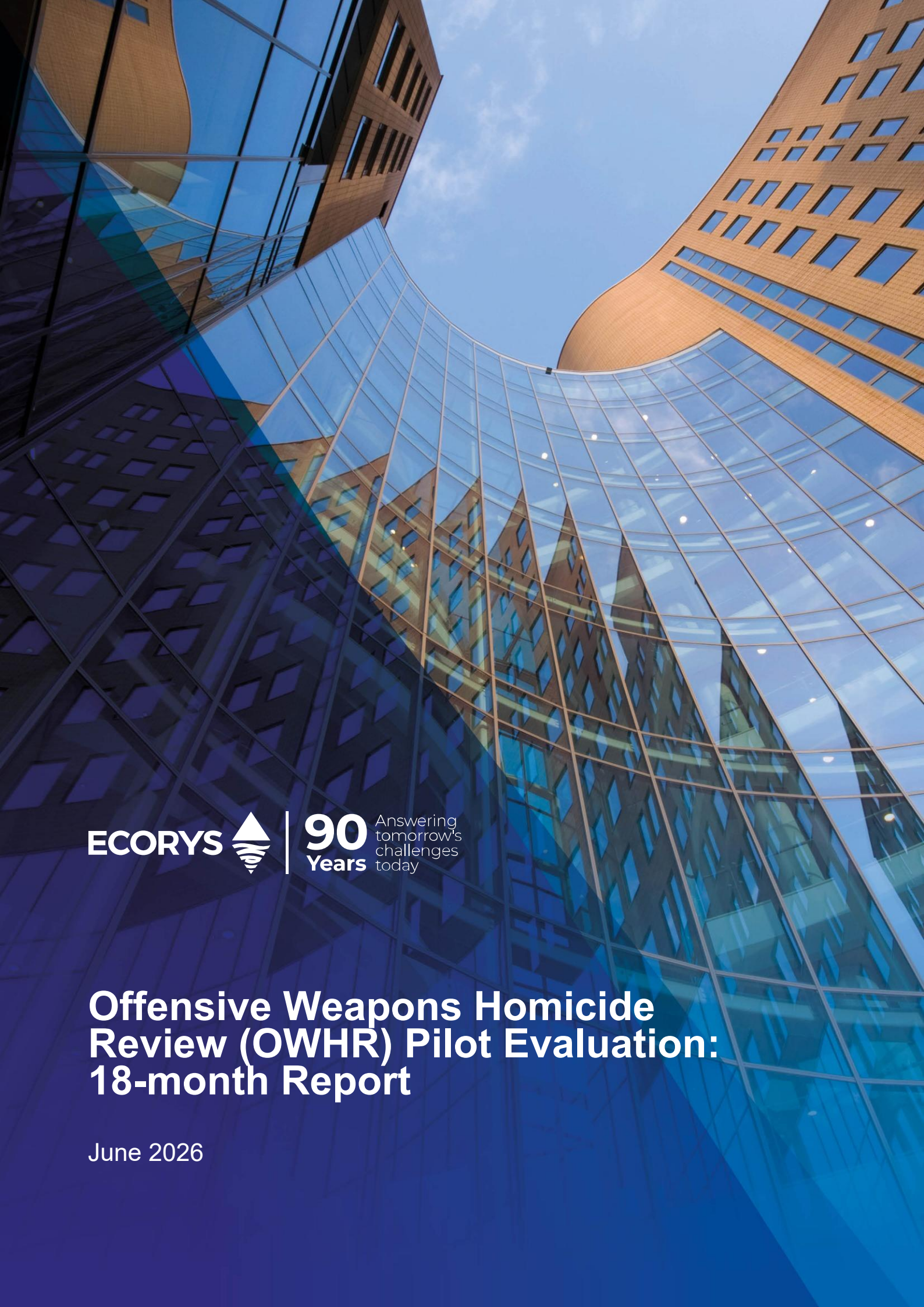

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Offensive Weapons Homicide Review (OWHR) Pilot Evaluation: 18-month Report

June 2026

Ecorys

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List of Abbreviations

ADHD	Attention-Deficit / Hyperactivity Disorder
CSP	Community Safety Partnership
CSPR	Child Safeguarding Practice Review
DHR	Domestic Homicide Review
FLO	Family Laison Officer
IC	Independent Chair
ICB	Integrated Care Board
KLOE	Key Line of Enquiry
LA	Local Authority
MHHR	Mental Health Homicide Review
OWHR	Offensive Weapons Homicide Review
QA	Quality Assurance
RCT	Rhondda Cynon Taf
RRP	Relevant Review Partner
RSB	Regional Safeguarding Board
SEND	Special Educational Needs and Disabilities
SIO	Senior Investigating Officer
SUSR	Single Unified Safeguarding Review
SWP	South Wales Police
ToC	Theory of Change
VPU	Violence Prevention Unit
VRP	Violence Reduction Partnership
VRU	Violence Reduction Unit

Acknowledgments

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Executive Summary

Policy and Evaluation context

The Offensive Weapons Homicide Reviews (OWHRs) pilot was launched by the Home Office on 1st April 2023 in specified areas within three pilot regions: London (Barnet, Brent, Harrow, Lambeth, and Southwark), South Wales (Swansea, Neath Port Talbot, Bridgend, Rhondda Cynon Taf, Merthyr Tydfil, Cardiff, The Vale of Glamorgan), and the West Midlands (Coventry and Birmingham). OWHRs were developed to provide formal learning opportunities from qualifying homicide cases that were not previously subject to existing reviews. The qualifying criteria include, but were not limited to, homicides committed in a pilot area, likely to have involved an offensive weapon, and where the victim was older than 18.

The Home Office commissioned Ecorys, in partnership with the University of South Wales (USW), and the University of Hull (UH) to undertake a process evaluation of the pilot. The overarching aims of the evaluation are to assess the effectiveness of the implementation of the pilot and to produce recommendations for a potential national roll-out. The process evaluation follows a mixed methods approach, collecting and analysing quantitative and qualitative data to understand and assess the pilot.

This document is the final (18-month) report presented to the Home Office in February 2025, outlining key findings and recommendations about the OWHR pilot. The evaluation was informed by three waves of interviews with stakeholders, quantitative quarterly data collected from all pilot areas, and an online survey with key stakeholders.

Overview of the OWHR pilot

- 26 cases qualified for an OWHRs: 13 in London, 11 in West Midlands, and 2 in Wales. 5 cases were also considered and deemed out of the scope of the pilot.
- 25 Independent Chairs (ICs) were recruited to conduct reviews. Overall, 20 out of 25 ICs were commissioned to carry out OWHRs, with all 26 OWHRs being led by an IC.
- 4 members of an OWHR Oversight Board have been recruited and in place to receive and review completed OWHRs.
- OWHRs involved 27 victims and 41 suspects/ alleged perpetrators, most victims/ alleged perpetrators were male, but were of various ages, ethnicity backgrounds, and other characteristics such as known mental health diagnosis, special educational needs and disabilities (SEND), etc.
- Most cases (62%) were decided that they qualify for OWHRs within the first month of the homicide (meeting the set targets), however many OWHRs experienced delays in notifying the Secretary of State of the decision and to commission/start the reviews.
- OWHRs were suggested to be completed within 12 months from the decision to carry out the review, however at the completion of the pilot they are at very different stages across pilot areas. Those that commenced early in the pilot period are being completed or close to the end of the

review process, while others started more recently and are expected to be completed after this evaluation period.

Governance

- Across London and the West Midlands, the lead agency for all OWHRs was decided locally to be the local authority (LA), and specifically within the Community Safety Partnership (CSP). Although the legislation provides flexibility for other organisations to take on the role. In Wales (in line with the SUSR guidance) OWHRs are coordinated with the support of the Regional Safeguarding Board (RSB).
- Stakeholders agreed that LAs are the right Relevant Review Partner (RRP) to be lead agencies. However, some stakeholders suggested that the police may be a more appropriate lead agency due to their knowledge and understanding of homicide.
- The existing RRPs (LA, Police, and Health partners) were considered the right partners to be the RRPs. Some agencies that are appropriate bodies under the existing guidance were discussed as potential partners to be included as RRPs. However, these suggestions were grounded in experiences of stakeholders facing barriers when requesting information from these agencies.
- Local oversight processes varied across areas. In West Midlands a steering group and strategic oversight group provided this, in Wales this fell within the SUSR structure, while London had no official pan-London oversight but set up partnership meetings which facilitated the process. Flexibility in the local oversight process resulted in some confusion, which pointed to the need for clearer terminology and guidance on roles and responsibilities within OWHRs.
- The role of the OWHR Oversight Board has been limited, with only a small number of OWHRs submitted for review to the Board before publication, but it is expected to play a bigger role as more reviews are completed.

Establishing reviews

- Overall, stakeholders thought that the criteria for qualifying homicides are straightforward and easy to apply; however, one area of confusion was how to decide which type of review to commission where the offence appears to meet criteria for multiple reviews.
- Stakeholders expressed concerns about the age criteria for OWHRs and feel that a lot of learning around serious youth violence is being missed because of the current age threshold.
- The process for commissioning ICs for OWHRs has gone well, and stakeholders agreed that ICs are integral to the independence of the OWHR process. Pilot areas implemented different approaches to appointing ICs, with West Midlands and London implementing streamlined approaches. OWHRs in Wales were led by either one paid chair and two statutory sector reviewers, or one statutory sector chair and one paid reviewer, as per SUSR guidance.

Conducting reviews

- RRPs and ICs (and reviewers) have overall worked well to gather evidence from all relevant agencies to conduct the reviews. The following challenges were however identified: lack of familiarity, ownership, and/or understanding of statutory responsibilities, bureaucratic barriers,

lack of clarity in requests for information, low quality of responses to requests for information, and lack of information on victim/s and/or perpetrator/s.

- OWHRs are being successfully implemented in parallel with criminal investigations or other investigative processes. A challenge was identified where ICs were not able to speak to some perpetrator/s who are in prison and/or are appealing their conviction. OWHRs also worked well with parallel Mental health Reviews, where certain processes were streamlined.
- Participants agreed that it can be very difficult for families to engage in an OWHR. Stakeholders expressed the view that the point in the process that the families are approached needs to remain flexible and the bereavement journey considered.

Following the completion of reviews

- Each pilot area implements their own quality assurance (QA) process. As OWHRs are in various stages, with only a few at the QA stage, there is limited evidence about how well the processes have worked, however there are plans in place in each area.
- At the time of writing this report, none of the OWHRs had reached the stage of formally communicating recommendations to relevant agencies, however they have made plans on how they aim to share learning.

Factors affecting the implementation of the process

- There were mixed views in terms of the ability to effectively deliver OWHRs within the suggested timescales, as some reviews experienced delays. The key factors affecting timescales were delays in IC engagement with the process, balancing existing workloads, delays in receiving responses to requests for information from partners/agencies, and case complexity requiring greater or more complex information to be acquired.
- Staff capacity has been identified as the biggest challenge to OWHR delivery; additional challenges were also flagged around ensuring sufficient funding for ICs to deliver OWHRs in relation to wider aspects such as insurance costs.
- OWHR guidance and supporting materials were overall helpful in delivering OWHRs, however pilot areas made certain adaptations based on local context. This included adapting templates such as evidence gathering and referral forms, the report template, and letters to families.
- OWHRs have been working well within the SUSR framework, with certain benefits identified (centralised review process ensures consistency across reviews and learning events), as well as some challenges (running the OWHR and SUSR pilots at the same time and need for additional clarity on the grant award process)

Benefits and perceived outcomes

- Stakeholders agreed that OWHRs are filling the gap left by other statutory reviews. However, they expressed concern that OWHRs are still missing homicides due to peer-on-peer violence where the victim is under 18. They also emphasised the need for the evidence from OWHR reviews to be collated and used effectively.

- Stakeholders felt that there is great potential for OWHRs to contribute to preventing offensive weapons homicides, however that there has not yet been evidence of this during the pilot period as this is expected to materialise in the longer-term.

Emerging recommendations from reviews

- A range of recommendations have emerged from OWHRs so far, as evidenced by reviewing draft and summary OWHRs, as well as interview evidence. These included improvements in: policies and services related to youth crime prevention, information sharing and collaboration across agencies, support and services for vulnerable populations, support of young people (18-25 years old), education and training for professionals working with young people and vulnerable populations, safeguarding in housing and support of vulnerable target groups, local risk assessment processes, and the OWHR statutory guidance to facilitate the process.

Conclusions and recommendations

- The pilot has demonstrated significant potential in addressing gaps left by other statutory review processes, offering a comprehensive examination of homicides involving offensive weapons.
- Based on the evidence gathered in this evaluation, the following recommendations should be considered for a potential national rollout of OWHRs:
  - Establish clear governance structures
  - Enhance the appointment process for ICs
  - Improve information sharing and gathering
  - Review and adapt guidance, particularly to further facilitate family involvement, to improve how parallel investigations are addressed, and to promote learning and dissemination
  - Ensure adequate resourcing
  - Pilot rapid and extended reviews
  - Monitor and evaluate implementation

1.0 Introduction

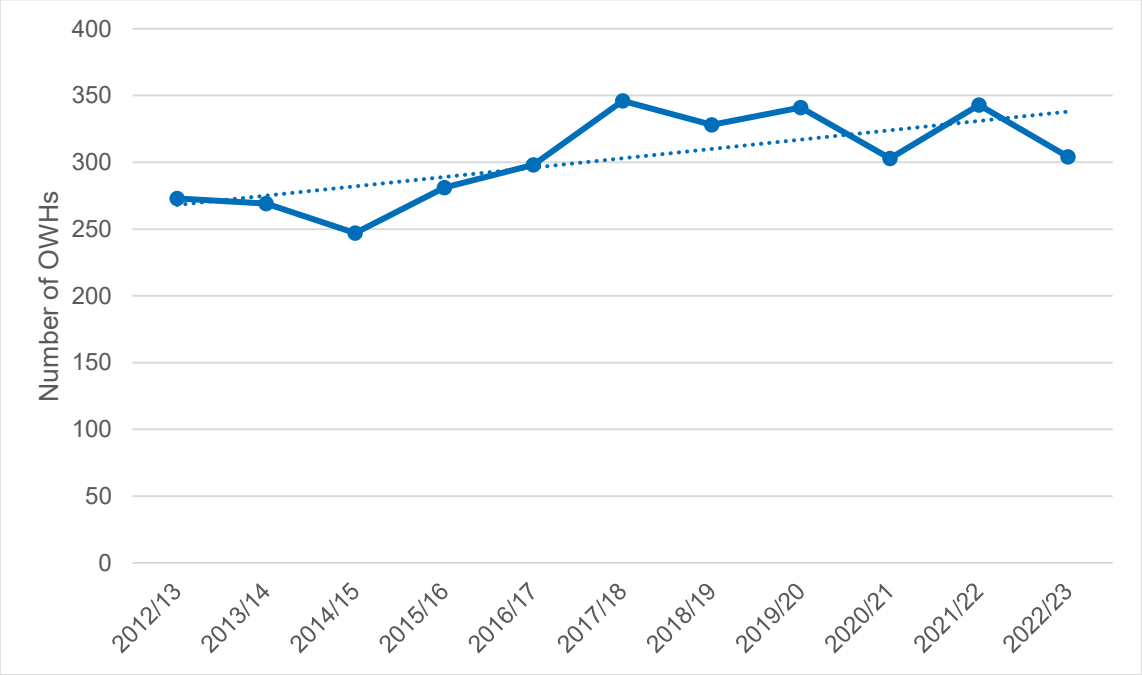
Ecorys, in partnership with the University of South Wales (USW) and University of Hull (UH) have been commissioned by the Home Office to deliver a process evaluation of the Offensive Weapons Homicide Reviews (OWHRs) pilot.

This document is the **final** (**18-month) report** to the Home Office, containing data and evidence regarding the entire course of the pilot. The report outlines the final findings of this evaluation, as well as key conclusions and recommendations for further development of OWHRs and a potential national roll-out.

1.1 Policy context

Homicides involving offensive weapons have been rising over the past decade and make up around half of overall homicides (347 out of 696 in 2021/22), as shown in Figure 1. While many types of other reviews exist (Domestic Homicide reviews, Child Death Reviews, etc.), it was estimated that more than half of overall homicides (483 out of 696 in 2021/22) did not meet the criteria for these. Many of those that did not meet the criteria for existing reviews involved an offensive weapon (220).

Figure 1 Offensive Weapons Homicides trends in England and Wales



Source: Ecorys analysis of Homicide Index data

To address this gap, the Police, Crime, Sentencing and Courts Act 2022 (PCSC Act) introduced the Offensive Weapons Homicide Reviews (OWHRs) as well as its pilot. OWHRs aim to ensure that when a homicide takes place in a pilot area, where the victim is over 18, which involved or was likely to have involved an offensive weapon, meets the qualifying criteria, and a relevant statutory homicide review is not already considered, local partners identify lessons from the death, consider whether any action should be taken as a result, and share the outcome to help tackle homicide and serious violence.

1.2 The OWHR pilot

The OWHR pilot launched on 1st of April 2023 and concluded as planned after 18 months, on the 30th of September 2024. OWHRs were piloted in the following areas:

- **London:**
  - Metropolitan Police Force covering the London Boroughs of Barnet, Brent, Harrow, Lambeth, and Southwark.
  - Local Authorities for the London Boroughs of Barnet, Brent, Harrow, Lambeth, and Southwark.
  - Areas of the NHS Northwest London, NHS North Central London and NHS Southeast London Integrated Care Boards within the London Boroughs of Barnet, Brent, Harrow, Lambeth, and Southwark.
- **West Midlands**
  - West Midlands Police Force covering the areas of Birmingham and Coventry Local Authorities.
  - Areas of Birmingham Local Authority and Coventry Local Authority which fall within the West Midlands Police Force area.
  - Areas of NHS Coventry and Warwickshire Integrated Care Board and NHS Birmingham and Solihull Integrated Care Board which fall within the local authority areas of Birmingham and Coventry and the geographic area covered by West Midlands Police Force.
- **Wales:** the geographic area covered by South Wales Police which includes the following organisations
  - South Wales Police.
  - Local Authorities for Swansea, Neath Port Talbot, Bridgend, Rhondda Cynon Taf (RCT), Merthyr Tydfil, Cardiff, The Vale of Glamorgan.
  - Local Health Boards for Swansea Bay University Health Board, Cwm Taf Morgannwg University Health Board, Cardiff and Vale University Health Board.

OWHRs are carried out by the **'Relevant Review partners' (RRPs)**, which are:

- The chief officer of police for the police force area in England or Wales.
- The local authority, or authorities.
- The integrated care board or, in Wales, the local health board.

OWHRs also include a local oversight process as well as the OWHR Oversight Board (national level), to ensure the effective implementation of reviews in the pilot areas.

A homicide of a person over 18 years of age, that takes place within a pilot area, that involves or is likely to have involved an offensive weapon, and which meets the qualifying criteria is eligible for an OWHR[1]. The pilot allowed for cases that happened in the first 9 months of the pilot to qualify and proceed as OWHRs. The second half (9 months) of the pilot was focused on delivering and completing OWHRs. OWHRs were suggested to be completed within a period of 12 months from the date the decision was made to carry out the review.

[1] More information regarding the qualifying criteria can be found in the published statutory guidance for OWHRs: Offensive weapons homicide reviews: statutory guidance (accessible version) - GOV.UK

1.3 The evaluation

The evaluation aimed to assess the implementation and perceived effectiveness of OWHRs over the pilot. The evaluation used a mixed-methods approach, utilising both quantitative and qualitative evidence for analysis. Separate reports have been produced every quarter (3 months) with key findings from quantitative and qualitative analysis. This reporting was used to keep the Home Office up to date with the latest findings and lessons emerging from the pilot, which informed course correction measures if needed.

This final report aims to consolidate all the findings and lessons learned from the entire course of the pilot, and produce evidence-based recommendations about the continuation of OWHRs to the Home Office. The following sections outline the methodology of the evaluation, research and data collection activities, findings, conclusions and recommendations.

