OWHR Review Report (England)

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

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

Birmingham City Council - Community Safety Partnership, West Midlands Police, Birmingham and Solihull Integrated Care Board

Case Reference Number: OWHR11

Pseudonym 1: V1

Victim 1

Pseudonym 2: P1

Perpetrator 1

Date of incident which led to the Review: November 2023

Date of death where applicable: November 2023

Review's start date (commissioned): 06/12/2023

Review completion date (approved and signed off): 25/11/2025

Publication date: Click or tap to enter a date.

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

This was a relatively straightforward review which could have been completed sooner. Whilst most agencies were prompt and efficient in providing the information requested, there were significant delays in receiving responses from Immigration, Housing and the Prison Service. Unforeseeable personal circumstances relating to Community Safety Partnership colleagues further compounded the delays.

Outline of circumstances resulting in the Review:

Notification

In the early hours of a morning in November 2023, West Midlands Ambulance Service called West Midlands Police (WMP) to report the stabbing of a male found slumped in a vehicle in Birmingham. Later that same day, the victim (V1) was pronounced deceased. Initial examination of the victim confirmed that he had received 2 stab wounds.

In accordance with the Offensive Weapons Homicide Review (OWHR) Statutory Guidance, Birmingham Community Safety Partnership commissioned an OWHR. The criteria for this Review are met under section 24 of the Police, Crime, Sentencing and Courts Act 2022 and the accompanying Regulations. Namely:

a. the death occurred in England
b. the person was aged over 18
c. the death involved the use of an offensive weapon
d. the body was located
e. the identities of both victim and perpetrator have been recorded
f. one or more of the review partners has information about the victim, and
g. this is not a 'death or serious injury matter' within the meaning of section 12(2A) of the Police Reform Act 2002.

Case background

This review relates to the murder of a 28 year old man (V1) by an acquaintance (P1). They had previously been arrested together in May 2023 for a cannabis grow robbery. A witness statement confirms that V1 and P1 had fought in the months preceding V1's death, and that V1 had chased P1 with a knife. No agencies reported prior knowledge of that incident.

Public source records report that on the night of V1's murder, CCTV footage showed P1 approach V1 and stab him twice. V1 was found seriously injured and was transferred to hospital where he later died. P1 handed himself into the police the following day. Whilst P1 claimed self-defence, he was found guilty of murder and sentenced to life imprisonment serving a minimum of 20 years.

In a family statement following his death, V1 was described as someone who 'brought smiles to everyone who knew him' and whose loss would be felt.

This OWHR should support local partners to jointly identify strategies for reducing future homicides. Partners, scope and methodology for the review are outlined at pages 12, 15 and 16.

Equality and Diversity:

	V1	P1
Age;	28	21
Disability;	Unknown	Unknown
Gender reassignment;	Not applicable	Not applicable
Marriage and civil partnership;	Not applicable	Unknown
Pregnancy and maternity;	Not applicable	Not applicable
Race;	Syrian/Arabic	Syrian/Arabic
Religion or belief;	Unknown	Unknown
Sex;	Male	Male
Sexual orientation;	Unknown	Unknown

Socio-economic disadvantage;

1. V1 and P1 were both Syrian nationals who sought, and were granted, asylum in the UK.
2. At the time of his death, V1 had no lawful basis to remain in the UK, though his refugee status also made him not liable for deportation.
3. Police records show periods where V1 was reportedly of no fixed abode.
4. Health records refer to depression, PTSD, self-harm, and suicidal ideation.
5. Immigration records suggest that during a Voluntary Returns Scheme (VRS) interview V1 expressed fear for his life if returned to Syria.
6. V1's record of offending behaviour includes 16 convictions for 25 offences between 2017 and 2023, 2 Community Orders and 2 custodial sentences.
7. No agencies were able to provide further relevant information on P1.

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

V1's only known relative in the UK is an uncle. His uncle was invited to participate in the review. He declined, though appreciated the work of the panel. Immigration records show that V1 referred to a father and siblings living in Syria. We did not contact them. There was also an ex-partner whom Police recommended we should not contact for reasons of trauma.

There was no contact with P1 or his family despite attempts.

Family History and/or Contextual Information:

V1 was a Syrian national, born in Damascus, Syria. He arrived, illegally, in the UK (Kent) in August 2015. He was 20 years old. He claimed, and was granted, asylum and had leave to remain until November 2020.

From V1's arrival in 2015 through to his death in 2023, there were repeated references to depression, self-harm, PTSD, substance abuse and suicidal ideation.

