2 as a relevant child in P1's life on the evidence available P1 should have been assessed by probation as a medium risk to a child in her care



In May 2023 P2 left his placement and he was missing for fifteen days. P1 confirmed P2 was living with her during this period. Strategy meetings were convened in response to missing episodes. During the period P2 was missing, chaired by the through care team. There was good professional representation at each meeting and detailed discussions took place around the missing episodes and action plans were agreed. The known risks were identified, namely, alcohol, drugs, involvement in criminality on his own or jointly with others and active evasion of the police and other professionals. The unknown risks were where he was staying, who he was associating with and what he was doing. The placement completed address checks and tried to maintain contact with P2. It was agreed any new information gathered about P2's associates were to be passed the police. P2 would continue to be discussed at the daily missing triage meetings, and the social worker was to explore the possibility of an alternate placement further away from his home area and explore options for education and training. The child exploitation tool was regularly updated to include new information. P2 was interviewed after he returned to the home and gave several explanations for his missing episodes, including boredom, wanting to be close to family and his girlfriend. There was police intelligence that P2 was committing burglaries with another young person from his placement, they would often go missing together.

Some information about P1 and P2's uncle was shared during the strategy meeting, but key information about P1's deteriorating mental health, alcohol use and violent behaviour was not fully shared with the professionals responsible for P2's care. There was an allegation made by P2's uncle that P1 was in a sexual relationship with P2 but this information was not adequately investigated. In May 2023 the police shared evidence that P2 had been found at P1's property, the circumstances clearly evidenced P1 was harbouring and colluding with P2, contrary to his welfare interests. P1 was drinking, had mental health issues, and was deemed to be a high-risk perpetrator of domestic violence against her partner. Professionals recognised P1 was likely to encourage P2 to drink but there does not appear to have been a focus on the other risks, namely actual violence or exposure to violence.

At the beginning of June 2023 P2 was moved to a 24-hour supported placement in his home area, a short distance from P1's home. P2 had access to the Community Initiative to reduce violence and access to



substance misuse services but refused to attend appointments or engage. P2's grandmother struggled to understand the decision to place P2 back in his home area given the issues when he previously lived there. The panel recognised this was a difficult decision, P2 was 16, competent, he had consistently stated he wanted to return to his home area and had refused to move to an alternative placement. A move to his home area was seen as a chance to stabilise him in preparation for work or training, a defensible decision.

Missing episodes continued, although their duration was shorter. The final missing from home strategy meeting took place a week before Peter's murder. The risks to P2 were identified as his use of alcohol, drugs and his declining mental health, P1's declining health and her misuse of alcohol. Following the meeting a placement outside the area was located and a plan to move P2 had been approved but it was not implemented before the murder.

Shortly before the murder P2 returned to his accommodation in the early hours of the morning, a 111 call was made to emergency services by a support worker from the home, P2 had an injury to his hand and had told the worker he had hit a man defending P1. The records indicate he attended accident and emergency and was treated for the injury. He changed his account at hospital and claimed he had hurt his hand hitting a wall. Accident and Emergency made a safeguarding referral to the local authority. This information does not appear to have been passed to the police or children services by the residential home. Around the same time K charity made a referral to the police and children's services (EDT) that P1 had claimed to have stabbed a man in the face the night before and that P2 had been present and had also assaulted the man. These two referrals do not appear to have prompted any action by children's services or the police prior to P2 arrest for murder.

Practice and organisational learning:

Individual: Peter

The risks to Peter in the community were clearly defined and articulated by his care -coordinator and his treating team. It was entirely predictable he would put himself at risk due to his behaviour and come to some harm. The extent of the harm or manner of his death could not have been predicted. His clinical team recognised, the only way to keep Peter safe would be for



him to remain in the care home and have restrictions placed on his liberty. Peter did not consent to this care arrangement. The question of capacity was therefore rightly identified as determinative of whether he lived in a care home subject to restrictions on his liberty or in the community free to live as he wished. Peter's care co-ordinator recognised care planning for Peter was complex and he was proactive in requesting the legal opinion to clarify the how the test of capacity should be applied to the facts of Peter's case. It is reasonable to conclude that the capacity assessments at HH were undertaken correctly, in accordance with the guidance.

Learning Points

- Legal planning outcomes need to be properly documented and uploaded to the relevant systems.
- Peter's transition to community care was high risk. Once capacity was confirmed, a multi-agency meeting should have been convened before discharge to agree a risk management plan.
- Peter's alcohol misuse was a known risk factor for his offending and safeguarding needs. Relapse prevention should have been integral to discharge planning.
- The psychological assessment in Oct 2022 was a missed opportunity to develop a risk mitigation plan tailored to Peter's behaviours.
- The Trust Safeguarding Team and the Trust Mental Capacity Act Advisor should have been consulted; they could have brought fresh insight to the concerns and would have advised a multi-agency meeting to be held.
- Peter's sexual needs were not addressed holistically. This omission may have contributed to risk; a safe sexual expression plan could have mitigated this.
- A carer's assessment was not offered to Peter's daughter, despite her involvement and concerns, potentially limiting the ability to escalate and support safeguarding.
- Peter's daughter's report in May 2023 that he was at risk should have triggered an urgent multi-agency review.



- Peter's GP failed to demonstrate professional curiosity around how he was spending his days and how his care and other needs were being met, in the context of Peter raising issues about sleep, lack of friends and anxiety.

Individual: P1

P1 is a mixed-race woman with diagnosed mental health conditions, a history of alcohol dependence, previous experiences of trauma, and housing instability. She was supervised by Probation, received mental health care through the NHS, support from K (a charity), and was known to police and housing services. As a female offender, P1 was subject to national strategies aimed at reducing female reoffending. Her case highlights the intersection of Race gender, mental health, trauma, substance misuse, and social exclusion. Her multiple co morbidities, were considered by the agencies but not collaboratively managed. There were missed opportunities to reassess P1's risk, strengthen supervision, and ensure a joined-up response to her difficulties. Her complex needs required a higher level of intervention and coordinated case management, which were not effectively delivered.

Learning Points

- P1's longstanding alcohol misuse was not considered in sentencing or intervention planning. The community mental health team did not refer to the dual diagnosis service or policy and did not explore her drinking in depth. A clear referral pathway to substance misuse services (CGL) was missed.
- P1's protective family relationships (mother and sisters) were not utilised. These networks could have helped monitor risk and support compliance. Key agencies did not effectively engage with her family, despite the family holding valuable information about P1's daily functioning.
- Probation missed three opportunities to revise P1's original risk rating from medium to high risk to known adults following her sentence and during implementation of the community order: -
 - When the OASys risk assessment was completed in March 2023. This assessment should have analysed the circumstances around the arrest of P1 for assault in February 2023 and the ongoing relationship between P1 and her