1.3.1 Evaluation methodology

This section outlines the analytical approach developed and used to assess the effectiveness of the implementation of the OWHR pilot. This comprised several data collection methods to facilitate a process evaluation.

Analytical approach

As part of the inception phase of the evaluation, we developed key research tools such as a **Theory of Change (ToC)** and an **analytical framework** (see Annex A). These provide the foundation for the evaluation, guiding research activities/tools and reporting.

During the inception phase of the evaluation (before the pilot commenced), we also engaged with the pilot areas to introduce the evaluation team, establish relationships, and consult them to ensure the evaluation plan and approach are well informed by local context. Since then, we frequently joined meetings with the pilot areas as observers, as well as to inform them of the planned evaluation activities.

As part of our analytical approach, we set out the following key overarching **Research Questions (RQs)**:

1. How effectively are OWHRs implemented in the pilot areas?
2. Are there differences in the implementation of OWHRs across the pilot areas?
3. What are the emerging challenges, barriers and best practices relating to the OWHR pilot?
4. Are there any lessons learned that could be adapted to a potential national roll-out?
5. What are the perceived (emerging) benefits of OWHRs?

This report provides evidence to answer each of the above questions.

Data collection

We made use of different **quantitative** and **qualitative** data collection methods, to ensure that key findings and lessons learned were captured during the pilot. Evidence collected was analysed to

produce recommendations to the Home Office regarding possible improvements to the pilot and the potential for a national roll-out.

In the below table, we summarise our approach to data collection for the evaluation, which aims to inform our understanding of the pilot implementation at the programme-level, as well as allow us to dive deeper into case-studies:

Programme-level understanding	Case-level understanding
▶ Desk review and initial consultations ▶ Quantitative data monitoring ▶ Financial data collection ▶ Online survey	▶ Interviews ▶ Observational visits ▶ Document review

The research included several data collection activities, namely desk review of key documents, quantitative (quarterly) data monitoring, an online survey, observational meetings with partners, and interviews with key stakeholders, and analysis of secondary quantitative data.

Quarterly quantitative data

During the first months of the evaluation, we established a **quarterly data collection system** to monitor key outputs regarding the effectiveness and efficiency of pilot implementation. We worked closely with the pilot areas and the Home Office to develop a quarterly data return template, to which RRPs gave feedback and informed our design in terms of expected data availability. The data return template was an Excel spreadsheet, which allowed RRPs to report on new data, as well as update data from previous quarters. This design was chosen as it could flexibly adapt to new data emerging from ongoing criminal investigations. For example, if a new perpetrator was identified at a later stage, RRPs could update the data return, ensuring we had the most up to date and accurate data in every quarter.

As part of this process, we produced **Data Sharing Agreements (DSAs)** to facilitate the secure transfer of this data, acknowledging its sensitive nature. At the time of this report, separate DSAs have been signed with all pilot areas: West Midlands, South Wales, and all 5 London boroughs in the pilot (Lambeth, Southwark, Brent, Barnet, and Harrow). Quarterly data was therefore available for all pilot areas, covering all 26 OWHRs which were established during the pilot.

Quantitative data in this report covers all six quarters of the pilot (18 months), meaning the entire course of the pilot (April 2023 to September 2024). The full list of quantitative output metrics captured in the quarterly monitoring, alongside corresponding Home Office output measurements, can be found in Annex A at the end of this report.

Online survey

An online survey was conducted to gather a range of views and perceptions about the implementation of the pilot from key stakeholders. At the time of writing, the survey had collected 36 responses across key stakeholders (Relevant Review Partners, Independent Chairs/ Reviewers, Panel members, OWHR Board members, etc.) and across all pilot areas. The survey was sent to 127 stakeholders, therefore

achieving an estimated[2] response rate of 28%. The majority of responses came from Relevant Review Partners (31%) and Independent Chairs (31%), followed by Panel members (19%), stakeholders involved in local oversight process (12%), and members of the Oversight Board (6%). Respondents came from various professional backgrounds, with most from Local Authorities/ government (37%), Police (21%), and Independent (21%), followed by retired/semi-retired stakeholders (11%), Health partners (8%), and those in Violence Reduction/ Partnership Units (3%). There was also a proportionate representation of pilot areas in the survey sample, as 44% were involved in OWHRs in London, 36% in West Midlands, and 21% in Wales. A breakdown of respondent characteristics is also available in graphics in Annex C, while the full survey questionnaire can be found in Annex D.

Other quantitative data

Additional quantitative data was also provided by the Home Office to facilitate the analysis and provide the full picture of the OWHR pilot implementation. This includes total numbers and timings of current OWHRs (through notifications received by the Home Office), updates on recruitment status of Independent Chairs, updates on status of OWHRs, and feedback from external OWHR training provider.

All quantitative analysis was conducted in Excel and R programming.

Interviews

During the course of this evaluation, we conducted three research waves (RW) of interviews with key stakeholders. We aimed to interview a range of stakeholders, such as relevant review partners across all pilot areas, Independent Chairs (ICs), member of local oversight processes (such as VRU members), other stakeholders from appropriate/ contributing organisations, as well as both members of the OWHR Oversight Board. The interview waves followed the timeline and key stages of the pilot. The first wave was focused mainly on the initial setup of the pilot and emerging lessons from establishing reviews, the second wave was more focused on the stages of conducting reviews, and the third wave was focused on the final stages of the reviews. The third wave was also utilised to inform the case studies (see below for more information). In this final report, we consolidate the evidence gathered from all interview waves since the start of the pilot evaluation.

In total, we have conducted 62 interviews with 44[3] key stakeholders to inform findings for this final report. Most interviews were with individual stakeholders, however in some cases, we conducted group interviews. This was done where we/the partners deemed it valuable to have multiple relevant partners in one room.

Table 1 shows a breakdown of interviews conducted for this evaluation.

[2] This is an estimate, as stakeholders were encouraged to forward the survey to relevant colleagues. It is therefore possible that the survey reached more than our initial list of 127 people.
[3] This number refers to the total number of people that participated in interviews across the three waves. Several stakeholders participated in more than one interview, which is why the number of interviewees is smaller than the number of interviews.

Table 1 Interviews with key stakeholders across all three Research Waves

Interviews	RW1	RW2	RW3	Totals
Number of interviews conducted	13	21	26	**60**
Number of interviewees	14	29	25	**44**

Interviews were conducted with stakeholders from different backgrounds and pilot areas to capture a range of views about OWHRs. In total, interviews were conducted with 12 stakeholders involved in OWHRs in London, 9 stakeholders in OWHRs in West Midlands, and 12 in Wales. This sample included RRPs, stakeholders involved in local oversight processes, and other appropriate bodies involved in OWHRs. Interviews were also conducted with 9 Independent Chairs/ reviewers and 2 members of the OWHR Oversight Board.

Interviews lasted around an hour, and all interviewees were provided with an 'information sheet' prior to the interview, informing them of our evaluation and how we plan to use this data. Interviews were conducted remotely through MS Teams, and recorded with the consent of the interviewee, for the purposes of producing detailed transcripts and write-ups.

Case studies

As mentioned above, the third and final wave of interviews was more focused on specific reviews, as they were the primary source of evidence for the in-depth Case Studies. Each Case Study focused on one OWHR, and aimed to capture the views of a range of stakeholders involved in the review (e.g., police, health, LA, etc.). The initial plan was to conduct 12 Case Studies, 4 in each area, however there were only 2 qualifying cases in Wales, and many others had not progressed sufficiently to provide enough case study material.

The final Case studies were selected based on the following **sampling criteria:**

- **Pilot areas:** conducting at least one case study in each pilot area to ensure learning is captured across all 3 areas.
- **Progress/ degree of completion:** selecting those OWHRs that have progressed the most, which were more likely to provide us with the most useful lessons learned about the whole pilot, and also likely to have produced draft reviews, which can be shared
- **Parallel reviews:** exploring any cases with a mental health aspect, especially those that were covered by a parallel Mental Health Homicide Review.
- **Nature of homicide and review:** exploring a variety of different cases (e.g., demographics of victims/ perpetrators, offensive weapons, whether linked to other criminal activity like knife crime/ county lines, etc.)

Based on the above criteria, we selected 6 OWHRs for Case studies: 3 in London (1 in Lambeth, 1 in Southwark, and 1 in Brent), 2 in West Midlands (1 in Coventry and 1 in Birmingham), and 1 in Wales (Rhondda Cynon Taf). Case studies were informed by interviews, draft and summary OWHRs (where available), and other data (quarterly data, background documentation, etc).

Findings from case study interviews have been used to supplement the qualitative data gathered from interviews with stakeholders that took an overarching approach to understanding the OWHR process. This decision was made to maintain the anonymity of stakeholders participating in the evaluation, as well as the victims, perpetrators, and families who were the subject of the case study OWHRs.

Data limitations

In this section we identify some limitations regarding the data and evidence in this evaluation:

- **Incomplete data due to different levels of completion of OWHRs across areas.** As OWHRs are in different stages, data is more complete and accurate for those nearing completion, while it is limited for those which have started later in the process (for example the two cases in Wales and the latest case in West Midlands started in the second half of the pilot). This has affected certain data such as metrics captured in the quarterly data returns, and in terms of the feedback that stakeholders can provide in interviews.
- **Quality and consistency of quarterly data.** The quality of data received from pilot areas has been good, however we were made aware of certain challenges. For example, challenges were identified in receiving accurate dates regarding notifications to the Home Office. This has been mitigated by requesting and receiving those notification receipt dates directly from the Home Office. Other challenges have included receiving accurate resource/cost estimates from pilot areas. Data was limited and in some cases was only a reflection of the expected costs set by the Home Office at the beginning of the pilot. Since quantitative evidence about resources and costs across areas has been limited, findings on this area are mostly based on qualitative feedback (e.g., from interviews).
- **Small sample size of online survey.** As mentioned above, the survey achieved a sample of 36 responses, which may mean a lack of representativeness of stakeholders involved in the pilot. Interpreting survey results is especially challenging for SUSR/ Wales-specific questions, where the sub-sample is even smaller as these questions were only relevant to stakeholders involved in Wales. It is however worth noting that even though the samples are small, the survey has managed to capture a good range of views across those involved in the pilot, providing more confidence in the accuracy of the results. Responses were received from a range of stakeholders across all pilot areas.

2.0 OWHR numbers and quantitative outputs

This section outlines key quantitative outputs throughout the course of the OWHR pilot. As mentioned in Section 1, the quantitative evidence used in this report comes from all 6 quarters of monitoring data, as well as notifications data provided by the Home Office and supplementary information from interviews.

Overview of OWHRs across all pilot areas

During the 18 months of the pilot, **26 cases qualified for an OWHR** across the three pilot areas, with 13 in London, 11 in West Midlands, and 2 in Wales. The qualified cases were fewer than the estimated 36 OWHRs that were expected for the pilot based on an impact assessment conducted prior to the pilot[4]. The estimate was calculated based on historical trends in pilot areas over the 5 years prior to 2021/22, and with an additional 20% optimism bias to ensure that sufficient funding was available for reviews. It is worth noting that the estimated cases without the 20% bias would be 30, which is very close to the actual number of cases that qualified over the pilot period.

Table 2 shows a breakdown of cases across all pilot areas.

[4] Update note: Offensive weapons homicide review impact assessment - GOV.UK (www.gov.uk)

Table 2 Overview of OWHRs in the three pilot areas

Pilot area	Ruled out of scope	Number of confirmed OWHRs
London	**4**	**13**
Barnet	-	1
Brent	1	3
Harrow	-	4
Lambeth	2	4
Southwark	1	1
West Midlands	**1**	**11**
Coventry	0	4
Birmingham	1	7
Wales	**0**	**2**
Cardiff	0	1
Rhondda Cynon Taf	0	1
Total	***5***	***26***

OWHRs across pilot areas were in different stages, with some nearing completion while others started later into the pilot and are expected to complete after the pilot has ended. For example, both cases in Wales happened towards the end of the first half of the pilot (9 months), meaning that they are expected to conclude after the pilot ends (as reviews are expected to take around 12 months to complete). Pilot areas were required to establish OWHRs based on cases which happened on the first 9 months of the pilot, and to use the second half of the pilot to focus on delivering these reviews. This meant that no new cases started in the second half, except one case in West Midlands. This case however happened in the first half of the pilot and was pending due to lack of sufficient information.

Out of scope cases

As noted in the table above, **5 cases were ruled out of scope**. Cases were ruled out of scope due to not fulfilling the eligibility criteria for an OWHR. Two cases, in Southwark and Lambeth respectively, were ruled out of scope as they were identified as domestic homicides and eventually led to Domestic Homicide Reviews (DHRs). Another out-of-scope case in Birmingham was due to unclear causes of death, lack of perpetrator/suspect to suggest the death was a homicide. Lastly, one case in Brent was ruled out of scope as it was deemed that it did not meet the criteria for a review, and alongside that would not produce meaningful learning to be adopted by RRPs, as is the main purpose of OWHRs. In detail, the victim was not known to any relevant partners in the Safer Brent Partnership and the

perpetrator was only known to Health partners in limited circumstance, therefore it was deemed there would be no lesson to be learnt from the death between partners in the Safer Brent Partnership. In considering the criteria for national rollout, this provides an example where the current criteria could be tightened, as well as pointing towards a need to clarify the OWHR guidance further.

Independent Chairs

During the pilot, 25 Independent Chairs (ICs) were identified by the Home Office to conduct reviews across pilot areas in England and Wales. ICs were sought with relevant knowledge, skills and experience and were required to pass an application process and interview. The 25 ICs were then required to complete the OWHR Training which they attended alongside RRPs. A list of ICs was provided to pilot areas, detailing a short summary of the individuals previous experience and area of expertise. Overall, **20 out of 25 ICs** were commissioned to carry out OWHRs, with the remaining 5 not involved in the pilot due to personal reasons or other work commitments. The available data suggests that **all (26) OWHRs had an IC**. In addition, most ICs were carrying out 1 review each, however 4 ICs were involved in more than one review.

It is worth noting there have been some delays in commissioning OWHRs, which has meant limited progress among some reviews. For example, Brent and Harrow previously experienced resource and capacity issues which led to ICs being commissioned later than expected.

Demographic data

Demographic data on the profile of victims and suspects/perpetrators was made available for all pilot areas with qualified cases. Table 3 provides a summary of demographic data available across OWHRs.

Table 3 Demographic characteristics of victims and suspects/ alleged perpetrators in OWHRs

Demographic characteristics		Victims (n=27)	Alleged perpetrators/ suspects (n=41)
Sex	Male	96%	90%
	Female	4%	5%
	Unknown	0%	5%
Age	Average	32	22
	Min	18	15
	Max	74	44
Ethnicity	White ethnic backgrounds[5]	30%	17%
	Ethnic minority backgrounds	37%	63%
	Other[6]	11%	10%
	Unknown/ missing	22%	10%

Ecorys analysis of Quarterly data (n=26 OWHRs).

The 25 approved OWHRs in our data involved 27 victims and 41 alleged perpetrators/suspects. Demographic data suggests there is diversity in terms of the characteristics of victims and alleged perpetrators/suspects across qualifying homicides, except for gender (as almost all were male). The data showed that 96% of victims were male, while suspects/alleged perpetrators have also been mostly male (90%).

Victims were of various ages, with the youngest being 18 and the oldest 74. More than half (52%) were between the ages of 18 and 28 years old, with 15% between 30-40 years old, and almost all the remainder (30%) were between 40-50 years old. Suspects/alleged perpetrators' age also varied, with the youngest being 15 and the oldest 44 years old. More than half of suspects/alleged perpetrators (56%) were between the ages of 15 and 20, while 31% were between 20-30 years old, and the remaining 13% were above 30.

Victims were of mixed ethnic backgrounds, with less than half (37%) being from ethnic minority backgrounds (black-African, black-Caribbean, Egyptian, and other/ multiple ethnic minorities), and 30% from white ethnic backgrounds. Most (63%) suspects/alleged perpetrators were from ethnic minority backgrounds, while 17% were from white ethnic backgrounds. It is worth noting that not all ethnicity data was available for victims (22% unknown) as well as suspects/ alleged perpetrators (10% unknown).

[5] Includes White-British and White-Other categories.
[6] Any other ethnicity which was not captured by the rest of the given options in the quarterly data form: White British, White other, Black African or Caribbean/ Black British, Asian/Asian British, Mixed or multiple ethnicities, Unknown.

In addition, 20% of suspects/alleged perpetrators were identifying as having special or protected characteristics such as Special Educational Needs and Disabilities (SEND), Attention-Deficit/ Hyperactivity Disorder (ADHD), and diagnosed mental illnesses (bi-polar disorder, paranoid schizophrenia, and other mental health issues). This could mean that OWHRs may provide valuable learning about suspects/perpetrators who were known to such services prior to the homicide. Almost half of suspects/alleged perpetrators (49%) did not have any special or protected characteristics, while 29% was unknown. Most of the victims (70%) did not have any special characteristics, and 22% were unknown, while only 7% presented with some known special characteristics (in this case religious beliefs, which however were not connected in any way to the homicides). None of the victims were identified as having SEND or known mental health diagnoses, although as mentioned above, 22% was unknown at the time of recording this data. It is worth noting that further updated data is planned to be collated by the Oversight Board as OWHR reports are being completed, therefore providing additional insights regarding protected characteristics of victims and suspects/alleged perpetrators.

OWHR timings

The quarterly monitoring data captures key dates such as the date of the homicide (when the incident occurred), the date the police recorded the homicide, the date the decision was made that a case qualifies for an OWHR, the date the Secretary of State or Welsh Government was informed of the decision, as well as the start and end dates of the review. Capturing these dates allows us to estimate the length of each process, and to assess whether processes are being implemented efficiently (i.e., within the legislative requirement of one month for a notification, and for all others, within the Home Office's suggested timeframes for implementation as set out in the OWHR guidance).

Table 4 outlines the average, minimum and maximum length of key decisions in the OWHR process, and compares against Home Office targets and suggested timeframes.

Table 4 Length of OWHR decisions against targets

Quantitative output metric	Average (days)	Min (days)	Max (days)	Home Office targets/ suggested timeframes
Length of time to decide whether the conditions for an OWHR was met	34	1	104[7]	<1 month (30 days) from date homicide was recorded
Length of time to notify the Secretary of State/ Welsh government of the decision	37	8	92	<1 month (30 days) from date homicide was recorded
Length of time between notification and commissioning of review	57	0	193	<5 days from notification
Length of time taken to complete each OWHR	-	-	-	<=12 months from the decision to conduct the review

Ecorys analysis of Quarterly data and notifications data (n=26 OWHRs). '-' indicates no data was available.

Current data suggests that the length of decisions made in the OWHR process has so far varied significantly across pilot areas and according to the circumstances of each case.

On average, it took **34 days from the date of the homicide being recorded by the police, until the date of the decision on OWHR eligibility**. While on average slightly higher than the expected Home Office target, most OWHRs (62%) were decided within 1 month from the homicide being recorded.

The varying levels of complexity of cases was expected to affect the length of these decisions. Some cases were decided within just a few days while others have taken more than 2 months to come to a final decision. Interviewees from the last rounds of reporting had flagged that there have been complexities in specific homicide cases (e.g., when it is unclear if the homicide involved a defined offensive weapon). These cases were discussed among partners and during local oversight processes, as well as consulting the Home Office and the OWHR Oversight Board. It is worth noting that there is a

[7] Note: the maximum number of days to decide whether OWHR conditions have been met appear higher than the maximum length of time to notify the Secretary of State of the decision. This is due to some cases where areas first informed of the decision to consider a review but expected delays. The earliest date of notification was used to calculate the length between decision and notification. In practice, some of these cases took longer to decide eligibility, which led to a second or third notification to inform the Secretary of State that the OWHR was going ahead.

downwards trend in the length of the decisions being made. This is somewhat expected and could mean that the pilot area is arriving to these decisions more efficiently as the pilot has progressed.