Between 2017 and his death in 2023, V1 was convicted for 25 offences, received 2 Community Orders and 2 custodial sentences. He had an extensive footprint across police force areas in the West Midlands, London, Oxfordshire, Northamptonshire, Hertfordshire, Surrey and Nottinghamshire.

In August 2020, V1 applied for settlement in the UK - essentially to renew his leave to remain. However, he failed to enrol his biometrics despite a number of warning letters and enforcement notices issued between January and October 2021. This finally resulted in V1's settlement application being rejected in November 2021. He no longer had permission to work in the UK nor recourse to public funds.

In January 2022, monthly immigration bail reporting arrangements were instigated. V1 confirmed that he had not submitted a new application for settlement and did not have representation to do so. V1 failed to attend future reporting.

In May 2023, the Voluntary Returns Scheme team (VRS) contacted V1 to explore options for him to voluntarily return to Syria. Their records show that, whilst expressing a desire to *'go back home and see his family'*, he feared that he would be killed – like his brother - if he returned to Syria.

In August 2023, the Immigration Compliance and Enforcement team (ICE) required V1 to attend a first reporting event (FRE) - the purpose of which is to ensure that those without leave to remain in the UK stay in close contact with the Home Office to enable case progression. V1 did not attend his FRE. By the time follow up action was initiated in November 2023, V1 was already dead.

At the time of his death, V1 was in the unenviable position of neither having leave to remain in the UK, nor meeting the criteria for deportation. He therefore had no right to work and no recourse to public funds.

Whilst there is none of the usual evidence of V1 being at risk of becoming a victim of a homicide involving an offensive weapon (e.g. gang involvement, school

exclusion, family background etc.), it is difficult not to conclude that his offending behaviour, uncertain immigration status, and poor mental health **were** significant factors that could have sounded warning bells.

No agencies were able to provide relevant information on P1 beyond the fact that he had lived in supported housing, and that he and V1 were arrested together in May 2023 for a cannabis grow robbery.

Agency Timeline:

Aug 2015: V1 arrives clandestinely and is held in Kent. He claims asylum.

Sep 2015: Transferred to accommodation in Scotland.

Nov 2015: Asylum interview conducted – mention of safeguarding concerns. Asylum and leave to remain granted.

2017-2019: Various arrests on suspicion of handling stolen goods, drugs and theft.

Aug 2020: V1 submits an application for settlement to the Home Office.

Jan 2021: V1 is serving an 11 month custodial sentence and Prison Service refers his case to the Foreign National Offenders Return Command (FNORC) for assessment for removal. Assessed as not meeting deportation criteria as he holds refugee status.

Jan 2021: V1 advised that his application for Indefinite Leave to Remain (ILR) will not be addressed within the anticipated 6 month timescale.

Jan 2021: V1 receives a warning letter regarding potential future deportation due to ongoing criminality.

Mar 2021: V1 erroneously served a RED.001 notice that he is liable for removal/ deportation when in fact his live ILR application naturally extended his refugee leave under Section 3C of the Immigration Act 1971.

June 2021: V1 advised by email of the need to register his biometrics in order for his application to proceed. Follow up letter sent in September.

Oct 2021: V1 in prison and again referred to FNORC for assessment for removal. He is again assessed as not meeting deportation criteria.

Nov 2021: Settlement application rejected for failure to enrol biometrics.

Nov 2021: V1 registers with a GP practice in London following an arrest – noted to suffer with low moods and depression, traits of PTSD and suicidal ideation.

2022: V1 arrested by the police 4 times on suspicion of vehicle interference, criminal damage, assault/domestic violence, and threats to kill. He is also stopped, but not arrested, when driving a stolen vehicle with only a provisional licence. And in December 2022, he is identified as the perpetrator of an actual bodily harm assault on a security doorman at a nightclub.

Jan 2022: National Command and Control Unit (NCCU) refers V1's case to ICE.

Jan 2022: Monthly immigration bail reporting instigated. V1 confirms that he has not submitted a new application for settlement and does not have representation to do so. V1 fails to attend future reporting.

Mar 2022: V1 threatens to kill himself whilst in custody.

Aug 2022: V1 sentenced to a 12 month Community Order, and later a 6 month Community Order. Both are managed by London Probation Service.

2023: V1 arrested 5 times on suspicion of burglary, possession of firearms, suspicion of theft, possession of class B drugs, and theft of a motor vehicle.

May 2023: V1 and P1 arrested for a cannabis grow robbery in Hertfordshire.