partner which led to P1 breaching her of bail conditions in March 2023

- When the OASYs was reviewed by the supervising officer, gaps were noted around safeguarding practices and the absence of a SARA were identified, but PP1 was not advised to review the risk assessment and P1 continued to be monitored as a medium risk.
 - In June 2023 when P1 told her probation officer of her declining mental health and increase in alcohol use, factors which could lead to a heightened risk of violence and the referral from K should have prompted a review of risk. This information should also have triggered a police officer check that might have revealed P1's arrest for assault in June, the circumstances of that offence and her involvement with P2.
 - P1 did not have a care coordinator or a comprehensive care plan in place. The community care team did not consistently respond to her needs or implement longer-term planning. The lack of central oversight meant the community team did not promptly respond to P1's deteriorating mental health and increased risk indicators in June 2023.
- P1 did not have a comprehensive risk management plan in place, and risk assessments were not consistently updated. The risk of violence was highest when her mental health deteriorated, and she was drinking too much, as seen in May and June 2023. The phone calls in June 2023 between P1 and the health trust administration services were a missed opportunity to fully assess the risks P1 presented at that time.
 - There should have been multi agency communication, including the Police, Probation, and mental health services and K charity, to consider strategies to reduce P1's presenting risk. Information sharing under formal agreements between these agencies could have provided a fuller picture and sharper focus on the risk of violence.
 - The MARAC was a missed opportunity to coordinate a response to risk and identify gaps in risk management. Statutory agencies must ensure accurate information is presented to MARAC and account for the actions they propose and agree to and must communicate the



safety plan and actions within their agency and ensure actions are tracked and signed off and escalate internally if there is a failing.

Individual: P2

P2's early experiences, his mental and developmental conditions, his substance misuse, ongoing criminality, moves of placement and frequent missing episodes would have been significant barriers to building positive relationships with professionals and his ability to engage in any meaningful way with the interventions put in place. The Youth Justice Board and children's services use a relationship-based model, recognising that positive relationships are essential for effectively engaging young people in the criminal justice system. The professionals who have worked with P2 have been committed to keeping him safe and wanted to achieve the best outcome for him. The evidence shows P2 was able to engage for limited periods with interventions when he had a high level of support from workers he trusted.

Learning points for P2

- All relevant professionals followed the missing from care protocols, the strategy meetings were well attended, and actions were agreed at the conclusion of each meeting, but it was not apparent how they were tracked, and the outcome was not recorded.
- Return home interviews took place, and there is evidence information from these interviews was used in care planning and to update risk assessments.
- Not all the information gathered was passed on to the police or children services in a timely way. Reassurance was given by the IRO that information from return home interviews is now uploaded on to the child's records in a timely way so the information can be accessed quickly.
- P2's early exposure to trauma (e.g., family instability, possible abuse) increased his susceptibility to emotional and behavioural difficulties. His mental health and emotional wellbeing were being addressed by his Social Worker, but this was inadequate due to his refusal to engage with services. Barriers to engagement such as bureaucratic requirements like completing forms and attending a specific venue for appointments and long waiting lists, hindered P1's access to mental health and substance misuse services These services must



be tailored for children in crisis who cannot engage through conventional pathways.

- During his involvement with children's and youth services P2 needed a consistent adult in his life who had the skills to engage with him, someone who was available at critical moments, when the child is receptive to an offer of support, following arrest, during return home interviews, when his care arrangements changed or when new risks emerged.
- Logging incidents with the neighbourhood police team helped build a picture of P2's activities, but there was a lack of focus on his violent behaviour towards his grandmother, community members, and in the residential unit. P2 often faced no formal consequences for his actions which risked undermining deterrence and accountability.
- By June 2023 if the information held by all agencies involved with P1 and P2 had been shared this may have led to a sharper focus on P1 as a direct risk to P2 and prompted a more in-depth look at measures to safeguard P1 including a legal planning meeting to discuss the legal options available.

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

The review recognises it is not possible to predict individual acts of violence accurately. These recommendations are therefore about reducing risk and improving risk management.

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

Probation

The review emphasises the need for better communication and oversight within probation services. A comprehensive action plan has been implemented to address individual practice failings and ensure management oversight (see Appendix F). Managers have had reflective practice discussion with the individual probation officers involved in P1's case around the key learnings from this review and what best practice



would have looked like and assurances have been provided around their current safeguarding practices.

The management report for probation highlights several failings, inadequate reading of case records leading to inadequate risk assessments, incomplete safeguarding checks, lack of liaison between probation and other key agencies. These findings, often seen after a serious further offence, underscore the importance of a skilled workforce, manageable caseloads, and managers with sufficient time for effective supervision to ensure systems work efficiently.

The Mental Health Treatment requirement guidance (2021) outlines that Probation should maintain day-to-day communication with mental health treatment providers, share sentencing outcomes and work collaboratively to develop tailored solutions to ensure the individual is provided with support and intervention to enable successful rehabilitation and reintegration into society. This guidance should be extended to apply to all persons with a mental health diagnosis to ensure probation officers are invited to key meetings to discuss care planning, treatment and discharge.

Alcohol was a risk factor for Peter and P1. There is now a commissioned rehabilitation service linked to Change Gow Live, which Probation frequently refers individuals to this service when there is no there is no clinical need for alcohol and drug misuse, treatment. It offers a tailored set of sessions aimed to educate, support individual reduce usage, promote safe usage, maintain abstinence and work on relapse prevention techniques. The learning from this review should be used in staff training to ensure awareness of this service.

West Midlands Police

An inspection by HMICFRS found poor-quality investigations in West Midlands Police, leading to the creation of Operation Vanguard for rapid improvement. Ongoing training aims to enhance investigative standards, and a new model now assigns local teams to neighbourhood crimes, while PPU and Force CID handle serious and complex cases. These changes are expected to address some of the investigative shortcomings identified by the review. The review also highlights the importance of police training and inter-agency collaboration and makes the following recommendations:



The policy that officers have a duty to make referrals irrespective of other agencies involved should be reinforced through training.

Frameworks to verify and record information about the mental and physical health of offenders to inform its investigation and charging decisions should continue to be explored.

The systems for information sharing between police and probation services and other agencies including the provision of a named officer for local areas should continue to be explored.

Evidence-led prosecutions should be encouraged and actively pursued.

Mental Health Services

The review stresses the need for multi-agency collaboration and effective risk management.

Referrals to the adult safeguarding team should always be considered as part of discharge planning for vulnerable service users.

Multi-agency meetings should be held at key points in care planning to ensure effective information sharing and risk management.

The learning from this review in staff training to ensure awareness of duties under the adult safeguarding policy and the need to consult with the Head of Legislation and the Trust legal department in cases where there are complex issues around capacity.

Every service user should have a primary contact responsible for oversight of their care. This includes developing care plans, coordinating all aspects of care, and ensuring effective communication pathways with partner agencies and third-sector organizations.

GP Services

The review recommends that GPs continue to improve appropriate safeguarding coding in primary care and enhance professional curiosity and the "think family" approach. These issues will be addressed in training events and feedback to individual GP practices.



Children Services / Youth Justice Service

Children services should continue to explore ways to provide consistent adult support for children at critical moments

There should be greater engagement with the MARAC process to ensure vulnerable children are identified.

MARAC

The Chair should have oversight of actions and be able to track individual agencies and report for non-compliance.

Agency-Wide Recommendations

Agencies should have systems in place to follow up on referrals, establish actions taken and outcomes, and escalate concerns if appropriate action has not been taken.