Some delays were also experienced during the time between the decision being made and notifying the Secretary of State or Welsh government. On average, it took **37 days from the date of the homicide being recorded by the police till the date when the Home Office was notified.** Overall, half (50%) of notifications were within the 1-month target. Although this deviated from the target again, the data suggests that the Home Office has been notified about progress in decisions and potential delays along the way. Where needed, pilot partners reached out to request more time to make a decision, suggesting there is good communication between the Home Office and pilot areas.

Lastly, **delays were also present in commissioning the reviews after formal notification was made**, as it took on average **57 days** (against a 5-day[8] target since the notification). While the length again varied across cases, there were only 5 cases (22%) which started within 5 days, suggesting that **most OWHRs experienced delays in starting**. The data suggests that almost half of the reviews (48%) started more than 1 month after the notification, with London reviews experiencing the biggest delays. Delays in London were mostly caused due to capacity and data sharing issues, while there were also delays in appointing Independent Chairs across all pilot areas. It is worth noting however that at the time of writing, all 26 OWHRs have appointed ICs and started the process of conducting the review, so no more delays are expected due to these issues.

Resources spent and other data

Lastly, as the pilot has progressed there has been data available regarding the resources spent so far on OWHRs, although very limited and could include inconsistency in terms of how this was recorded in each pilot area. The current data covers only Lambeth and West Midlands, and therefore may not be representative of the pilot as a whole.

This data suggests that **a total of 3,428 hours has been spent across RRPs** in these areas, with an **average of 229 hours per review**. It is worth noting that reviews are in different stages, which means that this average may not be representative of the true length required to complete a review. As Lambeth and West Midlands are very different pilot areas, this is also reflected on the hours and costs they have estimated. On average, Lambeth estimated on average 815 hours have been spent across partners (varying between 800-860 hours), based on 150 hours per partner (450 in total), and around 350 hours on administrative tasks. This is remarkably different to hour estimates from West Midlands which was on average 15 hours across partners (varying between 3-30 hours).

The same can be said about financial cost estimates between the two areas. While West Midlands has reported the expected cost of £11,132 per review on average, Lambeth has reported much higher costs, at £30,418 per review on average. This seems to be driven by higher costs across Police and LA partners in Lambeth, as both areas have estimated the same (expected) cost for ICs of £8,688 per review. Police work in Lambeth was estimated to cost an average of £4,853 pre review (compared to the expected estimate reported by West Midlands of £1,222, and LA work was estimated as an average

[8] Noting that this is measured against a target of 5 working days, as per OWHR guidance, as opposed to the rest of the metrics which were estimated based on calendar days (30 days calendar days = 1 month).

of £16,875 per review (again compared to the expected £1,222). It is worth noting that there were no estimates available for health partners in Lambeth, which means the actual costs for this pilot area may even be higher.

OWHRs are suggested to take 12 months to complete, some of the metrics which focused on the completion of OWHRs and beyond were not fully captured, for example the length of time taken to complete an OWHR, and the length of time taken to publish after completion.

As noted below, we recommend that further monitoring and evaluation of this strand would be required in the case of a national roll-out, so that costs and resources across partners are fully understood and so that sufficient support is provided to deliver OWHRs.

3.0 OWHR pilot implementation

3.1 Local context and overview of cases

In this section, an overview of local contexts and cases to date is provided. This is helpful context for the discussion of implementation that follows.

All pilot forces cover an overall similar sized population of around 1.5 million but there are differences in their composition:

- In London, the pilot includes five similarly sized, urban, and densely populated (c.300,000) Local Authorities (LAs).
- The West Midlands pilot covers just two LAs, but this includes Birmingham, which is the largest LA in the UK (more than 1.1m in population).
- South Wales covers all LAs, which vary in size. Cardiff, Swansea and Rhondda Cynon Taf are the largest and of a similar size to the LAs in the London pilot. Whereas other LAs have much smaller (and typically more of a mix of urban centres and rural areas) populations (<150,000).

OWHRs are intended to be carried out for qualifying homicides (involving the use of an offensive weapon) that are not covered by other reviews. Stakeholders noted some confusion around which review should be chosen and/or which process to follow. Although an issue across pilot sites, there was a particular case in Wales where it was felt an OWHR would be more appropriate than a DHR, especially taking into account ongoing legislative changes to the statutory definition of domestic abuse. Following discussion and advice from the Home Office DHR Quality Assurance Board, the decision was taken to conduct an OWHR.

As noted above, there are currently 26 cases considered eligible for OWHRs across all 3 pilot areas (13 in London, 11 in West Midlands and 2 in Wales). Ongoing OWHRs are currently at very different stages across pilot areas, with the most recently confirmed ones starting in the second half of the pilot, while others have completed drafts/ are closer to the end of the review process.

3.2 Establishing an OWHR

This section presents stakeholders views and experiences of the structures and processes that underpin the formation of an OWHR.

3.2.1 Governance

3.2.1.1 Lead agencies

For the West Midlands and London, the lead agency for all OWHRs was decided locally as the local authority (LA), specifically the Community Safety Partnership (CSP). It is worth noting the legislation provides flexibility for other organisations to take on the role. As lead agency, the CSPs have been the coordinating and administrative agencies for OWHRs. Stakeholders explained that this approach is in

line with how other statutory reviews (such as DHRs) are run; therefore, CSPs are viewed as having the necessary skillset to take on the role of lead agency.

It is of note that some ICs expressed surprise that the CSP were the lead agency, as this did not align with their understanding of the three RRPs that are referred to in the OWHR training and guidance. Namely, during OWHR training it had been specified that the RRPs are the LA, the integrated care board (ICB), and the police, and that one of these agencies would be the lead agency; however, across London and the West Midlands, the CSP took the role of the lead agency.

"[I was] quite surprised at [the] Community Safety Partnership almost taking over and running with lots of the process."

Nevertheless, there was broad agreement that CSPs have been the right agency to take on the lead agency role for OWHRs in England and should continue in this role if OWHRs are rolled out nationally. However, another view was that the police may be a more appropriate lead agency due to their knowledge and understanding of homicide. It was also suggested that the police have more capacity and resources to be the lead agency (regarding resourcing challenges, see section 4.5.1).

"I think [the] police should be the lead because they have got resources that they are able to manoeuvre better. I think it needs to be led by police. It's a homicide, it's an investigation."

In the London boroughs, the OWHRs have been co-ordinated by the local CSPs; however, the CSPs (with the exception of two boroughs) do not have OWHR co-ordinator roles that are funded specifically for the pilot. Therefore, the OWHR co-ordinator roles in the other three London boroughs have been in addition to existing workloads, which some stakeholders suggested has contributed to delays in the OWHR process.

In the West Midlands, a role for an OWHR co-ordinator was funded from the beginning of the pilot, covering both Birmingham and Coventry. The role of OWHR co-ordinator has included (but has not been limited to) receiving notifications from West Midlands Police, sending out scoping documents, collating evidence, commissioning the ICs, and managing the quality assurance process. Stakeholders expressed the view that the OWHR co-ordinator has played a critical role in the success of the pilot in the West Midlands.

Wales differs to the West Midlands and London, with OWHRs delivered with the support of the Regional Safeguarding Board (RSB). This approach was taken because Wales is adhering to the SUSR guidance, under which the RSB has responsibility for coordinating the statutory review process. Similar to the OWHR co-ordinator role in the West Midlands, business co-ordinators within two RSBs have managed OWHRs carried out under the SUSR process in Wales. Stakeholders explained that the business co-ordinators' roles have included receiving the notification from South Wales police and notifying the Home Office. They have identified the chairs and reviewers and co-ordinated the SUSR panels for the OWHRs (see further, section 3.2.3.1). They co-ordinate all parts of the OWHR until completed. It is anticipated that Wales will continue with this approach if OWHRs are rolled out nationally.

Overall, stakeholders expressed the view that lead agencies had played a pivotal role in the delivery of OWHRs. This aligns with the survey results, which found that most (73%) survey respondents reported that the support and co-ordination provided by the lead agency had been very or extremely helpful.

For national roll-out, there was agreement among stakeholders across pilot areas that there is a need for a consistent and structured approach to managing and co-ordinating the OWHR process. As part of this, it was emphasised that dedicated regional OWHR co-ordinators will be critical to ensuring the smooth delivery of the reviews under a national roll-out.

3.2.1.2 Relevant review partners

There was overall agreement across stakeholders that the existing three RRPs (i.e. the LA, police, and health [ICB in England or the Local Health Board in Wales]) have been the right agencies to be the RRPs for OWHRs. It was noted by a range of stakeholders (ICs and RRPs) that the existing RRPs understand what is required for OWHRs because they have experience of other types of statutory reviews, such as DHRs.

There was a slight divergence of opinion about whether additional RRPs should be brought into the OWHR process at national roll-out. While one view was that bringing in additional agencies could complicate the process, another view was that some select additional RRPs could prove helpful. Specifically, the immigration service, probation service, prison service, and housing providers were identified as key agencies that often hold relevant information for OWHRs, but from which it can be challenging to obtain information. Stakeholders expressed the view that if these agencies were named as RRPs or appropriate bodies, the process of obtaining information would be more efficient. Where agencies are already specified in the guidance, stakeholders emphasised that work is needed to raise awareness of OWHRs and the statutory responsibility of agencies to engage with requests for information (see section 4.3.1 regarding gathering evidence for OWHRs).

3.2.1.3 Oversight

Local processes

- In London, there has been no official pan-London local oversight process during the OWHR pilot; however, partnership meetings have been set up to bring together the CSP leads from each pilot borough and the Home Office to discuss learning, emerging issues, and progress towards addressing actions identified as part of the review process. These meetings have taken place every six weeks and are chaired by the London VRU. Stakeholders agreed that the VRU is the natural home for coordinating OWHRs across London as OWHRs sit alongside the VRU's existing responsibilities for the Serious Violence Duty (SVD).
  - There is little information at the borough level regarding the local oversight process. However, evidence from one borough provides some insight. The borough's CSP is the lead agency, which retains overall responsibility for local oversight, sign off of the OWHR reports, and has responsibility for implementation of any recommendations arising from the OWHR. The CPS has formed a local OWHR Strategic Group, which reviews all OWHR reports before they are approved for sign-off and are sent to the Home Office.
- In the West Midlands, two groups have provided governance and oversight: a steering group and a strategic oversight group. The steering group has met once a month and has been the "tactical

arm of the governance process" comprised of all key partners.[9] The group has made the decisions about OWHRs and has overseen the process. The strategic oversight group has met quarterly and represents the local oversight process. The group has been chaired by the head of the Violence Reduction Partnership (VRP) and comprises senior staff from all the key partners.

- In Wales, oversight of OWHRs has fallen under the SUSR governance structure. The day-to-day management and governance of SUSRs is held within the RSBs. Earlier in the pilot, an OWHR Task and Finish Group was created, which met every three months. Attendees at this meeting included the VPU, South Wales Police, Welsh Local Government Association, RSB, local authority representatives, Home Office and representatives from the SUSR. More recently, stakeholders reported that an internal task and coordination group meeting has been created. This group meets fortnightly and includes heads of service to discuss which SUSRs have been commissioned and which SUSRs are being completed.

When asked about the local oversight process earlier in the pilot, there was confusion within stakeholders' responses, with some querying what is meant by the 'local oversight process'. However, others described various meetings and groups. For stakeholders from London and the West Midlands, the confusion may point to the need for clearer terminology and guidance on roles and responsibilities within the OWHR process. The current guidance provides flexibility for local areas to decide on the most appropriate process, which could be to establish a new structure or use already established processes for this purpose. In Wales, it was suggested that the confusion is because 'local oversight process' is not a term used in the SUSR process, as well as the very early stages of the Welsh OWHRs. For national roll-out, stakeholders expressed the view that local oversight needs to be a robust process with identified governance structures in place.

In the early stages of the pilot, stakeholders with knowledge of the local oversight process explained that they viewed the role and value of the oversight process as limited. At that point in the pilot, a core benefit of local oversight groups/processes reported by stakeholders had been the help that they had been able to provide to resolve obstructions to the review process (e.g. where partners had not understood the relevance of requests or how they should be involved; see further, section 3.3.1 on gathering evidence). Stakeholders also described how the oversight groups/processes had been a helpful forum within which to discuss emerging themes from OWHRs. More recent findings from the survey found that most survey respondents (61%) agreed or strongly agreed that the local oversight process has worked well and has provided sufficient support to partners and ICs during the pilot.

Moving forward, as reviews are completed, stakeholders have reported that they expect the role of the local oversight process to be more significant – namely, quality assuring reviews and holding agencies to account in relation to the implementation of review recommendations. See further, section 3.4.1, regarding the quality assurance process.

OWHR Oversight Board

The role of the OWHR Oversight Board, from here on identified as the 'Oversight Board' is to review the OWHR reports to identify national learning, as well as to support delivery of reviews, where appropriate.

[9] Earlier in the pilot, the steering group met fortnightly; however, as the pilot progressed the frequency reduced to monthly.

As no reviews have been completed to the point of publication at the time of writing this report[10], interaction and engagement between the Oversight Board and stakeholders has mainly been limited to attendance at key meetings such as quarterly meetings for partners and ICs and the six-weekly London partners meetings, as well as responses to ad hoc queries in relation to the reviews. Earlier in the pilot, stakeholders explained that they anticipated engagement would increase towards the end of the pilot when reports are being finalised and recommendations made.

At the time of writing this report, a small number of OWHR reports have been submitted to the Home Office and Oversight Board for their final review before publication. Stakeholders noted that the Oversight Board had provided some light feedback in the quarterly meetings; more in-depth engagement from the Oversight Board is expected as more OWHRs are completed. Namely, the Oversight Board will have a pivotal role in assessing whether lessons learned from reviews are being acted upon and shared locally and nationally. However, as the pilot and evaluation have now finished, evidence relating to the implementation of this element of the OWHR process is beyond the scope of this report.

The findings from the survey mirror the qualitative interview data. Namely, less than half of survey respondents (41%) agreed or strongly agreed that the OWHR Oversight Board has provided sufficient support to partners and ICs during the pilot. However, 50% of respondents neither agreed nor disagreed with this statement. These results are somewhat expected, considering that the Oversight Board's role has not been as prominent in the initial stages of the pilot, but it is expected to play a bigger role as OWHRs are completed.

3.2.2 Identifying qualifying homicides

3.2.2.1 Interpreting and applying the criteria

Overall, stakeholders thought that the criteria for qualifying homicides are straightforward and easy to apply. Most survey respondents (61%) reported that establishing if a death was a qualifying homicide had not been at all challenging and a large majority (86%) agreed or strongly agreed that the eligibility criteria have been used as intended to identify qualifying OWHR cases.

Stakeholders noted in interviews that while there had been some "struggles in the beginning", particularly around what should be classed as an offensive weapon, through "trial and error" the process has become clearer and the criteria easier to apply. It was also noted that the initial struggles were not due to the guidance from the Home Office being unclear; rather, there were some unusual cases that were not obviously covered by the guidance and therefore required consultation with the Home Office. For example, there have been two incidents in the pilot areas where a vehicle had been used to commit a homicide. These incidents prompted the need for consultation with the Home Office and legal services to decide if a vehicle should be considered a weapon within the context of an OWHR. Stakeholders explained that the decision was taken that if there was clear evidence that the vehicle had been used to intentionally kill the victim/s, then the incident would qualify for an OWHR (if all other criteria were met). For both incidents, it was decided that they qualified for OWHRs.

[10] We are aware of at least 10 reviews which are at the drafting stage, some of which are close to completion.

One further area of difficulty discussed by stakeholders was where a case looks to meet the criteria for an OWHR and another type of review (typically a DHR). While the legislation is clear in its exemption, that where another review qualifies an OWHR does not, this did result in a lot of discussion and back and forth between various partners (including the Home Office), which delays the process. Stakeholders would like to see clearer guidance on how to navigate decision-making where a case could meet the criteria for multiple types of review.

A consistent view expressed within stakeholders' accounts across all data collection waves and reports, has been the need to review the age criteria for OWHRs:

- Stakeholders expressed the view that OWHRs do not address deaths that occur as the result of peer-on-peer violence among under 18s. Under current legislation, existing statutory reviews relating to child deaths, such as Child Death Reviews (CDRs) or Child Safeguarding Practice Reviews (CSPR), while carried out into the death, would not be appropriate. For example, stakeholders noted that CSPRs are typically focused on deaths that occur due to neglect and abuse by parents or caregivers, rather than by peers.

"I don't think the terms of reference for CSPR are aligned to what we're trying to achieve from OWHRs, which is around homicide prevention. It's [the CSPR is] more around the safeguarding processes."

- Stakeholders expressed concern that there will be many situations where there is a perpetrator and victim under 18 for whom an OWHR or other statutory review would not be applicable (under current legislation).
- There was a view that the Home Office should consider the 16-25 age 'risk period' and the prevalence of peer-on-peer violence within this age-group as part of OWHR qualifying criteria.
- To this point, stakeholders suggested that adjusting OWHR criteria (or the criteria for other statutory reviews relating to the deaths of children) should be considered.[11] Stakeholders expressed the view that at present, a lot of learning around knife crime is being missed because of the current criteria for these reviews.

"So, by making the age of the OWHR [victim] over 18, I think we're missing a lot of learning because actually you would think with children, we could intervene more in their lives than we can with adults who subsequently go on to commit murder."

Some stakeholders also suggested that the OWHR criteria should be broadened to include 'near misses' and that some of the richest learning could come from cases that are currently excluded because the victim survived. However, there are practical challenges with this approach (such as funding and capacity).

[11] We note that the Home Office is aware of this point and are in discussions with the Child Safeguarding Practice Reviews Team and Child Death Review Team.

3.2.2.2 Characteristics of qualifying homicides

While some stakeholders reported an absence of any patterns in the characteristics of qualifying homicides, others described how the majority of OWHRs have focused on young adults and involved knife crime.

Poor mental health among perpetrators was also noted as a prevalent theme, with some stakeholders expressing the view that some OWHRs should have been mental health homicide reviews. However, stakeholders representing health/mental health agencies explained that although a number of perpetrators have been seen by, or involved with, mental health services prior to the offence, the threshold for a mental health homicide review is very high. As such, an OWHR addresses this gap.

Finally, stakeholders highlighted that a number of homicides that are subject to an OWHR had occurred in houses of multiple occupancy, also known as 'exempt supported accommodation', or have had a connection to this accommodation type.[12]

In addition to interviews with stakeholders, Ecorys has been provided with draft/summary reports for some of the OWHRs commissioned during the pilot. These reports provide some additional information of the characteristics of the qualifying homicides. Of the OWHR reports and summaries that Ecorys has had sight of, the large majority of victims and perpetrators who were the subject of the OWHRs were male (aligning with findings from quarterly data, as shown in chapter 2 above). From information contained within the reports (or the information that has been available to the ICs), it is not always clear whether the victims and perpetrators were known to each other. Where this information has been provided, the qualifying homicides have included a combination of random attacks by strangers and altercations between persons known to each other that resulted in a homicide. The majority of homicides occurred in the street or a park, with a small number occurring at the victim and/or perpetrator's home. Where the time of day/night has been noted in the reports, most homicides occurred in the evening or early hours of the morning (i.e. around 3AM). The significant majority of victims died as the result of single or multiple stab wounds, either from a knife or other sharp or bladed article (i.e. a broken bottle or scissors). In two of the OWHRs, the weapon had been a vehicle driven intentionally at the victim/s.

More insights regarding the characteristics of qualifying homicides were available through the quarterly data and can be found above, in chapter 2 (OWHR numbers and quantitative outputs).

3.2.2.3 The impact of acquittals

A concern expressed by some stakeholders was the issue of how to navigate OWHRs when the alleged perpetrator/s are acquitted. While this issue is included in the current OWHR guidance, a view among stakeholders was the importance of a conviction in order for an OWHR to be appropriate. Namely, if an alleged perpetrator/s is acquitted, then there is a question of whether, in the eyes of the law, the incident qualifies for a review and/or the acquitted person/s should be included in a review. Stakeholders referred to a number of cases where the issue of if, and how, information about acquitted individuals should be included in OWHR reports is being considered. In one case, it was reported that the information about

[12] Regarding a definition of exempt supported accommodation and an overview of the issues and concerns around this type of accommodation, see here: https://commonslibrary.parliament.uk/research-briefings/cbp-9362/

the person who has been acquitted has still been included but has been re-drafted to be more vague, as to reduce the risk of identification. Further consideration and guidance on this issue is needed ahead of national roll-out.