May 2023: VRS team interview V1 – he states that he fears for his life if returned to Syria. ICE set up reporting arrangements.

May 2023: Department for Work and Pensions approach Home Office in relation to V1's application for a Personal Independence Payment. Home Office confirm that V1 is *'not present in the UK with legal status, nor with access to public funds'*.

Aug 2023: V1 fails to report for his FRE meeting with ICE.

Aug 2023: Universal Credit report concerns for V1 who fails to attend his appointment and reports having suicidal thoughts.

Oct 2023: V1 appears at Oxford Magistrates Court for 3 offences, including one of possessing a bladed article – to which he pleads not guilty.

Oct 2023: V1 registers with Birmingham GP practice following ankle injury but never attends surgery.

Nov 2023: V1 is murdered.

Nov 2023: P1 hands himself in to the police.

2024: Unanimous finding of guilt for murder, 20 year sentence handed down.

Practice and Organisation Learning

This review examined the very sad case of a young Syrian asylum seeker (V1) who arrived in the UK aged 20 with existing safeguarding concerns. Within 2 years of his arrival V1 was known to the police, and his offending behaviour increased until the time of his death. Because of his immigration status, he was also known to the Immigration Service. However, beyond those 2 agencies, there was very little information available about V1. His contact with the local authority, housing and health services was extremely limited and provided little to no insight. The perpetrator (P1) was also a Syrian asylum seeker. Whilst we know that V1 and P1 knew each other as they were arrested together in May 2023 – beyond that, no agencies were able to provide any relevant information on P1. As such, the learning from this review is limited, and largely based on the records of V1's interactions with the Police and Immigration services.

Good practice

1. **Safeguarding records:** Immigration, Health and Police all clearly documented safeguarding concerns relating to V1's mental health, PTSD, self-harming, suicidal ideation etc.
2. **Safeguarding assessment:** Police ensured that V1 was assessed by the liaison and diversion team whilst in custody in London, and he was given contact details for his local crisis line and support services and advised to contact his GP if he wanted to discuss medication or talking therapies.
3. **Safeguarding referral:** Police offered and sourced support for mental health and drug misuse from outside agencies whilst V1 was in custody. They also referred V1 to DIVERT (a custody-based intervention programme) for his cannabis use.
4. **Continuity:** When V1 moved from London to the West Midlands, his London Probation Officer continued to manage his Community Orders, offering a degree of continuity.

Organisational learning

1. **Safeguarding:** Whilst Immigration recorded safeguarding concerns for V1 at an early stage, there is no evidence of any action taken to address those safeguarding concerns. On reviewing their interactions with V1, the Asylum Chief Caseworker commented that ***"each arrest/incident of involvement with the police appears to have happened post-decision…It doesn't look like we've taken any actions re: safeguarding post-decision."***. Whilst correlation is not necessarily evidence of causation, it is reasonable to posit that had appropriate action been taken to address V1's safeguarding issues, V1 might not have been participating in criminal activity that put him at increased risk and ultimately ended in his death.
2. **Inconsistency:** Throughout 2021, there appear to have been conflicting messages from within Immigration Services – warning letters and a RED.001 enforcement notice confirming that V1 was liable for removal were issued, and there is a record of initial work to begin administrative removal of V1 from the UK. Yet during that same period, FNORC twice confirmed that V1 did **not** meet deportation criteria. This arguably suggests that the various arms of Immigration Services (ICE, VRS, FNORC, NCCU, Returns Preparation) were not coordinated and had limited options available to them when dealing with offending overstayers who could not be deported. The mixed messages may also have caused unnecessary confusion and anxiety for V1 – potentially further affecting his poor mental health, his failure to engage and/or fuelling his risky behaviour.
3. **Interventions:** Whilst most of V1's offending within the West Midlands Police (WMP) area was 'low-level' (e.g. cannabis possession), there were still some missed opportunities where better or faster interventions might have resulted in very different outcomes - for example:
    a. In November 2022, Central Motorway Policing Group officers stopped V1 whilst he was driving a stolen vehicle without a full driving licence. Inexplicably, V1 was not arrested on suspicion of theft of the vehicle. Had action been taken, it might possibly have disrupted V1's offending behaviour.
    b. In December 2022, V1 was identified as having assaulted a doorman at a night club. It took 10 months to arrange for V1 to be interviewed and at the time of his death, V1 had still not been interviewed. Had the incident been managed more efficiently, the victim would have received justice, and V1 might not have been on the streets at the time of his death in November 2023.

c. In July 2023, V1's fingerprints were located in a stolen vehicle linked to a firearms incident and it was later confirmed that his DNA was on the firearm. Whilst the investigation was completed to a high standard and in accordance with the relevant nationally agreed SLAs, V1 was already dead by the time the DNA was confirmed. Had the DNA results been known sooner, V1 might not have been on the streets at the time of his death.