Key agencies must ensure their processes for tracking actions arising from MARAC (Multi-Agency Risk Assessment Conference) are robust

Key Agencies should have a process in place to identify all partner agencies and third-sector organisations involved with an individual and to ensure there are effective communication pathways in place.

Issues for Wider National Consideration

The review highlights the severe delays in CAMHS (Child and Adolescent Mental Health Services) and the need for a review of the service to consider the referral system, management of appointments, and ways to meet the demand for services for young people who may not be able to access the service in a conventional way.



Dissemination

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

Date circulated to relevant policy leads: 25/03/2025

Organisation	Yes	No	Reason
Probation	☒	☒	To fact check and review the learning points and recommendations
Police	☒	☐	To fact check and review the learning points and recommendations
K a charity	☒	☒	To fact check and review the learning points and recommendations
Partnership Trust	☒	☐	To fact check and review the learning points and recommendations
Children's/ Youth Services	☒	☐	To fact check and review the learning points and recommendations

OWHR process

The process is set out in the preamble to the report

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

i. ☒

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

ii. ☒



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

The chair is a retired barrister with 30 years' experience at the criminal and family bar. She is familiar with the processes within the criminal justice system and children services and has been involved with several third sector organisations in a voluntary capacity. The chair has direct lived experience of violent crime and youth violence. The chair has no professional or personal connection with the pilot area in which this review took place or any professional or private connection with any of the agencies or key personnel involved in the review. The chair has had no connection with the relevant review partners or local oversight process for this review. She has also completed the on-line training provided by the Home Office through Enlighten Training. Beyond this review Beryl McConnell has never been employed by any of the agencies referenced in this review.

Signature: B McConnell

Name: Beryl McConnell

Date: 20/01/2025

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:



APPENDIX A – Terms of Reference and Methodology

Scope/Terms of Reference

INTRODUCTION

The police, local authorities in England and Wales and integrated care boards in England and local health boards in Wales are required to review the circumstances of certain homicides where the victim was aged 18 or over and the events surrounding their death involved, or were likely to have involved, the use of an offensive weapon. (Police, Crime, sentencing and Courts Act, section 24)

- Peter was killed in the summer of 2023. His body was found in the outbuilding of an address in Coventry with a rope around his neck and multiple injuries believed to have been caused by a machete. At the time of his death Peter was 74 years old.

THE SCOPE OF THE REVIEW

- To review the involvement of each statutory and non-statutory agency statutory with Peter, P1 and P2 from 1 January 2021 to 19 June 2023 inclusive. The scope of the review has been extended beyond twenty-four months to capture key events in 2021, including contact with the police, housing, mental health services, probation, youth justice service and children's services.
- Agency involvement prior to 1 January 2021 will be summarised save for specific and significant events which form the basis of later decisions or agency involvement or highlight important issues.
- P1 was open to mental health services and probation at the time of the homicide triggering an independent NHS Investigation to explore her care and treatment and a Further Serious Offence review (FSOR).
- P2 was a looked after child in the care of Coventry City Council and known to the Youth Offending Team. His arrest and charge for murder is a public protection incident and subject to mandatory reporting to the Youth Justice Board and would ordinarily trigger a Community Safeguarding and Public Protection Incident Review (CSPPI) The review partners have agreed that all aspects of the CSPPI will be covered by the OWHR.
- The independent chair will liaise with the independent NHS investigator and the author of the further serious offence review during the course of the review to ensure the parallel reviews align with and inform the OWHR, avoid duplication of processes and promote wider learning across agencies



THE PURPOSE OF THE REVIEW

- The purpose of the OWHR is to ensure the local partners identify the lessons to be learnt from the death of Peter including any early learning and to consider whether it would be appropriate for anyone to act in respect of those lessons learned, the timescales for action and what is expected to change as a result.
- The intention is not to apportion blame or responsibility but to use the learning from these reviews to improve the local and national understanding of what causes homicide and serious violence and to highlight effective interventions and good practice, to better equip services to prevent weapons-enabled homicides and in doing so save lives.
- This review is part of the pilot established under the Act to ensure the OWHR process meet the needs, expectations and ways of working of those involved ahead of a decision whether the OWHR should be implemented across England and Wales.

REVIEW METHODOLOGY

- The review will follow the OWHR statutory guidance which sets out the core components of an OWHR.
- The OWHR will be undertaken in a transparent manner with all participants being clear about the purpose, scope and direction of the review.
- Agencies will be asked to respond to the initial scoping questions (Part A of Annex 1) and provide a brief overview of their contact with the subjects of the review, to enable the Review Partners to decide whether to commission an OWHR and determine the scope and terms of reference of the review.
- After the notification period has passed and the review has been formally commissioned agencies will be asked to respond to a more detailed request for information (Part B of Annex 1). This is to encourage local partners, bodies, and practitioners to be professionally curious about the events which led up to the homicide. The emphasis is on whether the policies and procedures in place allowed for effective interventions.
- All relevant agencies will be required to share information in accordance with their statutory obligations under the Act.
- Information will be requested that is necessary and proportionate to enable the circumstances of the homicide to be analysed.
- Where necessary the legal requirement on any person/agency receiving a request to comply with a request for information will be legally enforced.
- The review panel will consider how to follow up the responses to the detailed questionnaire this may be by way of group briefing, meetings with individuals or communication in writing.



- The review will be undertaken in a way that does not compromise the integrity of the police investigation, and the SIO has a duty to co-operate with the review and provide information and guidance throughout the process.
- The material generated or obtained during the review is potentially disclosable within criminal proceedings. The Independent Chair will be responsible for disclosure of material to the Disclosure Officer.

THE REVIEW PANEL

- The review will establish a panel to participate in and contribute to the review.
- Panel members should be independent of any line management of staff directly involved with Peter, P1 and P2 and must be sufficiently senior to have the authority to commit on behalf of their agency to decisions made during a panel meeting.
- The same personnel from each agency should attend all the panel meetings, if possible, if this is not possible, the meeting should be attended by someone who has been well briefed and of sufficient seniority to take decisions on behalf of the agency.

THE ROLE OF PANEL MEMBERS

- To ensure case records are secured.
- To appoint a person to provide the information requested as part of the initial scoping exercise and the investigative stage of the review. This person should not be involved in the case or be the line manager of a person involved.
- To quality assure the information provided.
- To provide feedback to staff on completion of the OWHR report.
- To ensure timely and comprehensive responses from the organisations asked to provide information.
- To offer constructive challenge within their organisations.
- To agree and implement the relevant parts of the action plan.

PANEL MEETINGS

At the first panel meeting, the panel will agree the scope and terms of reference of the review, and these will be reviewed at each panel meeting to ensure the review remains focussed on its core objectives.

- From time to time there will be a need for others to attend the panel meetings for a specific purpose by formal invitation from the chair.
- Participation in panel meetings is the responsibility of individual agencies failure to respond and attend to an invitation will be noted in the final report.



REPORT AND DISSEMINATION OF LEARNING

The Independent chair will author the final report with the support of the review panel.