3.2.3 Independent Chairs

3.2.3.1 Process for appointing ICs to reviews

Overall, the process for commissioning ICs for OWHRs has gone well, as illustrated by the survey results. Findings from the survey show that only 16% of respondents reported that they found the process to be very challenging or extremely challenging.

In both London and the West Midlands, two approaches to appointing ICs have been trialled during the pilot. At the beginning of the pilot, the approach involved the CSP/LA team sending out a request for expressions of interest to the list of ICs and then applying a scoring matrix to the ICs who responded. However, the CSPs/LAs found that this process was too slow and onerous, which was leading to delays in appointing ICs. For example, some areas found that due to the time it took to administer and review the expressions of interest, by the time an IC was selected, they had already been allocated to another review, which resulted in further delays to the process. Subsequently, the processes in London and the West Midlands were changed:

- In the West Midlands, the OWHR co-ordinator went down the list of ICs and invited the next person on the list to chair a review, giving them five days to respond. Stakeholders expressed the view that this worked well and is “probably the easiest part of the whole thing.” While it was recognised that this approach improved the efficiency of the process, some stakeholders expressed the view that assignment of cases should be on the relevant experience and background of the ICs and not simply moving down a list of approved ICs.
- To this point, in London, stakeholders explained that the CSPs/LAs used the profiles of the ICs and a scoring matrix to create a list of preferred ICs. The first choice of IC was approached and if they were not available, the second choice was approached (and so on). For example, in one London borough, stakeholders explained that when selecting an IC, they considered the details of the case and the type of experience and expertise that an IC would need to effectively carry out the review. Based on this information, they looked at the list of available ICs and selected three individuals to approach.

As part of the SUSR framework, OWHRs (and all other statutory reviews) in Wales have been undertaken by either one paid chair and two statutory sector reviewers, or one statutory sector chair and one paid reviewer. In contrast to the process in England, the chair has oversight of the OWHR, ensuring that the process is adhered to, while the reviewers gather the evidence and write the OWHR report. Chairs and reviewers for statutory reviews under the SUSR process are selected from their own list of approved chairs and reviewers, which details their level of expertise, specialism, and training. The list allows the RSBs to ensure that those undertaking reviews are trained, competent, and hold the necessary qualifications. This provided a similar process to that for England (section 2.0).

Stakeholders have suggested that the different approaches might be a challenge for chairs who are working in both England and Wales. However, this may be an issue that can be resolved with additional communication about terminology and roles.[13]

Finally, stakeholders noted discrepancies in the contracts issued to ICs by the LA, as well as the duration and cost of the insurance that ICs have been required to have by some LAs. Some ICs understood from discussions during the training, that the LA would cover the cost of the insurance; however, this was not planned within the process. The Home Office has however provided up to £400 funding towards the insurance for all of the ICs in both 2023/24 and 2024/25 if carrying out reviews. The lack of clarity on these issues has caused delays for some OWHRs. In some cases, ICs do not have a contract and have not been paid for the work they have completed. Therefore, for the national roll-out, stakeholders have suggested that a standard template for the IC contract is developed and clear guidance on the insurance is produced.

3.2.3.2 The value of ICs to the OWHR process

Stakeholders agreed that ICs are integral to the independence of the OWHR process; however, they also expressed the view that the value ICs bring to OWHRs is (typically) related to their experience of conducting statutory reviews. While the ICs described breadth and depth of experience carrying out reviews and RRPs noted that some ICs are very knowledgeable of the review process, stakeholders also observed that the level of experience among ICs varied greatly. For some stakeholders, the ICs that they have worked with on OWHRs have not demonstrated sufficient review experience.

"[M]y understanding was that the authors were … people … who were very experienced at what they do, and that's kind of the idea of it, but it doesn't come across that way."

It was noted that the lack of experience of some ICs is translating into different approaches and styles of the review process, and ultimately a lack of consistency in the approach to gathering evidence and writing reports (see also section 3.2.4 regarding challenges around developing terms of reference). As such, while the value of experienced ICs was acknowledged, stakeholders also flagged the limitation that inexperienced ICs and an inconsistent approach can bring to the OWHR process.

Within interviews and survey responses, stakeholders reported specific challenges with some ICs, particularly those new to statutory reviews, who did not fulfil their role (e.g. did not draft terms of reference tailored to the review and/or asked the panel to draft them), did not understand the review process fully and/or did not engage with the process, were delayed in setting panel meetings, and were uncontactable. This led to delays and confusion for some reviews and impacted the overall timeline for delivery of reports. By contrast, other ICs who were experienced in statutory reviews and /or understood the process well were able to progress their reviews effectively and "just sort of ran with it."

For a potential national roll-out, stakeholders emphasised the need to clarify the role of ICs. As part of this, stakeholders suggested that a clear list of the requirements and responsibilities of the IC role,

[13] On p.35, the SUSR guidance already includes the following clarification: "Please note that this role [independent reviewer] is known as an 'Independent Chair' within Domestic Homicide Review and Offensive Weapons Homicide Review processes but will be referred to as 'Reviewer' throughout the Single Unified Safeguarding Review process."

including the timelines that they are expected to adhere to should be developed and disseminated. To support this, these expectations should be emphasised within the training programme for ICs.

In addition, consideration should be given to initiatives to support less experienced ICs to develop the skills and knowledge to effectively conduct OWHRs of the required quality. This may include additional training as well as peer mentoring and shadowing opportunities (see section 3.5.2.4 regarding mentoring).

3.2.4 Terms of reference

Overall, the ICs interviewed were happy with the process of drafting the terms of reference. Broadly, they have each taken a similar approach whereby they examined the facts of what had happened (based on information provided and early conversations with "key people"), drafted terms of reference that they thought were appropriate, and presented them at a meeting with RRPs and other relevant partners/agencies (a panel meeting) for discussion and refinement.

A key area of consensus across the ICs and RRPs was that the terms of reference must be focused and tailored to the case.

"I always prefer bespoke terms of reference for each case, rather than a generic set of questions."

It was noted that some ICs are "slavish" to the guidance and the extensive list of questions suggested for use to aid in setting the scope and terms of reference for the review. Others take a more streamlined and focused approach whereby they identify key lines of enquiry (KLOEs). Among the stakeholders interviewed, the tailored approach is preferred as it produces a review that is more relevant to the case.

"I do see it as my role to make sure that [the] terms of reference are appropriate and also are narrow and focused so that I'm only asking agencies to look at what's relevant."

To this point, stakeholders described instances where terms of references have clearly been copied and pasted from another type of review. Where this has happened, the terms of reference have not been fit for purpose and have caused delays to the review process. Therefore, stakeholders emphasised that it is important that ICs have the skills and knowledge to develop appropriate and bespoke terms of reference that home in on what is most important for each review (see also, section 3.2.3.2 on the issue of experience among ICs).

Stakeholders (RRPs) also expressed the view that some ICs have set a disproportionately long timeframe prior to the death to gather evidence from. They explained that because agencies will change policies and procedures overtime, it is often unhelpful to go too far back in a person's history. This is because what was in place a decade ago is unlikely to be in place now, in which case, any recommendation to change or update the policy will be irrelevant. However, some ICs expressed the view that the two-year timeframe suggested in the guidance could result in key learning being missed. By contrast, some ICs have found that the two-year timeframe has been too long and that most of the decision-making that contributed to the victim and perpetrator coming together to be in the situation that led to the homicide, occurred six months prior. However, the two-year timeframe is only a guide, and is meant to be adjusted depending on the needs and complexity of each review. This suggests that further clarity and awareness raising is needed to ensure that ICs and RRPs know that this timeframe is flexible and should be adjusted accordingly.

3.3 Conducting a review

This section presents stakeholders' views and experiences of conducting an OWHR.

3.3.1 Gathering evidence

Most survey respondents (81%) agreed or strongly agreed that RRPs have worked well with ICs to deliver OWHRs. Similarly, in interviews, stakeholders from across the pilot areas described how, overall, ICs and RRPs have worked well together to deliver OWHRS, and requests for information have been responded to without much challenge or difficulty, particularly where the main statutory review partners have been sent requests.

West Midlands

Stakeholders reported that RRPs and ICs have generally worked well together to gather evidence for OWHRs. From the perspective of the ICs interviewed, communication with the RRPs in the West Midlands has gone well. It was explained that the lead agency (the CSP) will meet with the IC within the first week of the IC signing the contract to go through the review process with them. The lead agency then sets up a briefing meeting between the designated police contact (not the SIO[14]) and the IC. The lead agency then collates the scoping information, produces the scoping document, and sets up a panel meeting.

Stakeholders noted that the three RRPs and partners local to the West Midlands had been very cooperative and responsive from the beginning of the pilot. However, there were challenges engaging with local authorities and CSPs in non-pilot areas, due to a lack of awareness about OWHRs. In addition, it was noted that national agencies such as probation and immigration services have been slow to respond to requests for information. In particular, it was reported that ICs had been faced with resistance and a lack of engagement when attempting to communicate with the immigration service (see further, section 3.3.1.1 regarding challenges gathering evidence for reviews).

"Immigration is such a labyrinthine kind of organisation and agency. If you're not going into the right part of it, then you don't get what you need […] eventually we got to the right people, but it took an inordinate amount of time"

Stakeholders suggested that having designated officers for OWHRs within each relevant RRP, as well as wider partners and agencies, would help to streamline the process and facilitate an open line of communication.

London

Stakeholders with knowledge of all London pilot areas observed that communication and collaboration among agencies had been inconsistent during the pilot. Similarly, tor the London OWHRs, ICs reported having varying experiences of communicating with the lead agencies (CSPs) and other RRPs, as well as variations in the administrative processes adopted by each lead agency. For some OWHRs, ICs have experienced slow communication from CSPs, which they recognised was likely due to capacity issues.

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[14] SIO = Senior Investigating Officer. See below, under "Access to SIOs" for more information on designated police contacts and SIOs.

Conversely, experiences have been better where the CSPs appear to have more resource and capacity to put into the co-ordination of OWHRs.

Similar to experiences in the West Midlands, stakeholders in London noted that the three RRPs had been engaged and responsive to requests for information, while challenges were faced when trying to engage with wider partners. Where the ICs have faced these barriers to receiving information, the CSP / lead agency has been integral to resolving the issue. For example, in one borough, the CSP sets a date for a case review meeting and invites partners to attend to present relevant information (in addition to providing a written response). The CSP will also follow up information requests on behalf of the IC until they are returned.

Wales

Stakeholders reported that, overall, the RRPs, reviewers and chairs in Wales have all worked well together to gather the evidence required from agencies. As noted in section 3.2.1.1, the business co-ordinator typically manages the flow of communication between all parties involved in contributing to the review. Although, in one area, the chair has taken on this role.

3.3.1.1 Challenges to gathering evidence

Accessing all necessary information to conduct the review was reported to be very challenging or extremely challenging by 44% of survey respondents. As part of open text survey responses and interviews, stakeholders highlighted various challenges faced during the review process, which have impacted delivery of the reviews.

- **Lack of familiarity, ownership, and/or understanding of statutory responsibilities:**
  - Across interviews with stakeholders, there was agreement that challenges around gathering evidence from organisations/agencies was typically grounded in a lack of familiarity with statutory reviews in general or OWHRs specifically. However, stakeholders reported that most queries have been resolved by providing guidance and legal clarifications to these organisations/agencies. In some cases, the partners have been invited onto the panel, which has facilitated engagement.

    "I … felt that lots of the agencies I was dealing with didn't have that understanding of the statutory requirement to comply. I still feel there's a bit of 'who are you?', 'why are you asking for this?'"

  - Stakeholders described instances where they have experienced challenge when asking local authorities in non-pilot areas to engage with an OWHR when the homicide did not happen in the non-pilot area, but the perpetrator or victim lived there. Similarly, where the offence meets the criteria, but the perpetrator and the victim/s are not from the pilot area, local partners have struggled to see the value that carrying out the review locally will bring.
  - Under this theme, stakeholders also described experiencing challenge from medical professionals who have expressed concern about releasing patient information. This has in part been due to a lack of familiarity with OWHRs as well as a lack of awareness of the legal requirement to share information where an individual is subject to an OWHR. Stakeholders

have highlighted how the challenge of obtaining information from medical professionals has been a major barrier to completing OWHR reports.

- **Red tape:** Some stakeholders described facing bureaucratic barriers to accessing information or people needed to gather the evidence for a review. Examples include contacting perpetrators in prison and accessing immigration information[15].

- **Access to SIOs:** Some ICs have expressed a need to speak directly to the SIO but have experienced a barrier to gaining access. For the West Midlands, the ICs do not meet with the SIO - all police communication is via a designated police contact. The police contact provides a briefing to the IC about the case to avoid the IC having to speak to the SIOs, except in exceptional circumstances. This is because SIOs often do not have the capacity to take part in the review process. The police contact can also be reached via email to ask questions or gather additional material from the investigation. Some ICs have been content with this approach, while others have pushed back and been more insistent on speaking with the SIO. Similarly, in London, ICs have to access the SIO via a police officer from the Metropolitan Police Serious Crime Review Group. While some ICs expressed the view that this process can work well, others felt that this approach added another stage to the process, which could impact the efficiency of the review. In Wales, challenges in engaging the SIO in the OWHR process were also reported. Stakeholders expressed the view that an SIO was reluctant to become involved in the OWHR because they were busy with the homicide investigation. However, the SIO did eventually attend a panel meeting and provided a lot of detailed information about the incident.

- **Lack of clarity in the request for information:** From the perspective of appropriate bodies, while stakeholders reported that they were aware of the OWHR process, upon initial receipt of a request for information, the requirements were not clear. It was explained that appropriate bodies/partners would like to receive information that clearly sets out the expectations and the rationale for the request.

"[W]hen … the offensive weapons homicide review requests came in, it was not clear what they wanted us to do."

- **Low quality of responses:** Some stakeholders reported that the quality of some responses to requests for information have not been of the quality that is expected. It was suggested that this was due to a lack of familiarity with completing these requests as well as a lack of time to complete the forms. A further reason may be due to the suitability of the template used for requests for information – some stakeholders reported that a lot of the forms contain 'not applicable' responses to many of the questions.

- **Lack of information on victim/s and/or perpetrator/s:** Stakeholders explained that some reviews had been challenging to complete due to a lack of information available on the individuals involved in the incident because of limited engagement with partners/agencies.

For national roll-out, stakeholders expressed the view that standardised agreements for data sharing should be established and emphasised that it is important that organisations' statutory responsibilities

[15] It is worth noting that the Home Office put a process in place for identifying both immigration and contacts in prison from the beginning of 2024, to avoid these issues occurring.

are communicated and understood, so that ICs do not continue to face barriers to obtaining information. A robust and well-thought-out communication plan will be critical for this. Ahead of a national roll-out, stakeholders suggested that a series of training and/or webinar sessions are delivered to a wide range of agencies/organisations to show the outcomes of the pilot and the key responsibilities of different agencies/organisations. These suggestions add to those made around development of a short and easily digestible version of the guidance that can be shared as part of requests for information.

3.3.2 Information sharing processes

While some agencies (particularly health agencies) were initially unsure about what they could legally share, stakeholders explained that once this was resolved (i.e. legal services consulted, the statutory requirement was understood), the process of sharing information had been largely unproblematic. However, some ICs have faced challenges receiving information directly from partners where they are using a personal email address. While some LAs have provided ICs with a LA email address to use while conducting the OWHR, others have declined to do so, which has presented a barrier to effective information sharing. This points to a need for a standardised mechanism for data sharing in relation to OWHRs. Some stakeholders suggested that ICs are provided with a Home Office or LA email address and/or a secure data sharing platform is set-up for OWHRs.

3.3.3 Parallel investigations, proceedings, and reviews

3.3.3.1 Parallel investigations and proceedings

The majority of survey respondents (75%) agreed or strongly agreed that OWHRs are being successfully implemented in parallel with criminal investigations or other investigative processes. However, within the interview data, some stakeholders expressed concern that IC engagement with alleged perpetrators and family members of the victim/s and the alleged perpetrator/s prior to a conviction has the potential to jeopardise the criminal investigation and trial (see also, section 3.3.4). Stakeholders suggested that more careful consideration of the acceptable parameters of engagement is needed for OWHRs that are commissioned prior to a conviction, beyond that set out in the current guidance.

A related issue identified by stakeholders was where ICs have not been able to speak to some perpetrator/s who are in prison and/or are appealing their conviction. In these instances, the perpetrator's solicitor has typically advised them not to speak to IC about the offence and/or engage with the OWHR process more generally.

In Wales, one of the OWHRs was paused until the criminal trial ended. It was noted that in Wales, most statutory reviews are postponed until the conclusion of any trial or criminal proceedings;[16] therefore, stakeholders wondered whether further guidance was needed for Wales ahead of national roll-out.

[16] As suggested by the SUSR guidance, this is not the SUSR process and represents a misunderstanding by the participant/s.

3.3.3.2 Parallel reviews

While stakeholders identified the main overlap in reviews had been around OWHRs and mental health homicide reviews, no issues around completing parallel reviews were reported. Stakeholders explained that where there have been parallel reviews, steps were taken to ensure that the terms of reference for each review were agreed in unison so that the lines of enquiry for each review were clearly demarcated.

Where OWHRs have been carried out in parallel with mental health homicide reviews, those involved have described a positive experience. The ICs for both types of review have worked together to gather information and have benefited from each other's professional knowledge.[17] The partnerships have also allowed the ICs to have joint meetings with families to ensure streamlined communication. This approach helped keep loved ones informed without causing additional distress.

However, a specific issue affecting the finalisation and publication of reviews emerged near the end of the pilot where an OWHR and mental health homicide review have been carried out in parallel. Specifically, stakeholders reported that NHS England have decided to put a hold on the publication of mental health homicide reviews because they have concerns relating to GDPR that need to be resolved. Therefore, where OWHR reports have included information from the parallel mental health homicide reviews to supplement the OWHR, the ICs have had to amend their reports.

3.3.4 Family involvement during the review

Overall, stakeholders agreed that family insights are important for understanding the context and impact of homicides. However, while some ICs have been able to meet with families as part of their reviews, others described limited family involvement and engagement. Where there has been a lack of involvement, stakeholders explained that some families had declined participation completely or requested that they are contacted after the court case (see section 3.3.4.1 on timing below). In other cases, the families live abroad and/or do not speak English (see section 3.3.4.2 on 'Language, culture, and peers' below).

Where ICs had spoken with families, introduction and access had been via a gatekeeper: for some, this had been the police family liaison officer (FLO), for others the LA/CSP had acted as a conduit. One view was that the police should be the organisation that makes the introduction between the IC and family. As part of this, the police (FLO) should brief the IC before they meet with the family to ensure that the family is only provided with relevant information (i.e. nothing sensitive is disclosed). It was suggested that this needs to be a part of the guidance for the national roll-out. However, another view was that there should be flexibility in who connects the IC to the family, with it being important that the introduction is made by someone who knows the family well. This is the position set out in the current OWHR guidance.

While the police (via a FLO) have facilitated family involvement in some OWHRs, stakeholders also provided examples of the police (via the SIO) blocking access to families. This has typically been where an SIO has not considered it appropriate for the IC to engage with family members while they are

[17] It was noted that the ICs for the different types of statutory review have different professional backgrounds, which can mean that working together can bring added value to each review by contributing different perspectives and interpretations of the evidence.

grieving and/or concern about the IC prejudicing the investigation. Stakeholders acknowledged that the guidance sets out that the IC can contact the victim's family; however, they suggested that the guidance should state clearly that the IC is able to do so without explicit permission from the SIO, as well as noting that families' wishes regarding involvement may change over time.