WMP recognise the need to improve their standards of investigation and following a June 2023 inspection by His Majesty´s Inspectorate of Constabulary and Fire and Rescue Services, they have committed to addressing this through an improvement plan - Operation Vanguard.

4. **Follow-up:** On multiple occasions, V1 failed to comply with reporting requirements/arrangements and appointments (Courts, Health, Immigration, Probation, DWP etc.). If agencies had the capacity to systematically follow up on missed appointments, the outcome for V1 might have been very different.
5. **Joining-the-dots:** Partners followed procedures to share relevant information, but they could not reasonably have known that V1 was at risk of becoming the victim of a homicide involving an offensive weapon. Despite the early safeguarding concerns and V1's repeated failure to engage with support services, diversionary alternatives, health and immigration - his interactions with relevant partners were most often as an offender, not a victim. It is perhaps unsurprising that those flags were not recognised as potential warnings.
6. **General:** A number of partners highlighted that time and resource pressures make it increasingly necessary for them to prioritise their interventions, which means that even though there may be early safeguarding concerns and flags (such as a failure to engage), those concerns will not be addressed until or unless they become acute.

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

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

Home Office

1. Review, strengthen, and clearly communicate both the strategy and arrangements for managing those who are in the UK without leave to remain yet do not meet the criteria for deportation. Someone with no right to work

nor access to public funds, is predictably at heightened risk of engaging in criminal activity that negatively affects the wider community.

2. Improve systems for sharing information and coordinating action between those agencies (e.g. Immigration, Department for Work and Pensions, Housing, Probation, Police, Prisons etc.) working with asylum seekers in order to improve the support, decision making and outcomes for asylum seekers and the communities within which they live.
3. Consider whether earlier intervention and better support should be provided for young, vulnerable, unaccompanied asylum seekers (e.g. coordinating and resourcing early access to appropriate mental health services, support to renew ILR applications etc.) to reduce the likelihood of them engaging in risky offending behaviour.

Immigration Service

4. Review the training of staff who assess asylum seekers and ensure that they can consistently identify and record safeguarding and/or welfare concerns that make individuals more vulnerable (e.g. drugs, mental health etc.).
5. Record the follow up actions required to address welfare concerns and allocate them to named owners. Ensure that welfare concerns and actions form an integral part of the asylum seeker's immigration record/case file. This should lead to greater transparency and allow for better visibility and attention to safeguarding actions – ensuring that they do not get lost or relegated.
6. Review the role of immigration key workers to include:
    a. Acting as the central repository for information about asylum seekers, on which other agencies can rely for the coordination and sharing of relevant information.
    b. Proactively confirming the whereabouts and welfare of asylum seekers who fail to comply with requirements (e.g. completing applications for ILR, attending reporting events etc.).
    c. Actively encouraging and supporting claimants to regularise their immigration status.
7. Ensure that ATLAS (the platform used by Immigration) is accessible to, and systematically used by, **all** departments/teams likely to be involved in the case management of asylum seekers (ICE, VRS, FNORC, NCCU etc.). This should ensure that all those handling a case are fully aware of the actions being taken by other teams and reduce opportunities for duplication and

contradictory messaging to claimants (e.g. issuing warning letters and RED.001 notices to those who clearly do not meet deportation criteria).

Police

8. Monitor and evaluate the effectiveness of Operation Vanguard in improving investigation standards, with particular emphasis on improved outcomes for victims.

Dissemination

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

Date circulated to relevant policy leads: 17/09/2025

Organisation	Yes	No	Reason
Single Competent Authority	☒	☐	Click or tap here to enter text.
West Midlands Police	☒	☐	Click or tap here to enter text.
NHS Birmingham and Solihull Integrated Care Board	☒	☐	Click or tap here to enter text.
Change Grow Live	☐	☒	N/A
Birmingham City Housing/ Sustain Housing	☐	☒	N/A
Immigration Services	☒	☐	Click or tap here to enter text.
Probation Service	☒	☐	Click or tap here to enter text.
Prison Service	☒	☐	Click or tap here to enter text.