BCST will have responsibility for ensuring the completed OWHR report is at a standard ready for publication when it is submitted to the Home Office.

- The dissemination process will be agreed by the review panel and set out in the final report.

KEY LINES OF ENQUIRY SPECIFIC TO THIS REVIEW

- To examine the processes within agencies, identify, assess and address Peter's vulnerabilities.
- To examine the arrangements in place to safeguard Peter in the community and their effectiveness.
- To examine the measures taken to identify, assess and manage the risk of violence posed by P1 and P2.
- To examine how agencies identified, assessed, and treated the substance misuse.
- To examine their engagement with treatment and services and any barriers to engagement.
- To examine how information was shared between the agencies involved with P1, the quality of information shared and the effectiveness of the policies, protocols and agreements in place.

EQUALITY AND DIVERSITY

- The Review Panel will consider all protected characteristics (as defined by the Equality Act 2010) of Peter, P1 and P2 (age, disability (including learning disabilities), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation) and will also identify any additional vulnerabilities to consider (e.g. armed forces, carer status and looked after child). The Review Panel identified the following protected characteristics as requiring specific consideration: age, disability, race, and sex.
- It is important to have an intersectional framework to review the life experiences of Peter, P1 and P2 to ensure the full impact of their difficulties are explored and understood.



CONFIDENTIALITY DISCLOSURE AND INFORMATION SHARING

All parties are bound by a signed confidentiality and information sharing agreement signed at or in advance of the first panel meeting.

CHAIR

The independent Chair for this review is Beryl McConnell she will oversee the review process. The functions of the chair are set out within the terms of reference.

INVOLVEMENT OF FAMILY/NEXT OF KIN/PERPETRATORS AND OTHER RELEVANT PERSONS

The independent chair will be the primary point of contact for the family members of Peter, P1 and P2.

- **Contact with Peter's family/next of kin**

The independent chair will seek to meet with the family of MB when the terms of reference have been agreed to give them an opportunity to feed into the review. The involvement of the family is important to ensure Peter remains at the centre of this process and his voice is heard.

The family will receive regular updates about the progress of the review the draft final report will be shared with them prior to its submission to the Secretary of State for publication.

- **Contact with P1, P2 and their families.**

The independent chair will seek to engage with P1, P2 and their families The review panel will agree the strategy for this contact in consultation with the senior investigating officer. It is agreed no direct approach will be made to P1 or P2 until the completion of the criminal trial.

SUPPORT

The OHWR administrator will provide administrative support to the independent Chair and the review.



APPENDIX B – Integrated Chronology for Peter

DATE	EVENT	AGENCY RESPONSE	OUTCOME
2018			
June	P presenting with manic symptoms, grandiose delusions, and sexually disinhibited behaviour.	P detained under section 2 Mental Health Act (MHA) and admitted to hospital Diagnosis Bi-polar disorder and possible dementia	p detained under section 3 MHA for treatment.
July	MRI identified benign cyst on the brain left anterior cranial space.	Clinicians debate whether this cyst and or other degenerative brain changes were a contributory factor in his sexualised behaviours.	The prevailing view was that these physical issues did not cause or contribute to his behaviour.
September	Decline in mental health after discharge from hospital	P agreed to admission as a voluntary patient in hospital	P allocated a care co-ordinator
	P displaying sexually disinhibited behaviour on the ward and during periods of home leave		P detained under section 3 MHA
November	clinical review of detention	Section 3 detention discharged	P discharged from hospital into the community on a community treatment order.
2019			
March / April	Arrest for harassment of a female acquaintance and allegations of sexually inappropriate behaviour.	Context deterioration in mental health and heavy drinking	Community Treatment Order discharged, detention under section 3 Mental Health Act.
May	Mental Health Tribunal P was discharged for section 3 detention but remained in hospital as a voluntary patient	Issues related to alcohol consumption and sexual behaviour	
June	Brain Scan	Possible diagnosis of dementia, subject to further testing	P informed of diagnosis but did not accept he had dementia and declined medication to slow the progress of his condition
	Occupational Therapy functional assessment	P scores indicate a moderate cognitive disability	Results shared with the care co-ordinator
July	Neuropsychology assessments undertaken	Assessments did not confirm dementia.	Noted his behaviour may be the result of long-term alcohol use.
	P sentenced to 18 months' Community Order supervised by probation.	Case allocated to a Community Rehabilitation Company.	



December	Allegation of inappropriate behaviour on the ward made against P	Police attended	No further action
2020			
February	Allegation of inappropriate sexual behaviour	Probation notified	Medical opinion: P's behaviour is unrelated to mental impairment; neither detention nor DOLs are warranted.
March	Start Covid -19 pandemic	In-person contact between P and probation ended, moving to phone check-ins and monitoring.	
May	Hospital placement no longer beneficial	P transferred to HL, a rehabilitation facility, for section 117 aftercare.	Plan to complete a short period of assessment of independent living skills.
June	Multi-disciplinary meeting to consider plan for P.	Plan to find accommodation that would monitor medication and mental state and alcohol use.	Care Co-ordinator to arrange a MARAC to manage his risks
	Incidents of sexually disinhibited behaviour at HL	Incidents not reported to probation	
December	MRI	No changes in size of cyst	Clinical notes document that cyst was deemed not to be affecting his sexually disinhibited behaviour
2021			
January	P completed his rehabilitation programme and deemed fit to be discharged.	P's treating psychiatrist writes to probation to advise of level of MAPPA support and consider placement in a probation supported unit	Probation asked for further information and queried if discharge was appropriate given the ongoing concerns and the need for support.
February	Community Order terminates. No response from the mental health team to queries raised by probation.	Final risk assessment - P assessed as medium risk of sexual harm to female adults	
March	Incidents of sexually inappropriate behaviour on the ward.	Both incidents reported to the police Alert put on P's notes	Police told P had a cyst on his brain which made him have sexual urges
April	Multi-disciplinary meeting including police and care co-ordinator	P Detained under section 5 (MHA) for 72 hours to assess risks to the public and personal safety.	Assessment concluded P was not detainable and he was discharged from section 5(2) (MHA) detention. P agreed to remain on the ward as a



			voluntary patient to assess if his behaviour was caused by organic changes to his brain
August	Report to hospital P knocking on doors during periods of unaccompanied leave in the community.	Mental health assessment conducted – evidence of cognitive decline and poor insight meant informal care was 'inappropriate and unsafe'	P was detained under section 3 of the Mental Health Act.
October	Mental Capacity Act Assessment	P did not have capacity to make decisions about his health, welfare, level of care needed or where care should be provided	
November	P moved to a residential care home	Risks to be managed under DOLs and a programme of work with care coordinator to look at responsible behaviour.	
November / March 22	Further incidents of inappropriate behaviour	Police contacted	Incidents reported
2022			
April	Referral for an independent advocate	Referral refused without a formal mental capacity assessment	
May	Sexual complaints inappropriate behaviour by P,	P was placed on an urgent 7-day Deprivation of Liberty Safeguards (DOLs) to ensure his safety.	P was discharged from section he was deemed to have capacity and as there was no legal framework to hold him or restrict his movements in the community.
June	Legal planning meeting	No power to detain P	Further plan to discharge P into the community
September	Diagnosis of Alzheimer's Dementia		
November	Peter moved into supported housing	The care plan allocates eight hours of care per day, seven days a week.	Police not consulted or involved in the operational planning for P discharge into the community
December	Peter's daughter raising concerns about her father's mental health and she questioned whether he was compliant with medication and was concerned he may be drinking.	Advised to call emergency services and the mental health crisis team if P needs support over Christmas	