Some stakeholders also questioned how appropriate it is to have ICs with a background in policing interacting with families of victims and/or perpetrators as part of OWHR evidence gathering. While it was recognised that knowledge of homicides and police investigations can be a benefit to the review process, it was also suggested that some families may not have a favourable view of the police and react negatively to an IC who was previously a police officer.

3.3.4.1 Timing

Participants agreed that it can be very difficult for families to engage in a review. Because OWHRs are supposed to start soon after the homicide, one view was that suggested timeframes for family engagement in the OWHR process comes too soon after families have experienced the bereavement.

"So, for the family part, I think [it] is probably an extra thing that they don't need in the early stages [be]cause [of their] grief".

To this point, an IC described a family's emotions as "raw" when they met. Stakeholders expressed the view that the point in the process that the families are approached needs to be remain flexible and the bereavement journey considered. As part of this, stakeholders suggested that the guidance also needs to emphasise the use of a trauma-informed approach when engaging with families.[18]

3.3.4.2 Language, culture, and peers

Not all OWHRs required the services of a translator and/or interpreter. For those that did, stakeholders held different views about the approach to using them. Some did not see the need for documents to be translated or an interpreter present when communicating with families as "there's always an English-speaking member of the family." Others explained that they did not want to make assumptions and decided to provide documents in English as well as translated in a person's first language. However, this approach takes time and can be costly and would need to be factored into funding allocations, as it was for the pilot, if OWHRs are rolled out nationally. To this point, stakeholders described how receiving approval from an LA to have a letter to a victim's family translated had taken months.

Stakeholders also raised the issue of culture, and the potential for a lack of cultural understanding when involving families in the OWHR process. One suggestion was for ICs and/or RRPs to have the option of reaching out to community groups to facilitate understanding of the local context and culture.[19]

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[18] The OWHR statutory guidance mentions the importance of a trauma-informed approach when ICs engage with families in paragraph 4.4: "Trauma-informed engagement with the bereaved and local communities should form a key part of an independent chair's experience, training, and skillset."

[19] The OWHR statutory guidance (paragraph 7.11) makes reference to considerations of culture and community when undertaking an OWHR.

As part of understanding local context and culture, stakeholders expressed the view that there may be value in widening the scope of 'family' to include peers – particularly for younger people. As part of this, it was observed that peers can often know more about the victim or perpetrator's life than the families.

"[W]hat are the dynamics within … the peer group and the community as well as any kind of other connected environment, not just looking through the lens of the individual and the family, because if we miss the peer group dynamic, the cultural dynamic that goes on or the community dynamic, we won't pick up the learning."

3.3.5 Communication, sharing, and learning during the review

Most survey respondents (72%) found the experience of sharing learning across partners during the pilot to be very or extremely helpful, and within interviews, stakeholders discussed a range of ways that experiences and early learning had been shared during the pilot.

London stakeholders described how the London Partnership meeting (which occurs every six weeks), has been a helpful forum within which to "take stock" and "resolve issues" at a local level. Stakeholders also explained that these meetings have facilitated a more collaborative approach to working and learning across the five London sites.

Within the West Midlands, the OWHR steering group (which has a core decision-making function in the OWHR process), discussed emerging themes from the commissioned OWHRs at the fortnightly (and subsequently, monthly) meetings, such as the prevalence of 'exempt accommodation' in OWHR cases (see section 3.2.2.2. on characteristics of qualifying homicides').

Also in the West Midlands, stakeholders described how draft reports and recommendations have been shared with the panel for their review prior to the report being submitted for formal quality assurance. This has provided an opportunity for early learning to be communicated to key partners and for preliminary feedback to be implemented by the IC. A key benefit of this process has been the opportunity for ICs to sense check recommendations to ensure that they are actionable and effective[20].

Stakeholders also spoke about the 'feedback and sharing best practice' meetings set-up by the Home Office, which were viewed as being crucial for bringing all the pilot areas together to share experiences and early learning.

"There's been a real openness and healthy discussions at … those meetings."

The OWHRs in Wales were commissioned at a late stage of the pilot; however, stakeholders reported learning from other pilot areas through the 'feedback and sharing best practice' meetings. Stakeholders felt that these meetings were helpful for hearing how other areas were progressing with the pilot, were a good resource, and provided a professional network of individuals to connect with. For example, stakeholders from Wales described how they had met with stakeholders from the West Midlands pilot

[20] It is also worth noting the Home Office have provided support by linking ICs and RRPs to policy leads in the Home Office and Other Government Departments to discuss the drafting of recommendations and provide additional background advice on key issues.

area who shared examples of toolkits and templates, and discussed their processes, early learning, and challenges faced.

The quarterly IC meetings were also discussed. While providing an environment in which to share experiences, one view was that ICs have not been given sufficient time to share their experiences within these meetings. As such, most sharing and discussion among ICs has occurred informally and outside of these meetings (see section 3.5.2.4 on mentoring and peer support).

Moving forward, stakeholders expressed enthusiasm for events to share learning and processes as well as to discuss implementation of recommendations.

3.4 Following the review

This section presents stakeholders' views and experiences of the OWHR process once reports have been written.

3.4.1 Quality Assurance process

The OWHR guidance allows for each pilot area to implement their own quality assurance (QA) process that aligns with the local management structure, which is reflected in the variation seen in stakeholders' descriptions of how OWHR reports are checked for quality. This section presents an overview of the QA processes across the pilot areas.

West Midlands

Some of the OWHRs from the West Midlands pilot area have been completed and submitted for quality assurance. As the lead agency, the CSP and OWHR co-ordinator manage the formal QA process in the West Midlands, which involves several steps.[21]

- **Review by OWHR co-ordinator:** The OWHR co-ordinator conducts an initial review, proofreading for grammar and checking for factual accuracy (police records, evidence/information submissions, and other information is checked as needed). Any uncertainties are clarified with the police. The OWHR co-ordinator also checks for readability, relevance, and appropriate language. Recommendations are checked to ensure they are owned by an agency and can be actioned.
- **Review by Head of Violence Reduction Partnership:** The report is then reviewed by the Head of the Violence Reduction Partnership (VRP). Stakeholders reported that the VRP carries out a QA check to ensure that the key lines of enquiry (KLOEs) were appropriate to the circumstances of the case, that the report has addressed the KLOEs, and that the recommendations are appropriate and actionable. According to stakeholders, the VRP QA review also ensures the report is equality and diversity compliant and that no individual community is unfairly biased.
- **Final review:** The report goes to the strategic oversight panel (the West Midlands' local oversight process, comprised of senior representatives from panel agencies). The representatives must include an agency member responsible for actioning the recommendations within the 12 months

[21] Prior to the formal QA process, it was explained by stakeholders that the steering group panel is responsible for reviewing each iteration of the report to ensure the content is accurate.

following the review. Panel members review the report and complete a feedback form. The IC then attends a meeting with the strategic oversight panel where they present their recommendations and listen and respond to any feedback.[22] Any necessary adjustments are made before the report is sent to the Home Office and final review by the OWHR Oversight Board prior to being published.

This process can take several weeks, depending on the complexity of the case and the availability of stakeholders.

Stakeholders reported that the West Midlands would continue with the above process if there is a national roll-out; however, funding would be required to support the administrative work involved in the process.

While the West Midlands appears to have a clear QA process (as set out above), there is evidence that clearer communication about the process and individuals' roles within the process is needed. Some ICs have reported being unaware of the QA process, while others have expressed the view that members of the local oversight process (strategic oversight panel) appear to be unclear about their role in the QA process. ICs also suggested that it would be more beneficial for the final QA meeting to focus on ensuring that the report meets all the requirements set out by the Home Office – not to simply go over the recommendations, which has been their experience so far.

London

Across the London boroughs involved in the pilot, there have been few OWHRs that have reached the QA stage of the process. However, stakeholders in one borough were able to provide a description of the QA process that they have implemented.

In this borough, the CSP co-ordinates the QA process for completed OWHR reports. The process is comprised of four stages:

- **Review by the case review group:** The IC provides a first draft of the report to the case review group (comprised of all review partners involved in the review). The members of the case review group review the report and provide feedback to the IC. The IC then amends the report to incorporate any comments provided. The amended version is then reviewed by the case review group again and discussed in a formal meeting. If any further amends are required, they are made by the IC before the report progresses to the next stage in the QA process.
- **Review by the OWHR strategic group:** The updated version of the OWHR report is then provided to the OWHR strategic group (comprised of the three RRPs, as well as probation[23]), which reviews and comments on the report. Following any requests for amendments, the report is finalised and ready for review by the victim's family.
- **Review by the victim's family:** The family is provided with the final version of the report that they can review prior to it being ratified (however, see section 3.4.2.1 regarding practical considerations).

[22] It was noted that IC are not commissioned (i.e. not required) to attend and present at the meeting, but all have done so.
[23] While probation is part of the strategic group, they cannot make decisions.

- **Review by the Safer Partnership for the area:** The report is shared with the area's Safer Partnership for their approval.

While the report is shared with the Safer Partnership for approval, the decision to ratify the final report rests with the OWHR strategic group.

Stakeholders reported that the QA process was intended to take two months; however, for the report/s that have been through the QA process so far, it has taken "a lot longer." Stakeholders explained that the main challenge has been the time that people have taken to respond to requests for clarifications and to provide comments. In addition, the QA process needs to align with the Safer Partnership meeting – the group only meets four times a year, so if the meetings do not coincide with when a report is finished and ready for review, it causes a delay to the QA process.

Wales

At the time of writing this report, no OWHRs in Wales had been completed; however, stakeholders were asked about the plans for QA once the reports had been written. Stakeholders explained that prior to the formal QA process, panel members will provide the first level of QA, and the report may also be reviewed by the Case Review Group, and the RSB, which includes representation from the Community Safety Partnership. Following this, the report will go to the SUSR Team for formal QA. As part of this, the Task and Coordination Group will check that the recommendations have been framed in ways that are actionable. Following which, the Business Unit will send the report to the Home Office and OWHR Oversight Board for publication. The report will also be submitted to the Wales Safeguarding Repository and shared with the coroner for their consultation prior to publishing.

Peer review

A view among some ICs was that the inclusion of peer review to the OWHR QA process could be considered for national roll-out. This could be integrated into the initial QA stages to avoid delays to finalising reports.

3.4.2 Communicating outcomes and learning from OWHRs

3.4.2.1 Engaging with families

West Midlands

Stakeholders in the West Midlands explained that their preference is for sharing of reports to be arranged by the police (i.e. FLOs) and the ICs, as they are better equipped to communicate and explain the findings. If the family is engaging in the process or has asked to see the final report, a copy of the report will be made available to them by the FLOs via the IC. Even if the family has decided not to engage with the process but still wants to see the final report, they will be provided with a copy. When sharing the report, the FLO will typically share a letter written by the IC, which explains that they will have sight of the report but that it should not be shared more widely. In addition, the family does not have a right of reply around the report, but they can pick up on any inaccuracies or information they would rather not be disclosed.

Wales

At the time of writing, neither report has been completed. However, stakeholders reported that there are plans in place for the reviewers of both OWHRs to meet with the families in person to share the reports with them.

London

As with the OWHRs in Wales, in London, completed OWHR reports have not yet been shared with family members. However, stakeholders explained that the intention is for the IC to meet with the family in person and provide them with a paper copy of the report to read. Some uncertainty about whether OWHR reports could be left with families prior to publication was expressed. While it is recognised that families should have access to the finished reports, partners have expressed concerns about families having access to the information contained within the reports without any parameters. Therefore, it has been suggested that only a paper copy of the report is shared, and that the report is returned to the IC.

Family responses

The stakeholders interviewed did not have direct experience of how families had reacted to OWHR reports; however, they reported that so far, where families have had sight of reports, there had been no issues that they were aware of.

Nevertheless, stakeholders also recognised the challenge of navigating when and how reports are shared with families. In particular, it was noted by stakeholders that care should be taken when considering when to share the report to ensure that it does not coincide too closely with the anniversary of the victim's death. However, this could prove challenging if OWHRs are to be completed in 12-months.

3.4.2.2 Communicating learning and recommendations to partners

At the time of writing this report, none of the OWHRs had reached the stage of formally communicating recommendations to relevant agencies. However, where possible, stakeholders provided descriptions of the planned approach.

West Midlands

Action plans

As few reviews have been finalised and progressed to this stage of the OWHR process in the West Midlands, the process for how recommendations and learning points will be taken forward and communicated to relevant agencies at the local level is under development. However, stakeholders explained that the CSP will co-ordinate this process and work has been undertaken to develop a centralised spreadsheet to track progress against all recommendations from OWHRs. The spreadsheet will contain all recommendations from all OWHRs, and which agency is responsible for each recommendation. A representative from each agency on the QA panel who is responsible for taking recommendations forward will then be able to access the spreadsheet and identify recommendations for their agency. Actions and progress against each recommendation will then be added to the spreadsheet as it occurs. The information within the spreadsheet will be able to feed into a progress report after 12 months.

Sharing learning

Stakeholders reported that an in person learning event for OWHRs is planned for early 2025. They explained that a wide range of agencies will be invited, and it will be an opportunity for these agencies to learn more about OWHRs in their area. There will be a number of speakers, including ICs, to highlight OWHRs and the role of the various agencies in the reviews.

Wales

Action plans

At the time of the latest wave of data collection, neither OWHR report had been completed. However, stakeholders were asked about how recommendations and learning points will be communicated. It was explained that any relevant learning will be disseminated via the SUSR to RSB business managers across Wales, and recommendations from reports will be drawn together into an overarching action plan. Although there are slight differences between the two OWHR areas in Wales in terms of how they envisage recommendations and actions will be monitored, RSBs will play a key role in the process, alongside the SUSR.

Moving forward, stakeholders explained that there will be an overarching SUSR Review Group, with two subgroups – Improving Practice Delivery Group, and the Engagement, Learning and Communications Group. The action plans will sit under the Improving Practice Delivery Group but will also cut across the Engagement, Learning and Communications Group.

Sharing learning

In Wales, stakeholders suggested that the Wales Safeguarding Repository would be beneficial to police and partners for sharing learning across Wales as well as to share learning across different review types.[24]

The SUSR will also produce fortnightly 7-minute briefing papers, based around thematic learning, and which can target particular audiences. Additionally, the SUSR will hold two bi-annual learning events each year through which learning can be disseminated.

Stakeholders also noted that they are also looking to implement a condensed briefing that could be circulated with the completed OWHR reports, so that learning can be accessed quickly.

In terms of sharing learning with England, it is anticipated that this will happen through the Home Office, OWHR Oversight Board and/or through the SUSR ministerial board. It is expected that these processes will be refined over the coming year. However, staff in the SUSR raised concerns about whether and how learning will come into Wales from England.

London

Across the London boroughs involved in the pilot, stakeholders explained that it was too early to report on how learning was being communicated and shared with partners, with some noting that this process

[24] The Wales Safeguarding Repository (WSR) "stores reviews and extracts learning from them. The WSR is a unique system utilising social science and computer science methodologies. It seeks to enhance future safeguarding practice of professionals" (Single Unified Safeguarding Review | GOV.WALES)

was more advanced in the West Midlands. In one borough, stakeholders reported that planning is underway for implementing the recommendations from completed OWHR reports. Recommendations will be converted into action plans and presented to the relevant partners/agencies to ensure that actions are feasible, and that key partners and organisations are prepared to implement the action plans. Once agreed, the actions and owners of the actions will be finalised. This process will be overseen by the CSP.

3.4.3 Implementing learning and progress reviews

At the time of writing this report, none of the reviews across any of the pilot sites have progressed to the final stages of the OWHR process. While some reviews have been completed and plans made for how recommendations will be actioned and their progress tracked, none were completed early enough for an assessment of how recommendations have been actioned.

However, while plans are in place to implement recommendations, and organisations are receptive to information sharing and reviewing existing systems, stakeholders also noted that some agencies/partners have expressed concern regarding financial and resource implications for implementing actions and recommendations. This is a point to be mindful of when assessing the progress of recommendations.

3.5 Implementation factors

This section presents stakeholders' views and experiences of factors that have affected the implementation of the OWHR process.

3.5.1 Timescales, funding, and resourcing

3.5.1.1 Timescales

Almost half (45%) of survey respondents agreed or strongly agreed that OWHRs had been delivered effectively within the suggested timeframes but over a third (39%) reported that they had found the timescales very challenging or extremely challenging. However, within interviews, stakeholders recognised the importance of implementing learning as soon as possible after a homicide involving an offensive weapon has been committed. To this point, stakeholders expressed concern that without these timescales, OWHRs could end up in a similar situation to DHRs, which have experienced extremely long delays and limited actionable learning as a result.

"[it's important to] get the learning out quickly." … "Otherwise, things drift, and you get to the point of what's the point of doing it at all?"

However, the need for some flexibility within the overall OWHR timeline was highlighted by stakeholders. For example, delays appointing ICs, slow responses to requests for information, and the challenge of balancing existing workloads were noted as factors that influence how closely the suggested OWHR milestones can be adhered to. These challenges have been seen across a number of OWHRs during the pilot period, resulting in reviews not keeping to the suggested 12-month timeline. It follows that some stakeholders suggested that an 18-month timeline might be more realistic.

While stakeholders from Wales also recognised the need for learning to be identified quickly, they expressed concern about the suggested 12-month timescale for completing OWHRs because most of their existing reviews take longer. Stakeholders explained that they had found the 12-month timescale (from point of referral) to be unrealistic for the OWHRs carried out during the pilot. If there is a national roll-out, stakeholders expressed the view that the timescales would be too tight to meet, considering the sheer volume of referrals they would be receiving under the SUSR process. It was suggested that the timescales be reviewed and that the 12-month deadline should be from the date of the first panel meeting.

Factors affecting timescales

While stakeholders recognised the value of completing OWHR reports within 12-months and reported that a number of the OWHRs have kept to the timescales set out in the guidance, others have faced challenges. Stakeholders noted four key factors influencing whether reviews were completed on time during the pilot period:

- **IC engagement with the process:** Where reviews have kept to the expected timeline, this has typically been where ICs have set the terms of reference and held panel meetings promptly. By contrast, stakeholders explained that delays were often due to ICs being uncontactable or not setting their terms of reference on time.
- **Balancing existing workloads:** As reported in Section 3.2.3.1, under the SUSR framework, OWHRs in Wales are undertaken by a chair and two statutory sector reviewers, rather than one IC as they are in England. In Wales, those undertaking the role of reviewer (and sometimes chairs) often have senior roles within the public sector and must complete the review alongside their usual role, which often carries a substantial workload. Similarly, lead agencies in England have reported being under-resourced to cope with the extra workload associated with co-ordinating OWHRs.
- **Review partner engagement:** Stakeholders explained that there were challenges obtaining information from some review partners, which delayed the review process. The challenges have tended to be around the time it takes to receive responses to requests for information from partners/agencies. Stakeholders noted that there have been cases of responses being received at the last minute as the IC is about to submit the report, which then creates a delay[25].
- **Case complexity:** Stakeholders noted that complex cases with multiple perpetrators and/or victims can mean that the review takes longer as it requires obtaining information for multiple individuals from multiple agencies. Similarly, some cases where advice was sought from the Home Office regarding eligibility criteria have taken longer.

Rapid reviews

A theme within interviews with stakeholders was the value that inclusion of a rapid review option for OWHRs could bring to a national roll-out. Stakeholders explained that where cases are “clear-cut” and relatively straightforward, it would be more efficient and cost-effective to undertake a rapid review,

[25] It is worth noting that the OWHR guidance outlines that a cut-off may need to be applied and it be accepted that information cannot be included if received too late in the process.

because it would eliminate the need to commission an IC for every OWHR. Where a case is more complex and there is potential for significant further learning, the review could progress to a full OWHR.

During the latest wave of data collection, stakeholders reiterated the perceived value of rapid reviews for less complex cases (i.e. where there is one victim and one perpetrator and/or cases where both victim and perpetrator are adults). To this point, in the West Midlands, a rapid OWHR process has been implemented for OWHR eligible cases that are occurring now the pilot has finished. It is important to note that these are internal and non-statutory reports that will not be published.