OWHR process

- The panel met on 4 occasions.
- Between meetings, information was gathered to complete the initial scoping document and the more comprehensive Individual Management Review documents (IMRs).
- Meetings were used to clarify and pursue lines of enquiry arising from the IMRs.
- Between meetings, attempts were made to reach out to family members and others (e.g. Probation) with relevant material or information to contribute.
- The draft report was scrutinised by both the panel and the Community Safety Partnership's Strategic Oversight Board.

Review Panel Members

Organisation
Independent Reviewer/ Author
City Council (Community Safety Partnership)
Social Housing
West Midlands Police Service
Home Office/Immigration
Birmingham and Solihull Integrated Care Board

Specialist support

We additionally approached 5 voluntary organisations with experience of working with refugees and asylum seekers. We received only 1 response from Asylum Matters.

Final confidence check

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

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

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

Statements of Independence

Statement of Independence by Chair: Please read and sign the following statement. Consider the section on independence in the OWHR Statutory Guidance before completing.
Chair 1: Charmaine Arbouin
Statement of independence from the case I make the following statement that prior to my involvement with this review: • I have not been directly involved in the case or any management or oversight of the case. • I have the appropriate recognised knowledge, experience and training to undertake the review. Therefore, I have met the criteria of an Independent Chair. • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference. I recognise that the purpose of this is to identify learning from the case, not to attribute blame to practitioners or agencies. • I have read and understood the equality and diversity considerations and will apply accordingly.
Please set out below how you meet paragraphs 3.14 – 3.19 of the OWHR guidance *Guidance: Explain the independence of the chair and give details of their career history and relevant experience. Confirm that the chair has had no connection with the relevant review partners or local oversight process for this review. If they have worked for any agency previously state how long ago that employment ended:* I am independent from the criminal investigation and the background of the case. I have no prior connection with the relevant review partners or the local oversight process for this review. I have been trained in delivering OWHRs and have experience of reviews in the wider public and voluntary sectors. I have over 25 years' experience of inspecting public services for quality, efficiency, effectiveness, and value for money. I have reviewed working practices to improve customer access to services; contributed to a national review of local government in Jamaica; and reviewed high profile consular cases, parole requests and serious police complaints and conduct matters. I have performed lead inspector, special advisor, sole reviewer and panel member roles. I have senior stakeholder and

community engagement experience; and am accustomed to communicating clear, evidence-based recommendations for continuous improvement in services.
Signature: *C. Arbouin* **Name:** Charmaine Arbouin **Date:** 28/09/2024

To be completed by the Home Office:

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

Scope/Terms of Reference

Timeline:

We initially agreed to look at the 23 months preceding V1's death – January 2021 to November 2023. As the information gathering progressed, it became clear that

1. partners held very little information on V1 and P1, and
2. some information dating back to V1's initial arrival in the UK in 2015 might be relevant.

As such, there is some reference to key events outside of the 23 months immediately preceding V1's death.

Terms of Reference:

1. We adhered to the suggested headings and questions outlined in the Offensive Weapons Homicide Reviews: Statutory Guidance
    a. Referral and assessment
    b. Services offered
    c. Outcomes and outputs
    d. Information sharing
    e. Potential learning
2. We additionally focused on identifying:
    a. Any factors that may have made it harder for those working with the victim to reduce the risk of violence to begin with.
    b. What can be done differently at an agency and system level to prevent future homicides and reduce serious violence.
    c. Areas of good practice and successful interventions which could be incorporated into general processes and system responses.
    d. Engagement, and any barriers to engagement, with agencies between November 2020 and V1's death (including London based agencies).
    e. Assessments of needs and vulnerabilities conducted by those agencies.
    f. Support offered and received by those agencies.
    g. Whether agencies, in particular the police, recognised a pattern to V1's previous risky behaviour that may have been an indication of future dangerous behaviour or endangerment.
    h. Any referrals to other sources of support.

i. Any additional issues/vulnerabilities specifically arising from V1 & P1's immigration status, and the extent to which agencies were equipped to respond to them.

j. Whether the policies, processes, services, and treatment were appropriate, effective, and provided in a timely manner.

k. Any lessons learned/suggestions for improvement.

Acronyms

DWP	Department for Work and Pensions
FNORC	Foreign National Offenders Return Command
FRE	First Reporting Event
GP	General Practitioner
ICE	Immigration Compliance and Enforcement
ILR	Indefinite Leave to Remain
IMR	Individual Management Review
NCCU	National Command and Control Unit
OWHR	Offensive Weapons Homicide Review
PTSD	Post Traumatic Stress Disorder
SLA	Service Level Agreement
SUSR	Single Unified Safeguarding Review
VRS	Voluntary Returns Scheme
WMP	West Midlands Police