2023			
January	Review of care plan	P, his daughter, care co-ordinator and a member of support service.	No change to plan or level of support
February	Report that P approaching women and girls in the community	P advised by police to leave the City Centre	Information report completed for intelligence purposes
March	Report that P had been harassing a woman in the community	Repetition of behaviour that led to conviction	The care coordinator stated that the incident should be reported to the police.
April	P informed the GP of having few friends and experiencing anxiety.		
May	Clinical review assessed his risk as nil although past and recent behaviour was acknowledged	Advice was given to P about behaviour in community	Plan to review in six months Role of care coordinator to end
May	Peter's daughter contacted the care coordinator P had gone to the home of unknown male with a sex worker.		No review of risk or plan in response to this information
June	Peter was killed by P1 and P2		



APPENDIX C – integrated Chronology for P1

DATE	EVENT	AGENCY RESPONSE	OUTCOME
2021			
January	P1 is subject to a community order after being convicted of assaulting police in 2017.	This order was completed successfully.	Order ended in February 2021
January	P1 is currently without permanent housing and residing in temporary accommodation with MU.	P1 Referred to K Charity for women who face multiple disadvantages	K allocated a Specialist housing practitioner to support with housing.
March	P1 allocated permanent accommodation	K continued to be involved to support with new tenancy	
March	Police responded to an altercation involving P1 and her partner. P1, who was intoxicated, assaulted an officer.	No action taken in respect of the police assault	Domestic abuse risk assessment (DARA) for P1: standard risk.
April	P1 reported problems with neighbours to K	Support offered to resolve housing issues.	K liaised with housing
May	Ambulance called for P1's male friend with chest pain.	P1 made an allegation against the male of sexual assault.	P1 refused to provide a statement complaint was filed no further action
June	Police attended P1's property in response to allegations by neighbours that P1 was causing a nuisance and had made threats of violence.	P1 alleged racial harassment by neighbour	The incident was recorded in the open anti-social behaviour log, and the overseeing officers were updated.
August	P1 reported to K that her alcohol use had escalated, and she had self-referred to Change Grow Live [CGL]	CGL confirmed the referral	Period of engagement with CGL began
September	P1 reported an unknown male attempted break-in at her property she suspected her partner	Referral to Haven Sanctuary Scheme	Marker placed on P1's address for domestic violence.
2022			
January	Outpatient review by mental health services	No significant issues revealed	P1 agreed to a referral to Wellbeing for support
February	P1 disengaged from K and Change Grow Live.	P1 and her partner, P2's maternal uncle were assessed as potential caregivers for P2.	The assessment was negative – Housing and mental health issues cited.
March	Police attend P1's property in response to a report about an altercation between P1 and her partner	Dara refused – Police completed assessment	P1 at risk of violence risk standard



March	P1 in contact with the community mental health team	P1 disclosed suicidal thoughts and violent thoughts against her partner	Request made for an outpatient appointment
April	P1 phoned the crisis team and made threats of self-harm.	Ambulance attend P1's property-P1 had taken overdose of her medication. P1 was heavily intoxicated	P1 was seen hitting her partner he declined a DARA; police assessed: medium risk.
21 April	P1 seen by consultant from community mental health team	Consultant advised an increase in anti-psychotic medication	GP informed
4 May	Ambulance attended P1's property. P1 had taken an overdose and was refusing to attend hospital	P1 assaulted an ambulance worker who was restraining her.	Ambulance worker did not want to make a formal complaint and the incident was filed No role identified for the mental health team following assessment
June	P1 reported to police she had been assaulted, had injuries and been racially abused.	Police attended	P1 withdrew the assault allegation, and the case was closed.
July	P1 called police her partner was drunk and causing a disturbance	Verbal argument	P1 refused DARA Police assessed: standard risk
July	Altercation between P1 and her partner when she refused him entry to her flat. P1 made a threat that she would stab him	Police attended P1 said she did not mean the threats	DARA refused police assessed: standard risk – A higher grading should have been higher considered given history and nature of the threat.
	P1 reported to police that two Asian men visited her flat regarding drugs sent by her partner.	Police Delay in responding to call and investigation did not proceed	Incident filed
August	P1 claims her partner was violent, pushed her chest, and seized her phone.	Police attended DARA completed P1 made a statement. Referral to Mental Health hub – P1 reported experiencing suicidal thoughts.	P1 did not want to pursue a prosecution and the incident was filed
August	P1 reporting theft of bank card from property	P1 unable to name possible person responsible	Incident filed
October	P1 alleged her partner struck her in the face, resulting in bruising.	Police attended P1 declined to give a statement or complete DARA.	Partner arrested denied assault. The police served a domestic violence



		Photographs were taken to document the injury.	prevention order on MU.
18 October	P1 visited the complainant's residence and was reported to have exhibited behaviour described as abusive and threatening over a period of several days.	Police attended after P1 reportedly threatened to assault the complainant and was found with a hand weight in a sock in her pocket. Both P1 and the complainant were intoxicated. P1 also made an allegation of sexual assault against the complainant, which was investigated separately.	P1 arrested and charged with possession of an offensive weapon
November	P1 Re-engaged with K– for support following the loss of father	P1 informed K of a possible throat cancer and liver cirrhosis diagnosis, and that her mother was unwell.	Support worker from the justice team allocated
	P1 informed K about the sexual assault currently under police investigation.	Police confirmed on-going investigation	Housing coordinates with police regarding P1's managed move.
	P1 reported concerns about her flat's safety to K, citing neighbourhood intimidation, harassment, and a reported break-in.	Housing had advised temporary accommodation	P1 reluctant to leave her flat
December	Pre-sentence report submitted to the court	Recommended a community order	Recommendations of the pre-sentence report accepted by the court.
December	P1 Sentenced for possession of an offensive weapon and criminal damage.		A 12-month Community Order has been issued, including a requirement to complete 20 days of rehabilitation activities, along with a four-month curfew from 7:00 pm to 7:00 am.
December	Altercation between P1 and her partner	Police attended but P1 not willing to cooperate	Police assessed the risk of domestic abuse as medium after a risk assessment was refused. Probation not aware of incident
December	Curfew violation	P1 claimed her partner had been	No action on violation