In developing the approach, stakeholders reported that they took learning from a locally applied rapid domestic homicide review process and applied a similar approach to rapid OWHRs. When carrying out a rapid OWHR, the same overall process as the full OWHR is followed, but a more streamlined approach is taken. However, a key difference is that the rapid reviews are currently completed by the police and the CSP, rather than an IC. It was highlighted that if rapid reviews were to be rolled out and became a statutory review, due to capacity concerns, they would need to be written by an IC. A further key difference between the full OWHR process and the trial rapid review process is that because the rapid reviews are not a statutory review, families of the victim/s or perpetrator/s are not invited to be a part of the review process.

The rapid review process in West Midlands:

- **Initial Incident Identification**: The process begins with identifying a qualifying incident and flagging it to the CSP. The CSP then determines if the incident meets the statutory requirements for an OWHR (although rapid reviews are not currently part of the statutory review).
- **Initial Meeting:** If the incident qualifies, relevant partners/agencies are identified and are invited to an initial panel meeting to discuss the circumstances of the incident and identify key lines of inquiry (KLOEs). The meeting is held before any requests for scoping information are sent out.
- **Document Preparation:** Agencies are asked to prepare a trimmed-down individual management review (IMR) document, capturing key relevant information aligned with the agreed KLOEs.
- **Second Panel Meeting:** In the second panel meeting, agencies present their findings from the IMR documents. The panel discusses potential learning points and recommendations.
- **Report Writing:** The police and CSP work together to write an abridged report based on the panel's discussions. This report is concise and focuses on the key findings and recommendations.
- **Review and Approval:** The report is shared via email with panel representatives for review and feedback. It is then presented to the Strategic Oversight Board (local oversight process) for final approval.
- **Learning Phase:** Once approved, the report moves into the secondary learning phase, where the recommendations are implemented to improve and protect people (as per the full OWHR).

Extended reviews

Some stakeholders also suggested that there should be an option for an extended or multi-part OWHR. This suggestion was made within the context of the delays experienced by ICs when attempting to speak with (alleged) perpetrators before they are convicted or when they are appealing their conviction (i.e.

they are typically advised by their lawyer not to speak with the IC). In addition, the backlog of cases in criminal courts can mean that many cases do not go to trial within the 12-month OWHR timeframe. Stakeholders suggested that a solution could be an OWHR presented in two parts: Part 1 would be the initial report delivered within the 12-month timeframe, and Part 2 would be a follow-up report that includes the perpetrator's perspective following a conviction. However, where a trial has not been concluded, careful consideration should be given to whether it is appropriate to publish an OWHR (either a 'Part 1' or a standard OWHR under the current guidance).

3.5.1.2 Funding and resourcing

Coordination capacity and costs

Overall, survey respondents identified staff capacity as the biggest challenge to OWHR delivery. More than half of survey respondents (55%) reported that staff capacity within partner organisations has been very challenging or extremely challenging during the pilot. In line with this, challenges with capacity continued to be emphasised within stakeholders' accounts across all three waves of data collection. Stakeholders expressed the view that the financial and staffing burden will be a "nightmare" if OWHRs are rolled out nationally without sufficient funding. A core concern is the capacity challenge that lead agencies would face without funding for OWHR-specific co-ordination posts and which local authorities described as invaluable during the pilot. To this point, stakeholders noted how lead agencies (particularly in areas with higher homicide rates) would require ringfenced resources and capacity if OWHRs are rolled out nationally.

"We wouldn't be able to do the coordination without the additional funding to pay for a post. We just wouldn't."

However, there was scepticism that it would be feasible for the national roll-out to include an additional post for every lead/co-ordinating agency in every local authority. However, stakeholders also recognised that there is variation in funding and capacity needs across the country, and that not all areas would require the same level of financial support. Nevertheless, it was noted that in order for good learning to come from OWHRs, adequate investment is required.

"[I[f the Home Office are serious about getting good learning from this … they need to make sure that it's adequately resourced."

IC fees and workload

While some ICs have expressed the view that the fixed fee they are being paid for a review is not sufficient, other ICs were in agreement that the fixed fee is adequate for a straightforward review and should continue if OWHRs are rolled-out nationally. Where there are more complex OWHRs that increase the workload of the IC, stakeholders suggested a tiered payment system based on the complexity of the review. However, stakeholders acknowledged the need to avoid OWHRs becoming prohibitively expensive, as has been the case with some other types of statutory review (e.g. DHRs).

In Wales, concerns have been raised about whether current arrangements for staffing and funding OWHRs under the SUSR process will have a detrimental impact on Wales, compared with England. It was explained how statutory reviewers and statutory chairs (see section 3.2.3.1) must complete the

review in addition to their usual workload. Furthermore, stakeholders noted that because only chairs and reviewers who are **not** from statutory agencies are paid, under the SUSR process, many chairs and reviewers for OWHRs will not be financially reimbursed for the work they complete to write the reports.[26] This points to a need for further clarification around the workload and payment arrangements for OWHRs carried out in Wales within the SUSR process, ahead of a national roll-out.

Overall, stakeholders expressed concern around the need for sufficient resource and capacity for a national roll-out of OWHRs – both in terms of the number of ICs needed and the resource required to effectively coordinate the assignment of ICs to reviews. A related concern identified by stakeholders was the possibility that if the same process was used for national roll-out, multiple local authorities could bid for the same author, which would be difficult for the ICs to manage on a national scale. It was suggested that in addition to recruiting and training more ICs, a solution could be to have the IC appointment process co-ordinated by a national or regional central body.

3.5.2 Guidance

The majority (70%) of survey respondents reported that they found the OWHR guidance and supporting materials to be very or extremely helpful, which was reflected in the interview data. However, while some stakeholders expressed the view that the OWHR guidance is helpful and more substantial than the guidance for other reviews, some adaptations were made at the local level and a number of areas for improvement have been identified over the course of the pilot.

3.5.2.1 Adaptations at the local level

Stakeholders have described a few adaptations made for their local processes:

- In both London and the West Midlands, the IC has not meet directly with the SIO; instead, a designated police contact has briefed the IC on the case and remained the core point of contact between the IC and the police for the duration of the review.
- OWHR start date: In the West Midlands, the lead agency adapted the start date of the OWHR to the date of commission not the date of notification.

Stakeholders in Wales also reported variations to the date of notification but explained that this was due to differences in how the OWHR guidance had been interpreted by the RSBs. In one case, the RSB notified the Home Office within one month that more time was required to make a decision about whether the case was a qualifying homicide. In the other case, the RSB thought that the guidance required notification to the Home Office with a decision within one month. As both options are set out within the OWHR guidance, the confusion points to a need for greater clarity within the guidance and/or communication from the Home Office on this point if OWHRs are rolled out nationally.

[26] The Home Office has clarified that fees are paid to the Welsh Government and that decisions regarding payment and how funds are distributed are made by the SUSR team.

Stakeholders also highlighted the challenge of working to two sets of guidance in Wales. This leads to feelings of uncertainty among stakeholders around whether they are adhering to guidance (and which guidance they should be adhering to).

"I think it probably has confused things at times, because of the two different pieces of legislation and because the SUSR guidance isn't actually ratified [at the time of interview], so we're also working to guidance that is potentially going to change … The challenges are the two different guidance documents and where they converge and where they don't… I think we still feel a bit like we're scrabbling around trying to understand if what we're doing is the right thing, if we are adhering to the guidance."

3.5.2.2 Suggestions for improvement

Regarding improvements for national roll-out, one view was that the guidance needs to be disseminated well in advance of a national roll-out. For the pilot, some stakeholders thought that the guidance was released too close to the launch date.

It was also suggested that the terminology of OWHRs could be improved as the current terminology for the various partners and agencies is not clear and leads to confusion.

"[T]he titles of the review partners are relevant review partners, I think they need to be differentiated a bit better because nobody remembers that."

As part of this, some stakeholders also expressed the view that there is a lack of clarity when it comes to 'health' as an RRP. That is, whether 'health' is the ICB, the mental health services, and/or local NHS trust. This points to a need to specify this more clearly in the guidance.

Finally, over the course of the pilot, stakeholders have highlighted specific parts of the OWHR process that would benefit from more and/or clearer guidance. These recommendations have been included in the relevant sections of this report.

3.5.2.3 Templates

Evidence gathering and referral form templates

In London, one borough's LA/CSP developed and operationalised a decision-making process for OWHRs. This includes detailed templates, guidance, and timelines, which have been influenced by other types of statutory reviews (e.g., DHRs). Since then, the borough has shared these resources across other London LAs/CSPs involved in the pilot. Stakeholders from some other London LA/CSPs described using the resources provided and adapting them as needed. For example, adding a process map and checklist and creating a log to track how the CSP is meeting the targets/milestones set out in the process and how resources are being used.

The police in the London pilot area also reported that they have produced an extra briefing document, which they complete in addition to the scoping and information gathering templates in the guidance. The briefing document was described as being more comprehensive and tailored to the information relevant to recording police involvement/criminal history.

Within the West Midlands, stakeholders reported that they had clear processes and templates that they use for existing statutory reviews (such as DHRs), which were then either used or adapted for OWHRs. One view was this approach was taken to "normalise" the process for partners as they are already familiar with the DHR templates and forms; however, another view was that the OWHR templates were not fit for purpose and include irrelevant, poorly considered, and poorly worded questions.

The only OWHR template used in Wales has been the notification to the Home Office because all other templates are from the SUSR process. The SUSR forms were agreed initially with the Home Office but have been revised as the SUSR pilot has progressed and statutory guidance has been developed. Stakeholders involved in the OWHRs in Wales expressed the view that the information gathered through the SUSR scoping and evidence gathering documents was lacking in detail, depth and context compared with the IMRs they had previously produced or read in relation to other statutory reviews.

Stakeholders also reported that there have been challenges with the SUSR referral form. Specifically, partners found the form difficult to navigate because it relies on users clicking on an arrow for each victim and perpetrator added, which was missed in some instances. Information has been fed back to the SUSR and further guidance has been provided on the form.

Overall, for national roll-out, stakeholders expressed the view that there should be a set of well-considered standardised forms and templates for use by those conducting OWHRs. However, while standardised forms were advocated, it was also noted that templates should be flexible enough to allow for adaptation to the circumstances of each case.

Report template

Some stakeholders noted that ICs have varied in how closely they have followed the report template provided in the OWHR guidance, and that more guidance on how much flexibility is acceptable would be welcomed. While some ICs have closely followed the template and guidance, others have completely disregarded it, and some have changed the structure but have ensured that all key sections are still included. There is also variation in the formatting seen in the final reports. For national roll-out, stakeholders suggested that more guidance on expectations around what the final report should look like in terms of key sections, structure, and formatting[27] would be helpful for ICs and ensure that the final reports are of a consistent standard (this could include examples of 'good' reports). In line with this, one suggestion made by stakeholders is for the Home Office to outsource the final proofreading of the reports to ensure consistency across grammar, punctuation, and formatting. However, stakeholders also recognised that building in a proofreading panel would delay the completion of reports, which negates the aim of OWHRs being more rapid than existing statutory reviews.

Some RRP stakeholders have expressed the view that some of the OWHR reports have been too long and have included unnecessary detail, which has obscured the key learning. The need for guidance on the length and content of the reports to ensure they are concise and relevant has been suggested for national roll-out.

[27] It is worth noting that the current report template found in the OWHR guidance provides information on potential structure and formatting of a OWHR.

"We don't need an 80-page report on everything that's happened in these people's lives because … that's not what it's [the OWHR report] needed for, like it needs to be, actually, these are key issues."

Letters to families

Some ICs explained that when writing to the victim's family to notify them that an OWHR was being undertaken, they used the letter template but "softened" it to be less "jargonistic" and personalised it. A process which was encouraged within the OWHR guidance. Similarly, stakeholders in London described how the template used for writing to families has been adapted to be less formal and includes a list of appropriate support services. In addition, one London borough provided a leaflet with information on council support services as part of communication with families. Stakeholders explained that the leaflets were disseminated to community members as standard practice following an incident such as an OWH, rather than having been developed specifically for OWHRs. The inclusion of information on local support services and helplines was suggested within the OWHR guidance.

3.5.2.4 Mentoring and peer support

It was noted that after initial training, the ICs set up a WhatsApp group for peer support and mentoring. Since then, additional groups have been set-up (e.g. for specific pilot areas) to share experiences and advice, which the ICs continue to find helpful.

When asked about whether a more formal approach to peer support for ICs was needed, one view was that formal support is not needed and that the quarterly meetings with the Home Office are helpful and sufficient. However, another view emphasised the importance and value of peer learning; as part of this, it was suggested that peer mentoring forums and/or networks as well as online learning events for partners and ICs should be established, if OWHRs are rolled out nationally. The option for less experienced ICs to shadow those with more experience of chairing statutory reviews could also be considered.

"I think for the roll-out…people that haven't had the experience, it would really benefit them to learn from those that have been part of the pilot. I think that would be really important."

A further suggestion for national roll-out (and as already suggested in the current OWHR guidance) was to establish a network of local experts who can speak to the local context of an area, which the ICs can contact as part of their preparatory work for conducting a review. It was suggested that this would be especially relevant for ICs picking up OWHRs in areas that they are not familiar with.

"Are there people who … are able to describe that cultural narrative?"

3.5.3 How OWHRs have worked within the SUSR process

Overall, stakeholders reported that OWHRs have been working well within the SUSR framework. Staff within the SUSR felt that initially there had been some mistrust from the RSBs because they thought they were going to be inundated with OWHRs. However, this has not happened. The SUSR have met monthly with RSBs and have built a good trusting relationship with them, helping to resolve any issues that have arisen.

Stakeholders were asked as part of the survey and during interviews to provide feedback regarding any benefits or challenges of the SUSR process, which are summarised below.

3.5.3.1 Benefits of the SUSR process

- **Consistency:** The SUSR process was praised for its centralised review process, ensuring effective partnership interaction and cooperation. Stakeholders expressed the view that the SUSR process is straightforward and will provide consistency across statutory reviews. It is anticipated that the Wales Safeguarding Repository will be especially helpful, particularly from the perspective of managing learning and recommendations coming out of reviews. Through the Repository, reviewers will be able to spot thematic learning coming from reviews nationwide. This will help when compiling reports and identifying learning, actions and recommendations. Where themes are found to be impacting the whole of Wales, additional resources, focus, or support may be put in place.

- **Learning Events:** While Learning Events are a consideration when conducting an OWHR, they are a requirement as part of the SUSR process. Learning Events are held before the report is finalised and bring together frontline practitioners who have worked closely with the victim and/or alleged perpetrator/s, to identify gaps and provide further information and clarity. Reviewers and the chairs have been extremely positive about the benefits of conducting the learning events and have noted the rich learning that comes from them. However, it was also noted that there is a need to capture information and learning in alternative ways when an agency cannot attend a learning event.

3.5.3.2 Challenges of the SUSR process

Running two pilots concurrently

- Some stakeholders acknowledged the challenges of running the OWHR pilot at the same time as the SUSR pilot. A view among SUSR staff was that the OWHR pilot would now run more smoothly because of the processes and structures that have been put in place within the SUSR. For example, the SUSR are currently setting up secure shared file areas to enable information to be shared more easily between RSBs and the SUSR.

- Some stakeholders reported that there had been challenges because of the two different sets of guidance, which at times appeared to provide conflicting information (see section 3.5.2.1). If OWHRs are rolled out nationally, it is hoped that guidance for conducting OWHRs could form part of the SUSR statutory guidance, which would simplify the process for chairs and reviewers. Similarly, it is hoped that any specific OWHR training could be assimilated into the SUSR training, to avoid chairs and reviewers undertaking more than one set of training.

Grant Award

- Stakeholders explained that it had been agreed with the Home Office that the SUSR Team would administer the grant award and act as a ‘go-between’ between the Home Office and review partners. However, it was felt that this might not have been the best approach.

- Stakeholders noted that the Home Office had envisaged that the grant funding would be provided to relevant review partners; however, stakeholders highlighted that many more partners than just police, health, and local authorities contribute to reviews. It was suggested that funding is widened to recognise all partners who deliver reviews and helped to facilitate them[28].
- Stakeholders expressed the view that further clarity is needed in relation to how grant awards should be split between chairs and reviewers, although statutory chairs or reviewers receive no additional money for conducting an SUSR (see section 3.5.1.2).

Differences between processes in England and Wales

- Stakeholders noted that because OWHRs in Wales fall under the SUSR framework, there are slight differences in the review processes for OWHRs carried out in Wales and England. This has the potential to result in confusion and error when an OWHR requires involvement from agencies in both nations.

[28] For more information about funding set out for the OWHR pilot, see the Impact Assessment that took place before the pilot: Update note: Offensive weapons homicide review impact assessment - GOV.UK

4.0 Benefits and perceived outcomes

This section presents stakeholders' views on the emerging benefits and perceived outcomes of the OWHR pilot to date.

4.1 Addressing gaps

Most survey respondents (80%) agreed or strongly agreed that OWHRs are being used for homicides that previously did not qualify for a statutory review and are addressing gaps left by other statutory reviews. Similarly, within the interview data there was overall agreement among stakeholders that OWHRs are filling a gap left by other statutory reviews.

Stakeholders expressed the view that OWHRs are more comprehensive and "multifaceted" – allowing the IC to cover multiple issues relating to both the victim/s and (alleged) perpetrator/s, such as mental health and history of domestic abuse, within a single review. As such, they will provide learning not being captured by other types of review. For example, a case involving a parallel mental health homicide review illustrated how an OWHR takes a more comprehensive approach and gives more context to the circumstances leading up to the homicide than a mental health homicide review.

"The mental health review focused completely on the alleged perpetrator and only [on] the mental health input… [… The OWHR] focused across all, so it was on the victim and all of their input with services and their background, [how] that person ended up in that place at that time, in that vulnerable situation, and the alleged perpetrator in all their context and all their input services, and whether there were opportunities missed."

Moreover, within the open text survey responses, respondents highlighted a number of benefits that OWHRs will bring. Respondents felt that OWHRs will be beneficial to families, peer groups, and communities affected by homicides, providing closure and understanding of underlying causal factors.

However, stakeholders expressed concern that OWHRs (and other reviews) are still missing homicides as a result of peer-on-peer violence where the victim is under 18. For example, it was noted that Child Safeguarding Practice Reviews are focused on cases where there is neglect or abuse rather than serious youth violence between peers.[29]

"One area that does concern me that is certainly not getting picked up in an OWHR – [is] your under 18s. That is a real concern because a large proportion of them will not get picked up as Safeguarding. That was the assumption, that they'd get picked up as Safeguarding. I can guarantee they will not."

In line with this observation, stakeholders suggested that a focus on the context of the crime rather than age would add clarity to the criteria and remedy the issue ahead of a national roll-out.

Regarding the effectiveness of OWHRs to provide a better understanding of the antecedents of offensive weapons homicides and where services can be improved, a prevalent view in interviews was that it is

[29] Please see footnote 12.

still too early to tell. However, there was hope among stakeholders and a view that findings from OWHRs will allow agencies to reflect on where they are doing things well and where improvements are needed.

"I do think it's [OWHRs] the right process and I am optimistic."

4.2 Preventing harm

While most (78%) survey respondents agreed or strongly agreed that OWHRs are producing useful insights, only half of survey respondents (50%) agreed or strongly agreed that recommendations from reviews will help to prevent homicides in the future.

Furthermore, although stakeholders felt that there is great potential for OWHRs to contribute to preventing offensive weapons homicides, they noted that there has not been evidence of this during the pilot period (that is, the pilot and evaluation have been too short to see whether OWHRs are effective in preventing harm).

"[T]his is only the start of the process, this isn't the end of the process."

Stakeholders spoke positively about the potential value of OWHRs, particularly the focus on developing actionable recommendations that will (hopefully) lead to change more quickly than other reviews. However, this was accompanied by the caveat that the added value of OWHRs is linked to them being completed in good time and the learning disseminated promptly. Stakeholders emphasised that it will be critical to "cascade" the findings so that lessons can be learned and put into action. However, some stakeholders acknowledged that learning is not always embedded into practice.