		taken to hospital, but no evidence provided to probation officer to verify	
December	P1 told police her partner was aggressive and threatening.	Police attended; both parties were intoxicated and uncooperative.	DARA completed: medium risk Referral via the vulnerability portal for P1's partner regarding drink and mental health Probation not aware of this incident
2023			
January	Probation office visit	Focus on housing issues and finances	
February	Allegation that P1 assaulted her partner with a saucepan causing an injury to his head that required hospital treatment. The domestic abuse risk assessment tool assessed her partner as at high risk and the police made a referral to MARAC.	P1 arrested but her partner did not want to co-operate with the police or provide a statement	P1 bailed subject to conditions not to have contact with partner.
	Curfew violation – day after assault	P1 blamed faulty tagging equipment	
	P1 informed probation of arrest gave her version denying any assault or issues with her partner	Probation did not follow up with the police or complete wider checks	
	K refers P1 to Valley House for Counselling	Valley House felt P1's case was complex and needed an alternate resource	
March	P1 contacted K requesting assistance, stating that she was unable to function and indicating she intended to harm herself.	K asked Police to undertake safe and well check P1 and partner present in property – allegation by her partner that P1 had made threats to kill him	Police removed her partner as P1 in breach bail conditions P1 denied making threat to stab him.
	P1 invited partner to the flat in breach of her bail conditions to help care for the cats as she had hurt her foot.	P1 contacted police and alleged her partner had attended her property pushed her and taken her keys	P1 retracted allegation when police attended. DARA completed: standard risk Risk changed from standard to medium by reviewing sergeant
	MARAC meeting	Key agencies not present probation and K	The meeting concluded the risks were being



			managed by probation
	Offender Assessment System (OASys) completed	this assessment did not identify all the groups at risk from P1 or the nature of the risk.	Insufficient liaison with key agencies to ensure all individuals at risk were identified and did not complete a spousal assault risk assessment
April	Outpatient appointment to review P1's medication	Assessment revealed no disordered or abnormal thoughts	Anti- psychotic medication increased
	P1 reporting to K numerous problems at her accommodation, males hanging around the flat, drug dealing people knocking her flat	Multi Agency meeting arranged by K with housing and probation	P1 Advised to keep a log and call the police when necessary- K to lead on contact with police re housing issues.
	Report to police by P1 - unknown Male with machete outside her property	Police attended and undertook a search of the area no-one found	P1 did not want to provide a statement incident filed
May	Windows at P1's flat smashed	Incident reported to police and housing	Police/housing
	P1 informed her key worker at K of a deterioration in her mental health, an increase in alcohol consumption, and ongoing difficulties coping with the recent bereavement of her father.	K make referrals – to Change Grow Live, the mental health crisis team and the National Centre of Domestic Abuse	K to explore alternatives to Valley House to provide therapeutic support
	P1 and her partner report P2 to police for aggressive behaviour.	Police attended and P1, P2 and his uncle confirm a verbal argument only between P2 and his uncle.	No further action incident recorded but not as a domestic incident P2 missing from care and recorded as found on the missing person system The incident should have been recorded as a domestic abuse non-crime incident because of the relationship between P2 and his uncle
	K make referral P1 to a local law centre for help with housing issues		



	Third party report of disorder at P1's address	Police attended P1 claimed a youth had attended her property with a hammer and made threats to kill her.	Allegation was retracted by P1 Mash referral for youth P2: Missing person
2 June 2023	Report to police by K -P1 alleged that her neighbours have made threats to set fire to her flat to police	P1 discloses to probation that she is drinking, has not taken her medication for four weeks and is at risk of hurting herself or someone else.	Probation contacted mental health team re concerns about P1
3 June 2023	P1 makes an allegation of assault against P2 and alleges he misuses drugs and alcohol	Police attend P1's property P1 arrested for obstructing P2's arrest	P1 alleged she was pregnant whilst in police custody- Multi agency safeguarding referral made.
	P1 notified K of a break-in at her property.	Incident reported to police Support worker via webchat reported bleach thrown through window of P1 property	Matter filed no suspect identified lack of evidence
	P1 made an allegation of assault against P2	Police attended and P1 retracted the assault allegation	DARA completed: medium risk The incident recorded as a domestic abuse non crime incident
	K contacted by multi agency safeguarding team about the police referral re suspected pregnancy P1 reporting further incidents at and around her home to K	P1 denied pregnancy claim and told K a test was taken at the police station that was negative.	The negative test was not recorded in the custody records.
	P1 reported an incident of criminal damage to probation	Probation liaised with housing around incidence of harassment	P1 to be supported to find alternative accommodation
15 June	Police responded to a 999 call about a dispute at P1's property.	Police attended and arrested injured male who made an allegation of assault against P1 and P2	Incident under investigation at the time of the murder
16 June	P1 informed K that she had stabbed a man in the face the previous day, accompanied by P2, who also assaulted the individual. She expressed concern that she may pose a risk to herself and others.	K made referral to mental health, police and Children Services.	No urgent inter agency response to the referrals
17 June	Neighbour reporting harassment from P1 -she	Report to police	The incident was filed



	was spreading rumours that he was a paedophile and threatened to get her son to shoot him.	Victim reluctant to make a complaint	
19 June	P1 arrested for the murder of Peter		



Appendix D- Integrated chronology for P2

DATE	EVENT	AGENCY RESPONSE	AGENCY OUTCOME
2019			
November 2019	P2, aged 13, was initially assessed by the neurodevelopment team for possible diagnoses of autism spectrum disorder (ASD), attention deficit hyperactivity disorder (ADHD), and Foetal Alcohol Syndrome (FAS). Impulsivity and poor concentration were noted suggestive of ADD.	Referral to Speech and Language (SALT) Neurodevelopment team to continue assessment for FAS and ADD	The outcome of the referral to SALT is not recorded. Neurodevelopment team refused the referral for FAS rationale for refusal not detailed in the clinical notes.
November 2019	Transition to extended learning centre for education an alternative provision.	P2 had difficulty settling attempts to keep him in education failed	P2 disengaged from education
December 2019	Paediatric clinic review.	Diagnosis of ASD confirmed. Referral to Community MIND Children Autism Support service	Maternal grandmother and P2 did not engage with support - P2 discharged from service
2020			
2020	P2 involved in 8 recorded incidents of anti-social behaviour and criminality.	Canon crime recording for P2: elevated risk of criminal exploitation and potential association with gang activity.	
2020	Child in Need plan	Support with education and work with MGM	Case allocated to the horizon Team: specialist Child exploitation team sexual and criminal exploitation
2021			
January	P2 allocated an offender manager (OM)	The OM made home visits and liaised with other agencies	Aim to disrupt and divert P2 from offending. P2 did not engage.
February	Child in need meeting	P2 given Right Trax to address education and training needs	P2 did not sustain attendance at Right Trax
February	P2's social worker reported P2 exhibiting high levels of anxiety and	with the name of P2's consultant and details of Navigation Hub	



	attachment difficulties	(CAMHS) and Reach for support	
March	P2 not co-operating with his offender manager and deselected from the scheme.		
April	P2 listed on proactive management plan for the neighbourhood policing area, to monitor his behaviour	P2 noted in several anti-social behaviour incidents	
May	P2's family requesting support to manage P2's behaviour.	Youth worker requested assessment for foetal alcohol syndrome and a review of P2's medication	
June	P2 reported to police -missing from home	Professionals meeting arranged by social worker	Safeguarding plan agreed with maternal grandmother -P2 to be reported to police as a missing person. Actions: Referral to Dare to Dream and Positive Choices to contact P2 Foetal alcohol syndrome assessment and review of medication referral to be chased.
July	SW requested referral to CAMHS for P2 to assess for ADHD	Referral for ADHD assessment	P2 not seen by CAMHS due to waiting times for appointments
	anti-social behaviour by P2 in community: verbal threats to kill	P2 spoken to by police and warned about his behaviour	Details of incident filed
August	P2 -victim of street robbery pushed to the ground and sustained minor injuries	P2 refused to make a statement	Details of incident filed
September	Allegation -P2 involved in a burglary, made threats to kill and caused Criminal damage. The victim was an elderly	P2 was arrested but the victim did not want to make a statement The investigation into the burglary was inadequate no statement taken form	Details of incidents filed



	person in the community	the police community support officer who identified P2 as one of the young people involved in the burglary.	
	Multi agency child exploitation meeting to review current level of exploitation and safety plan.	No evidence of grooming/ exploitation but evidence of criminality Risk of exploitation assessed as low	More targeted direct work with P2 to divert him from crime and embed learning via Youth crime diversion programme
	P2 made threats to kill a local resident	Police inspector completed a threat to life assessment in accordance with policy P2 was arrested The victim did not wish to make a statement	No further action; details of the incident filed
October 2021	Threats to P2 by young people in the community	Police attended home of maternal grandmother to investigate allegations	P2 refused to name the people threatening him: details of the incident filed was filed
	Referral to the National referral mechanism to access support for P2 Initial Child Protection Conference	P2 subject to a child in need plan	Reasonable grounds decision January 2022 Child protection social worker allocated
	P2 : threats to police whilst holding a baseball P2 arrested for possession of an offensive weapon in a public place	police referred to the Youth Justice Service via an out of court disposal referral and initial assessment.	Youth Conditional Caution in accordance with the code of practice for Youth Conditional Caution under crime and disorder act 1998 as amended.
November	P2: burglary and theft	P2 arrested and police make Referral to multi agency safeguarding hub.	No further action by police details of the incident filed
	Social worker: Concerned about criminal exploitation of P2 and ability of maternal grandmother to keep him safe	Review child protection conference: Continuing presenting concerns Criminal exploitation/missing episodes/ not engaging in	Child in Need Plan stepped up to a Child Protection Plan



		education /substance misuse and anti-social behaviour	
2022			
January 2022	P2 stopped by police as a potential victim of trafficking and found in possession of suspected class A drugs. This was a pending investigation at the time of the murder.	P2 arrested for possession of class A drugs with	The exploitation hub made aware of arrest and information was shared with other professionals involved with P2
February	P2 displaying challenging and aggressive behaviour towards his grandmother	Review appointment with paediatric team Medication reviewed and changed review in 4 months	Horizon asked for CAMHS appointment to be expedited.
14 February	P2 arrested for criminal Damage	P2 damaged windows at his grandmother's house during an argument P2 seen by Court Liaison and Division team whilst in custody – underlying anger identified as a concern appropriate liaison with the youth offending service no role for mental health services identified.	
	P2 referred back to the officer in charge of the offensive weapons offence for a charging decision due to non-engagement with Youth Conditional Caution	Delay in charging decision by police	The youth offending team tried to escalate the charging decision.
	P2 making threats to harm his grandmother and damage her property	Police and social care informed	
March	P1 made an allegation to the police that there were drugs at the home of P2's girlfriend	Joint working between children's services and the police neighbourhood team.	Information treated as intelligence after investigation
MARCH	Joint visit police youth worker social worker	P2 discussed being threatened by older males	P2 did confide names to his youth worker -trust Section 47 enquiry initiated but P2



		He was stealing bikes to order during missing episodes	would not co-operate
	9-month referral order imposed by the youth court for the offence of criminal damage committed in February	P2 would not engage with the order for the first four weeks	
	P2 makes threats to kill in the community within days of the referral order	P2 not spoken to about this offence	No rationale for filing report
	P2 visited by officers from Operation guardian a task force targeting knife crime		
	Report by P2's grandmother to police that he had caused damage to her property and made a verbal threat of physical harm.	MGM unwilling to support a prosecution by providing a statement	Case filed
	Social worker reported to police statements made by P2 that he had a gun and would shoot professionals	Police visit re possible firearms	no firearms found referral to the guns and gangs' team
April	Strategy meeting following missing episodes.	Information shared about allegations made by P2's sister against him	Joint visit child protection social worker and the exploitation team Buddy tag to be explored by the police
	Referral order contract completed	P2 declined emotional and mental health support –	Period of Positive engagement
May	P2 tried to enter the home of his grandmother with cannabis and alcohol	Maternal grandmother contacted the adult crisis mental health treatment team but advised to call the police.	Maternal grandmother reluctant to provide statement despite reassurance given by police
	P2 made threats to damage his grandmother's property and damaged a bedroom door with a hammer,	DARA not completed due to P2's age and he was allowed to remain.	Police make referral to vulnerability portal in respect of maternal grandmother



	P2 made threat to physically harm his grandmother	Social worker attended	Maternal grandmother willing to act on threat.
	P2 attended the home of his girlfriend and caused damage to a car and made threats to physically harm her mother	Police contacted and requested CCTV of incident	Case filed pending contact regarding CCTV-
June	P2 disengaged from the youth justice service	Missed appointments with youth offending officer.	
	P2 arrested for assault on 17 year old girl causing injury	P2 seen by Court Liaison and Division team in custody no role identified.	Incident filed victim not able to cope with the process of prosecution.
	P2 placed with his sister for safeguarding. The victim of assault believed to be the sister of a young person with gang connections	Placement with sister broke down P2 made Threats to kill his sister and younger brother in response to attempts by sister to put boundaries in place	
	Strategy meeting.	Allegations of sexual exploitation by P2 section 47 enquiry initiated	outcome of the investigation is not recorded.
	Legal Planning Meeting	Approval for section 20 accommodation given	
July	P2 missing for three days	P2 located with other homeless males intoxicated	Police exercise police protection powers to return him to his grandmother's home
	MGM agreed section 20 accommodation	P2 moved away from his home area to a residential home in the North of England	
November	P2 discharged from Coventry Paediatric services following move to residential care		
2023			
January	P1 completed his referral order final panel meeting	Closure plan in place which focussed on ongoing work at the placement and his existing care plan	Involvement of the youth justice service ended
February	Breakdown of placement	P2 moved to a placement close to his home area	



	Missing 5.5 days Police followed the missing person policy	Measures considered to prevent missing episodes -Software tracking device on phone and DOLs considered – not deemed appropriate.	
March	Strategy meeting P1 reported missing from placement	P2 spending time with girlfriend in his home area.	Consideration to be given to a safety plan around staying with girl friend
April	P2 missing from placement found intoxicated and assaulted his care worker when she tried to take him back to the placement	Incident reported to the police	the care worker did not respond to police request for a statement
May	P2 missing from placement for 15 days	Strategy meeting to consider missing episodes	Referral made to youth Promise P2 allocated an intervention worker but could not be enrolled until end June -worker to undertake light touch support and rapport building
	Strategy Meeting	College courses to be explored for P2 Address checks to continue.	
	Strategy meeting	Alternate placements to be explored and risk assessment to be updated.	
	Police called to a disturbance at P1's home P2 involved in an argument with his maternal uncle	No crime detected No order to prevent P2 being at the property	P2 Recorded on the system as found but left with P1
	Police called to P1 property address following a third party report of a disturbance P1 alleged a young person seen leaving the property had threatened her with a hammer and made threats to kill P1 and P2 lied about his identity,	Two hammers were removed from P1's property.	A sighting report was added to the missing person record.
	Strategy Meeting	GP to support referral to CAMHS. P2 requested medication to help him sleep he had	



		been self-medicating with alcohol.	
June	Police called to P1 address, P1 alleged P2 had assaulted her by punching her to the face and alleged he was taking drugs.	P2 was arrested	P2 denied taking drugs but accepts drinking No further action P1 refused to co-operate incident not treated as a domestic incident.
	P2 assaulted two members of staff at his placement and made threats to burn down the unit.	Police not informed	
	P2 moved to a residential placement in his home area	P2's missing episodes continued	Debriefs conducted by support staff as police had no resources
	Strategy meeting	P2 assessed as at risk	Plan to move P2 out of his home area to safeguard
	Allegation of assault against P1 and P2	The incident was under investigation at the time of the murder. P2 returned to his placement with an injury to his hand that was treated in hospital	The victim did not respond to attempts to contact him This incident was filed Hospital made a referral to children's services.
	P2 arrested for murder		



Appendix E – Documents reviewed

Prosecution opening note

Sentencing remarks Trial Judge

Victim impact statement (Peter's daughter)

Post-mortem report

Pre -sentence report (P2)

Health trust Dual Diagnosis – Policy for the Care Treatment, Jun 2013 & Dec 2015

Health Adult Safeguarding policy

Strategy meeting minutes February to June 2023

Viability assessment P1 and MU (February 2022)

Letter from Dr C to Probation (January 2021)

CWPT Multi Agency Public Protection Arrangements (MAPPA) Policy, Date of Review 28/01/2022.

CWPT Safeguarding Adults Policy, Date of Review 01/11/2026. CWPT Violence Prevention and Reduction Policy (Including Positive Behavioural Approaches and Restrictive Practices), Date of Review 01/06/2023.

K Safeguarding Policy



Appendix F -Summary of completed work to address issues identified by the review for Probation.

The Court Case Audit Tool (C-CAT) has being rolled out across the region on, which will support Court supervising probation officers in completing Quality Assurance (QA) activities for report authors within their teams.

The current regional Court processes of requesting Police domestic abuse callout checks and Children's Safeguarding information are under review, The aim is to place the report author at the centre of making the requests to assist their preparation of pre-sentence reports

Additional training is being launched imminently across the region for new probation officers joining the service, in line with national recognition that the current package is inadequate. The additional modules include: '1) OASys - a run through of completing an OASys with a case study, looking at hands on good practice 2) Engagement and the professional practitioner – What is Effective Supervision, Working with those who Maintain Innocence, Minimisation & Blame, Power Dynamics, the Professional Relationship, Interviewing skills and 3) Enforcement – an overview of enforcement, legal principles and how to do this.'

In January 2023, the new 'Practitioner Dashboard' was introduced across the region, which allows all key performance data related to case management to be viewed on one platform. This can be used to quickly and accurately access data related to individual cases, which is useful in the event of any staff member being absent, for staff in managing and prioritising their tasks, and to supervisors using it to facilitate line management supervision with individual staff.

On 02/01/2024 the local office transitioned from 'Red' status on the Prioritisation Framework to 'Green'. This means operating to Probation National Standards.

The local office plans to introduce specialist Women specific teams, where all female cases will be managed by all female practitioners. This will ensure that the diversity needs of this cohort will be managed in line with Probation Service guidance.

The West Midlands continues to monitor and drive performance with respect of ensuring that ALL assessments of Curfew Requirement Suitability adhere to safer sentencing principles and Probation Service guidelines to ensure all risks are effectively managed.



Since January 2023, a 'Pre-Sentence Report Gatekeeping Form' and process was implemented via the National Court Strategy Group to provide a light touch quality assurance of all reports which was part of an action plan following a High Profile SFO.

With respect of information sharing agreements, there are no arrangements in place for Police to share arrest information with the local probation service, outside of those managed under specific multi-agency frameworks (MAPPA, Serial DA Perpetrator Forum, and Integrated Offender Management). These gaps are primarily attributed to resource implications for Police as well as sharing lists that will contain information related to individuals not subject to probation supervision, which would then potentially breach General Data Protection Regulations (GDPR). There are effective models of information sharing in other regions, which includes PSOs being co-located in Police stations and given access to daily arrest callout/lists, from which they identify those currently subject to probation supervision and share the relevant information with their supervising officers. The Head of Public Protection (HPP1) for the West Midlands recognized this as a key gap in practice, preventing effective risk management and had agreed to take the learning forward with her counterpart in the Police and explore how this issue could be addressed and progress is now being made in terms of a potential approach to daily sharing of all new arrests with probation.

HPP1 met with the Detective Chief Superintendent and Head of Public Protection for West Midlands Police on 25.10.2023 where learning from this case was shared. HPP1 relayed that she now understood that it would be the arresting officer who would be responsible for contacting the relevant Probation Office of any arrests, if there was a corresponding flag on the Police National Computer (PNC) alerting them to any current supervision. However, HPP1 relayed that this is only likely for License supervision cases following release from prison and that those subject to any form of community-based order may not be flagged in the same way, resulting in this gap in the information sharing process. The Detective Chief Superintendent has agreed to take this away to review their processes in this area. They have agreed to meet again to review the process and consider any potential actions for the Police, as well as the Probation Service, with regards to improving the information sharing in response to arrests or call outs that indicate escalating risks.

HMPPS Operational & System Assurance Group (OSAG) have produced a Court Case Audit Tool (C-CAT) to support Probation Regions to undertake local assurance activity. This activity is being monitored under the West Midlands Probation Quality Improvement Plan, which is targeted to improve the quality of practices in the areas of 'Assess, Protect and Change.' The C-Cat tool has since been piloted and is due



to be rolled out across the region on 1.11.2023.

Benchmarking exercises have been completed with the SPO group in preparation for this. SPOs will be expected to use the tool to audit 2 cases annually for each member of staff in their team.

Summary of next steps to address issues identified in the review:

Serious Further Offence action plan to be completed.

To ensure that the diversity needs of Women appearing before the Court and supervised by the Probation Service are allocated to female practitioners in line with the policy framework so that their diversity needs are fully considered.

To provide assurances that all PSR's being put forward to sentencers are underpinned by defensible risk assessments and proposals that prioritise public protection, through the implementation of the 'OASys Countersigning Framework (August 2021)' for all report authors.

To ensure Court staff receive line management supervision as required by Probation Service guidance, including reflective practice discussions/observations.

To ensure a supervision template specific to Court staff is created and implemented across the region to ensure that the agendas are clear, and activities relate to effective operational Court work.