"[W]e need to do more with the learning and the recommendations as part of daily practise and policy… there's a huge amount of time and effort that goes into reviews and my concern is that they're done and then the box is ticked, you've gone through a whole review and then they just sit there as a product. We need to be thinking more … how do we learn and use that learning?"

As part of this, stakeholders also expressed some concern around whether there will be sufficient oversight of the implementation of learning and recommendations from the reports.

"My worry is that nobody will come back in three years' time and check that they're [recommendations are] embedded, they've remained embedded and they're making a difference. That's where good governance is required, in how we track them."

To this point, stakeholders observed that because so few OWHRs were completed within the pilot period, the post-review period, during which the progress of the actions and recommendations from the reviews is monitored, will occur after the evaluation has been completed. Survey respondents also emphasised in their open text responses the need for further evaluation after full implementation to better understand the benefits and effectiveness of OWHRs.

5.0 Summary of emerging recommendations

This section presents a summary of the recommendations that are emerging from draft OWHR reports/summaries that we have had sight of at the time of writing.[30,31] It is worth noting that the available reports/ summaries are subject to change as they have not been through quality assurance processes, and are not yet ready for publication at the time of writing this report. At the time of writing this report, 17 draft OWHR reports/summaries where available to be reviewed in this analysis.

Recommendations from the OWHRs to date centre on developing and reviewing policies, strategies, and services at both local and national levels. Below is an overview of the emerging themes within these recommendations.

- **Youth Crime Prevention:** Recommendations focus on improving policies and services related to youth crime prevention, including mentoring for young people at risk of being drawn into crime / serious violence, consistency and continuity of social work provision, and public awareness campaigns. In addition, it has been recommended that policies, services, and campaigns are evaluated.
- **Protection of victims and witnesses.** Some victims and/or witnesses to crime can be reluctant to engage in police investigations due to fear of reprisal from the perpetrator/s. Recommendations include a review of the legislation around protection and investigation within the Criminal Justice system to establish if, in addition to the current special measures, what additional reassurance and measures can be put into place to protect fearful and intimidated victims and witnesses.
- **Information Sharing and Collaboration:** Recommendations put an emphasis on developing protocols for sharing information and risk assessments among relevant agencies, including police, probation, health services, mental health services, universities, and housing providers, to ensure effective communication and collaboration.
- **Support for Vulnerable Populations:** Recommendations highlight the need for better support and services for vulnerable populations, including those with mental health issues, neurodivergent traits, and those transitioning from adolescence to adulthood. As part of this, recommendations include a need for enhanced vigilance and monitoring of non-engaged people and families.
- **Support for the transitional cohort:** A number of recommendations address the need to support the transitional cohort – young people transitioning from adolescence to young adulthood (approximately 18-25 years of age). Formulation of strategies and delivery plans designed to support vulnerable young people transitioning to young adulthood is recommended. As part of this, extending the remit of the Youth Justice service to age 25 for complex and high-risk cases is also proposed.

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[30] The review reports that we have had sight of have been in varying stages of completion. While some have a full set of recommendations, others have incomplete lists or no recommendations at all.
[31] Where recommendations have been included, the number of recommendations varies quite considerably. Some reports currently have a handful of 4 or 5 recommendations, while others have a more lengthy list of 13 or 14.

- **Education and Training:** Focus on improving education and training for professionals working with young people and vulnerable populations, including awareness of neurodivergent traits, exploitation, and training on safeguarding and risk assessments.
- **Housing and Vulnerability:** Recommendations address housing referrals from hospitals and emphasise the need for housing referrals to more effectively consider vulnerability and safeguarding. Recommendations include reviewing available accommodation to make sure it is fit for purpose and training for housing staff on mental health, offending, exploitation, drugs, and alcohol. More generally, recommendations highlight the need for improved engagement between local authorities and social housing providers to support vulnerable individuals.
- **Risk Assessment:** Recommendations point to the need for a review of local risk assessment processes to ensure that they are fit for purpose, greater consideration of contextual safeguarding risk factors as part of the assessment process, and development of a multi-agency quality assurance processes aim at achieving greater consistency across assessments.
- **Changes to OWHR statutory guidance:** It is recommended that Central Government Departments are named as Appropriate Bodies in the Statutory Guidance for Offensive Weapon Homicide Reviews.

6.0 Conclusions and recommendations

The Offensive Weapons Homicide Review (OWHR) pilot has demonstrated significant potential in addressing gaps left by other statutory review processes, offering a comprehensive examination of homicides involving offensive weapons. The evaluation reveals several key findings:

- The OWHR pilot highlighted the importance of clear governance structures and the pivotal role of lead agencies in coordinating reviews. The pilot areas benefited from distinct approaches tailored to their local contexts. The involvement of Community Safety Partnerships (CSPs) in England and Regional Safeguarding Boards (RSBs) in Wales proved critical in managing and overseeing the reviews.
- The identification of qualifying cases was reported to have worked well. Generally, stakeholders found the criteria straightforward, and following some initial clarifications at the start of the pilot, had allowed for relevant cases to progress. Lowering the age criteria for victims to include those under 18 was a recurring theme. Whilst technically covered through other reviews, stakeholders were of the view that these do not always capture cases of peer-to-peer violence and important learning was being missed.
- The appointment of Independent Chairs (ICs) has been both a strength and a challenge. While ICs bring essential independence and expertise to the review process, variability in their experience has impacted the consistency and quality of reviews. The process for commissioning ICs may benefit from some refinement to ensure efficiency and appropriate matching of ICs to cases.
- Gathering evidence proved challenging, particularly due to unfamiliarity with the OWHR statutory requirements among some agencies and bureaucratic barriers. As familiarity with the statutory requirements increases, more effective information sharing processes could be expected.
- Family involvement is important but complex. Timing and sensitivity are key, as families' willingness to engage can vary based on their stage of grief and the progress of criminal investigations. Working with (police) Family Liaison Officer (FLO) or similar within LAs/CSPs enabled these interactions.
- Conducting OWHRs in parallel with criminal investigations and other review processes, such as Mental Health Homicide Reviews, has been feasible with clear communication and coordination. However, careful management is needed to ensure these parallel processes do not impede one another.
- The pilot has established mechanisms for sharing early learning and best practices, notably through local partnership meetings and Home Office-organised events. These forums have fostered a collaborative environment and facilitated the dissemination of emerging insights.
- Staff capacity within partner organisations remains a significant challenge. The pilot underscored the need for dedicated resources and funding to manage the additional workload associated with coordinating and conducting OWHRs effectively.

Recommendations for National Roll-out

Based on the findings from the OWHR pilot, the following recommendations are proposed for a potential national roll-out:

- Establish clear governance structures: Designate local authorities (CSPs in England and RSBs in Wales) as lead agencies for coordinating OWHRs. Ensure dedicated OWHR coordinators are in place, funded appropriately to manage the review process without overburdening existing staff.
- Enhance the appointment process for ICs: Develop a streamlined and efficient process for commissioning ICs, considering their expertise and experience relevant to each case. Provide additional training and mentorship opportunities for less experienced ICs to ensure consistency and quality in conducting reviews.
- Improve information sharing and gathering: Implement standardised data sharing agreements and secure platforms for exchanging sensitive information, including a secure email function. Conduct awareness and training sessions for partners to ensure understanding of statutory obligations and facilitate smoother information gathering.
- Facilitate family involvement: Develop flexible guidelines for engaging families, considering their grief stages and involvement preferences. Use trauma-informed approaches and provide translated materials and interpretation services as needed. Clarify the role of the FLO (or similar) and encourage consistent practices in facilitating family interactions.
- Address parallel investigations: Provide clear guidance for managing OWHRs alongside criminal investigations and other review processes. Establish protocols to prevent conflicts and ensure cooperation between different review types.
- Promote learning and dissemination: Organise regular learning events and workshops to share insights and best practices across all regions. Consider developing a repository for OWHR reports and thematic analysis to facilitate wider dissemination of lessons learned.
- Ensure adequate resourcing: Secure sufficient funding to support the national roll-out, ensuring all lead agencies have the resources needed to manage and engage with the OWHR process effectively. Consider adopting a tiered payment system for ICs based on the complexity of cases to ensure fair compensation and incentivise participation.
- Review and adapt guidance: Update and disseminate comprehensive guidance well in advance of the national roll-out. Clarify the roles and responsibilities of all relevant partners, including the definition of 'health' within the context of OWHRs. Develop concise and adaptable templates for evidence gathering and reporting.
- Pilot rapid and extended reviews: Consider introducing rapid review options for straightforward cases to enhance efficiency. Explore the feasibility of extended or multi-part reviews to address complex cases and ensure comprehensive learning.
- Monitor and evaluate implementation: Establish robust mechanisms for monitoring the implementation of recommendations and tracking progress. Conduct follow-up evaluations to assess the long-term impact of OWHRs on preventing homicides and improving practices.

By adopting these recommendations, the OWHR process can be effectively scaled up, ensuring that the valuable lessons learned from the pilot are integrated into a robust and comprehensive national framework.

Whilst not strictly a recommendation for the OWHR national roll-out, given the recuring view from stakeholders that lessons from peer-to-peer violent homicides are potentially being missed under existing reviews, the Home Office may want to consider providing additional guidance around this, or linking up with guidance on other types of reviews.

Annex A: Theory of Change & Analytical Framework

Figure 2 OWHR Theory of Change (ToC)

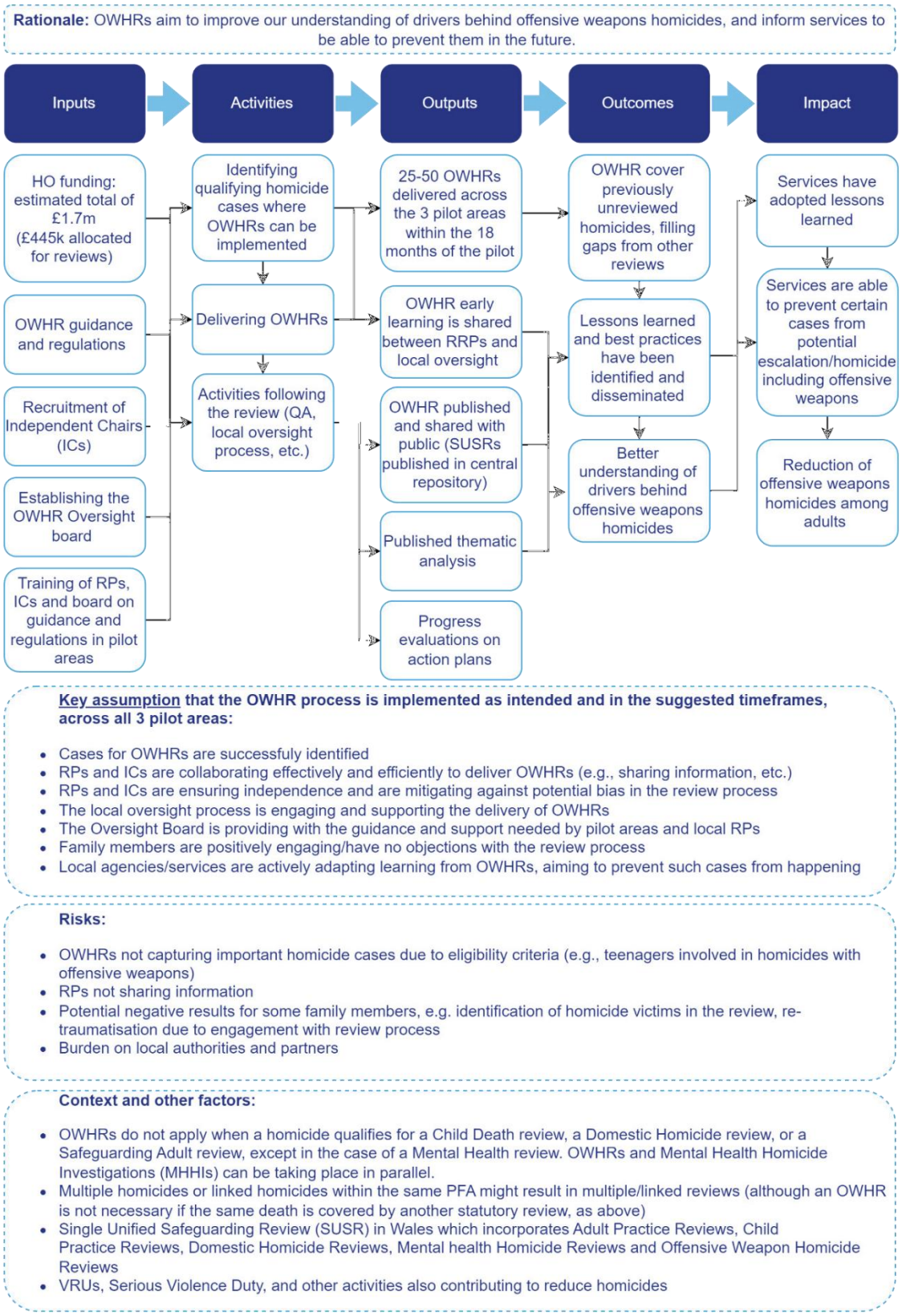


Table 5 Analytical Framework

ToC alignment	Research question
Inputs	How was Home Office funding used by pilot areas? Were there variations in costs? If so, why?
Inputs	To what extent and how did OWHR guidance and regulations inform the approach adopted in pilot areas? How was guidance adapted to consider local contexts?
Inputs	Did Review Partners attend the training on guidance as intended, and was this beneficial for them?
Activities	Were Review Partners able to identify eligible homicide cases for OWHRs? Did the eligibility criteria work as intended and were there any issues in identifying qualifying cases?
Activities	Were OWHRs implemented and delivered as intended, and in the suggested timeframes?
Activities	What was the relationship between Review Partners and Independent Chairs (ICs), and how did this affect the process of delivering OWHRs?
Activities	What lessons/ best practices can be learned from the involvement of independent chairs/ leading agencies in this process?
Activities	Was the delivery of OWHRs affected by parallel criminal investigations/proceedings or in cases of joint reviews (e.g., MHHIs[32])? If so, how?
Activities	Were the allocated funding and resources in each area sufficient to deliver OWHRs successfully?
Activities	Did the activities following the reviews (e.g., QA, local oversight process, etc.) take place as intended and in the suggested timeframes?
Activities	Was the local oversight process and the Oversight Board efficient and effective in providing with sufficient support to review partners in delivering OWHRs?
Outputs	How many OWHRs were delivered across the 3 areas by the end of the pilot? Was this in line with expectations (25-50)?
Outputs	Was early learning from OWHRs shared across Review Partners and local oversight?

[32] MHHI=Mental Health Homicide Investigation

Outputs	Were OHWRs published and shared in the intended timeframes?
Outputs	Were there any thematic analyses produced and shared by the Oversight Board? Were the analysis findings useful and adaptable?
Outputs	Were progress evaluations implemented by the Review Partners (alongside local oversight and Oversight Board contributions) in the intended timeframes? Did the Oversight Board conduct regular monitoring of the delivery of report recommendations within local action plans?
Outcomes	Did OWHRs cover previous gaps left by other review processes? What was the added value?
Outcomes	Were there lessons learned and best practices identified by the OWHR process?
Outcomes	Did the OWHRs undertaken lead to a better understanding of drivers behind offensive weapons homicides?
Impact	What are the perceived impacts of OWHRs for agencies and services?
Impact	Are there indications that OWHRs can lead to reducing offensive weapons homicides?
Impact	Are lessons learned from OWHRs adaptable to improve the prevention of offensive weapons homicides?

Annex B: Quantitative quarterly monitoring outputs

Table 6 Quantitative output metrics

Quantitative output metric	Target
Number of OWHRs carried out (total and each area)	Total: 25-50 (estimated 36)
Number of homicides considered for an OWHR but ruled out of scope (total and each area)	N/A
Demographic data and profile of victims and suspects/perpetrators when an OWHR is considered	N/A
Length of time to decide whether the conditions for an OWHR was met	<1 month
Length of time to notify the Secretary of State of the decision	<1 month
Length of time taken to complete each OWHR	<=12 months
Average resource required (hours worked) to complete an OWHR	N/A
Costs associated to the delivery of each OWHR, broken down by review partner and IC	Estimate per review = £12.3k (across all partners)
Number of reviews conducted by an independent chair	N/A
Length of time taken to publish OWHR after completion	30 days/ disclosure dependent

Annex C: Online Survey outputs

This annex contains summarised findings from the online survey analysis in the form of graphs:

Figure 3 Survey respondents' role in the OWHR pilot

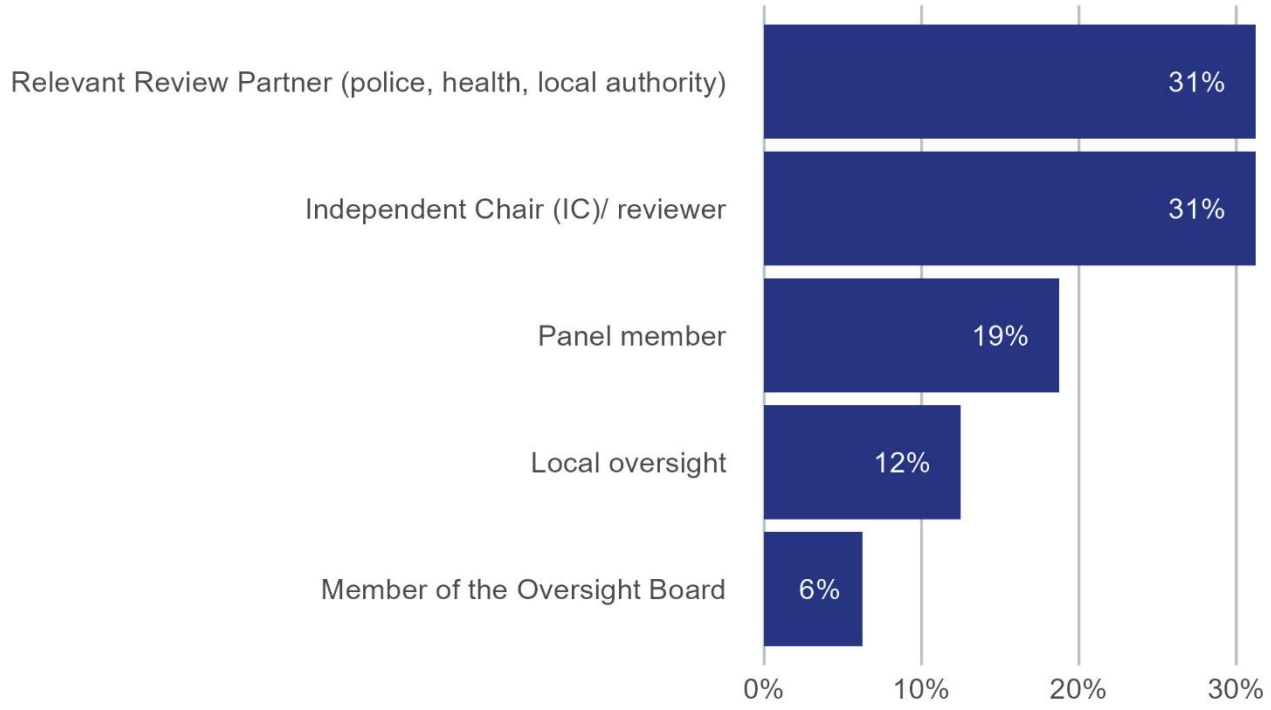


Figure 4 Survey respondents' organisation/ work status

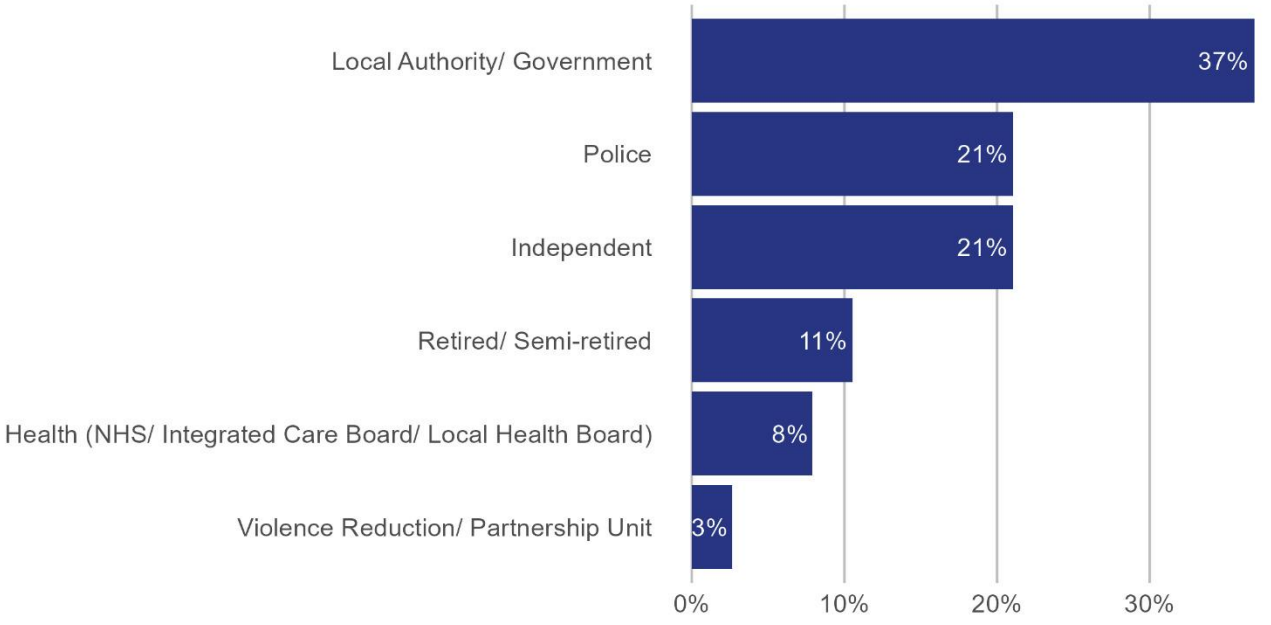


Figure 5 Survey respondents' involvement in pilot areas

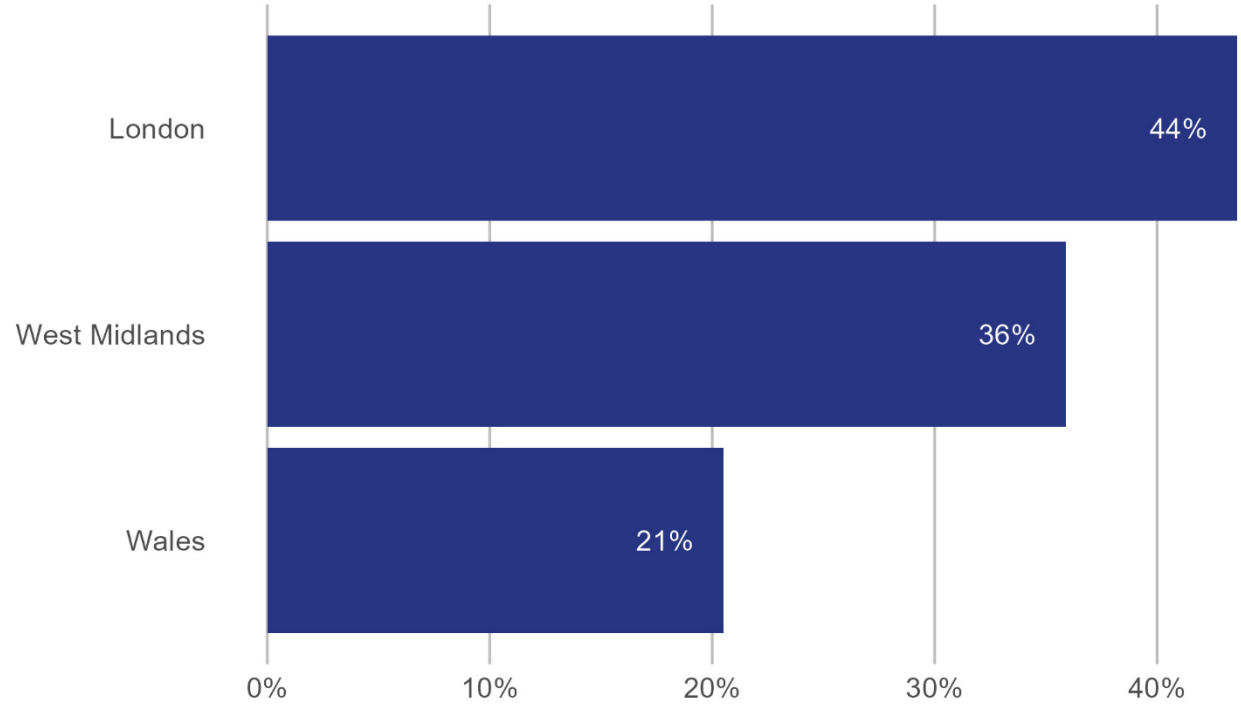


Figure 6 Survey views on OWHR governance

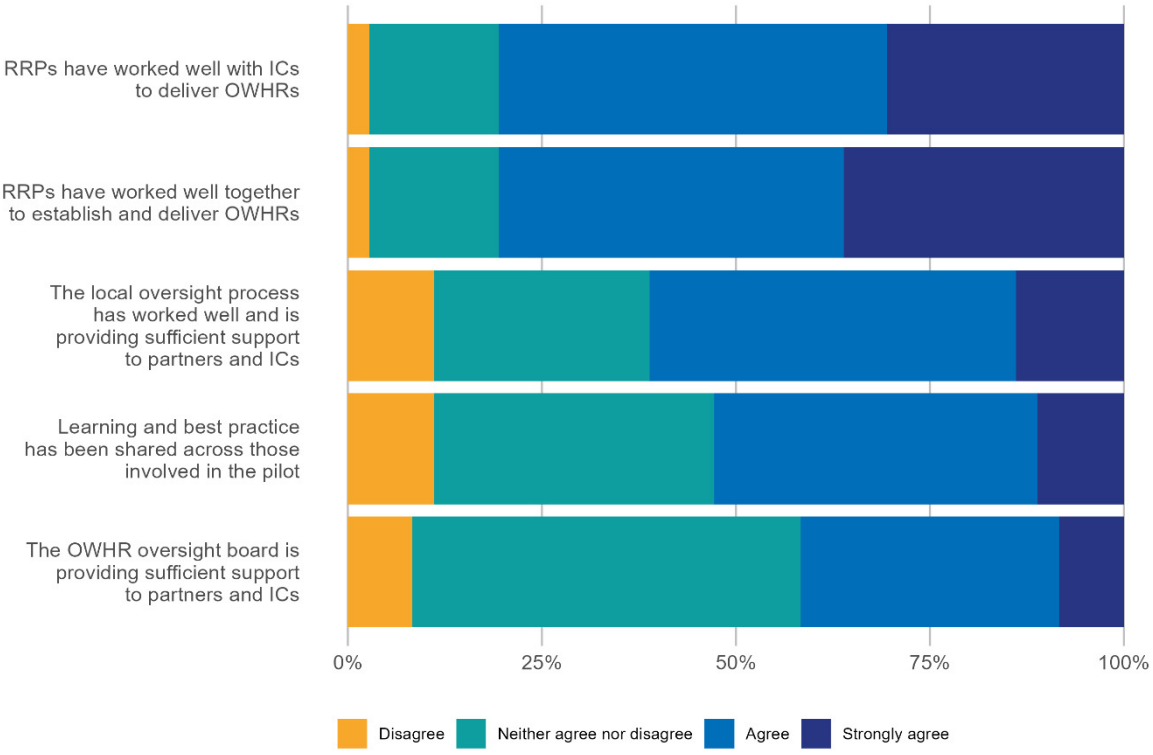


Figure 7 Survey views on challenges in the OWHR process

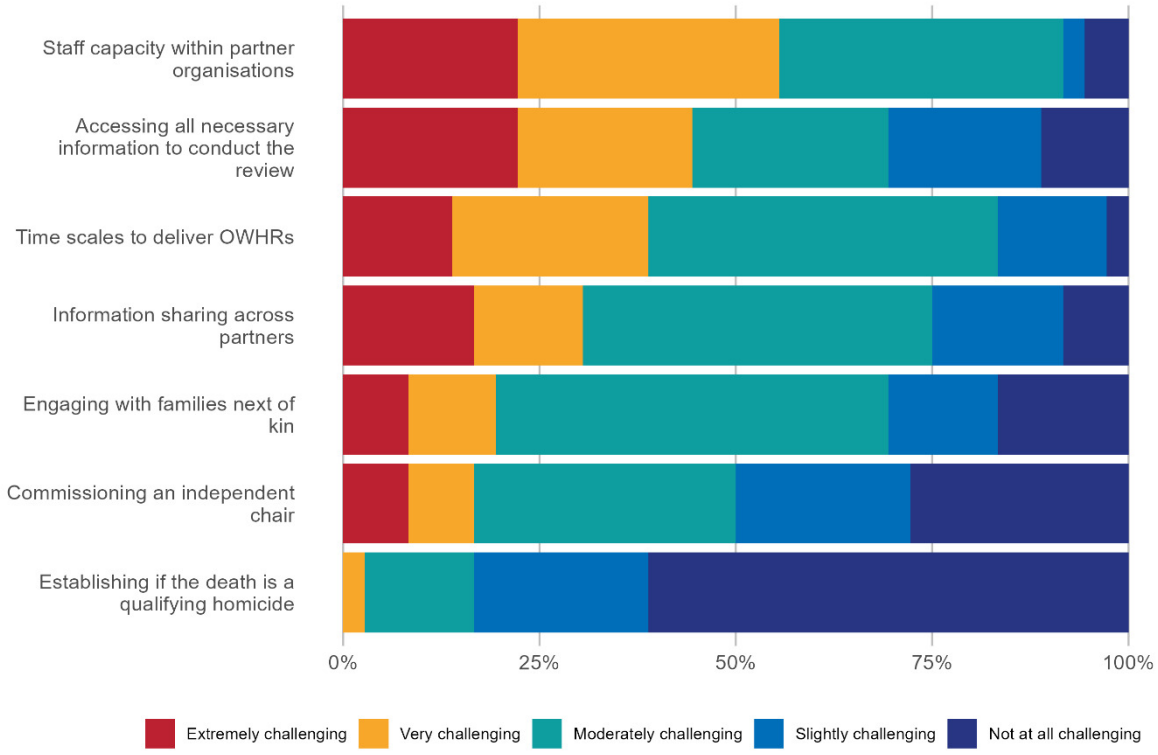


Figure 8 Survey views on enablers of the OWHR process

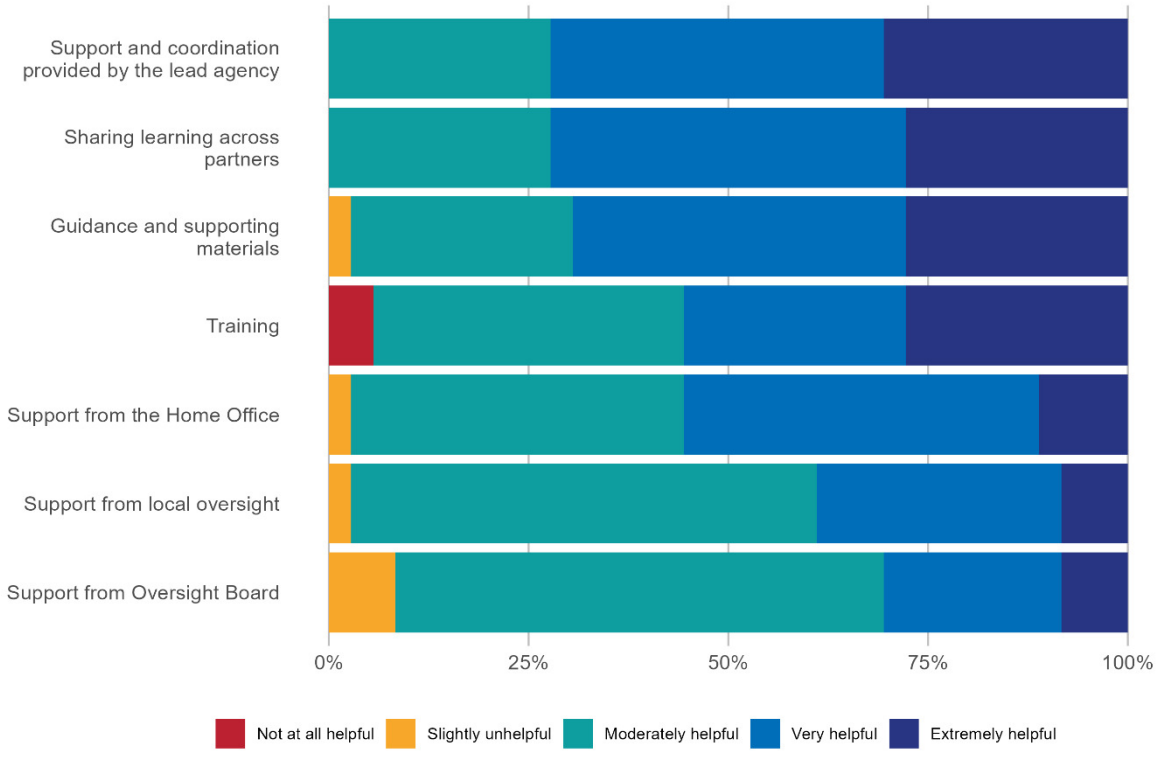
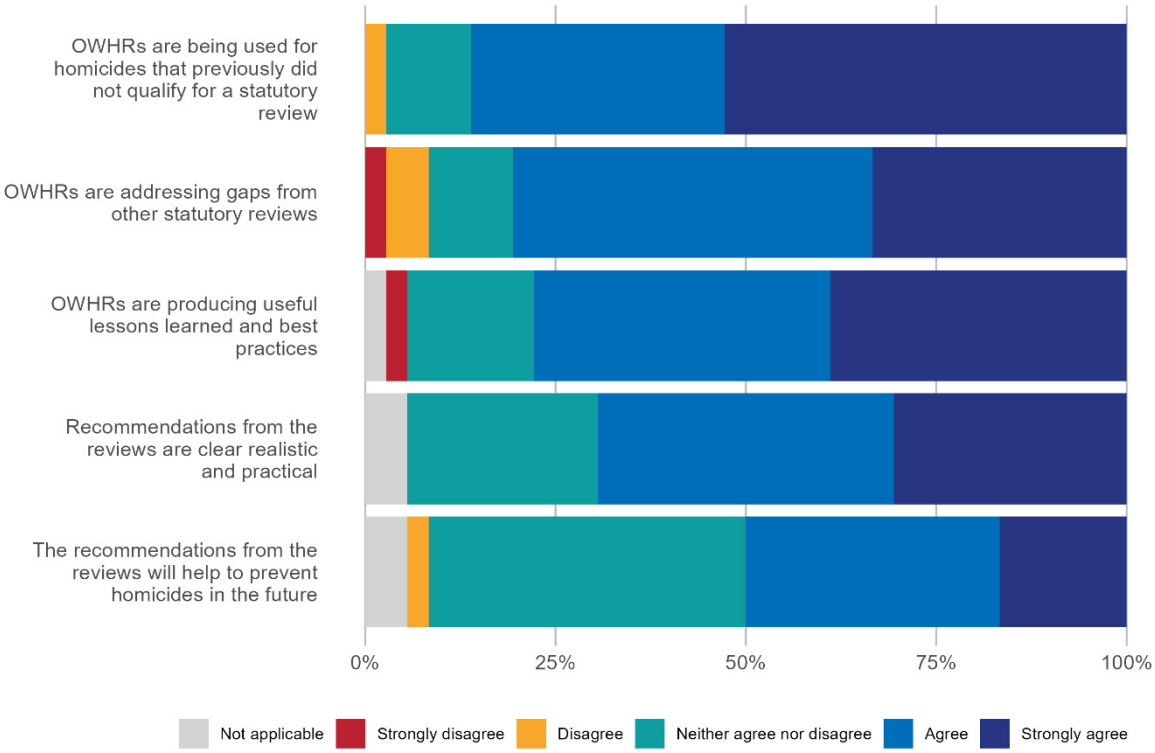


Figure 9 Survey views on emerging benefits and outcomes of OWHRs



Annex D: Online Survey Questionnaire

1. **Do you agree to take part in this survey?**

    a. Yes

    b. No [go to end of survey]

[single code]

Information about you

2. **Which of the following organisations/ sectors do you work for?** *[Subtitle: please select all that apply:]*

    a. Police
    b. Health (NHS/ Integrated Care Board/ Local Health Board)
    c. Local Authority/ Government
    d. Violence Reduction/Partnership Unit
    e. Immigration
    f. Probation
    g. Education
    h. Voluntary sector
    i. Retired
    j. Other [please specify]

[multi code]

3. **Which of the following pilot areas are you currently involved in?** *[Subtitle: please select all that apply:]*

    a. London
    b. West Midlands
    c. Wales

[multi code]

4. **Which of the following best describes your role within the OWHR pilot?** *[Subtitle: please select all that apply:]*

    a. Relevant Review Partner (police, health, local authority)
    b. Independent Chair (IC)/ reviewer
    c. Panel member
    d. Local oversight
    e. Member of the Oversight Board
    f. Other [please specify]

[multi code]

OWHR pilot implementation

5. **To what extent do you agree with the following statements regarding the implementation of the OWHR pilot?** *[Subtitle: RRP = Relevant Review Partner (police, health, local authority), IC = Independent Chair/ reviewer]*

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
The eligibility criteria have been used as intended to identify qualifying OWHR cases.					
OWHRs are being delivered effectively, within the suggested timeframes					
OWHRs are being successfully implemented in parallel with the criminal investigation or other investigative processes (e.g. coroner's inquiry)					
The OWHR process is clearly understood by all RRPs					
The OWHR process is clearly understood by all ICs					
The OWHR process is clear to all other appropriate contributing organisations, where those are involved					

[likert matrix]

6. **To what extent do you agree that OWHRs are being successfully implemented alongside parallel Mental Health Homicide Reviews?** *[Subtitle: If not applicable to your involvement with the OWHR the pilot, please select "not applicable".]*

    a. Strongly Agree
    b. Agree
    c. Neither agree nor disagree
    d. Disagree
    e. Strongly disagree
    f. Not applicable

[single code]

7. **To what extent do you agree with the following statements regarding the collaboration between those involved in the pilot?** *[Subtitle: RRP = Relevant Review Partner (police, health, local authority), IC = Independent Chair/ reviewer]*

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
RRPs have worked well together to establish and deliver OWHRs.					
RRPs have worked well with ICs to deliver OWHRs.					
The local oversight process has worked well and is providing sufficient support to partners and ICs.					
The OWHR Oversight Board is providing sufficient support to partners and ICs.					
Learning and best practice has been shared across those involved in the pilot.					

[likert matrix]

8. **To what extent do you agree that SUSR framework and arrangements have supported the effective implementation of OWHRs in Wales?** *If not applicable to your involvement with the OWHR pilot, please select "not applicable". [Subtitle: SUSR = Single Unified Safeguarding Review]*

    a. Strongly agree
    b. Agree
    c. Neither agree nor disagree
    d. Disagree
    e. Strongly disagree
    f. Not applicable

[single code]

9. **Have there been any benefits or challenges in working alongside the SUSR process? Please describe:** *[Subtitle: If not applicable to your involvement with the OWHR pilot, please leave this blank.]*

[open-text]

Emerging challenges, best practices, and lessons learned

10. To what extent have the following factors been *helpful* in the successful implementation of OWHRs?

	Not at all helpful	Slightly unhelpful	Moderately helpful	Very helpful	Extremely helpful
Training					
Guidance and supporting materials					
Sharing learning across partners					
Existing knowledge and experience from other reviews					
Support and coordination provided by the lead agency					
Support from local oversight					
Support from Oversight Board					
Support from the Home Office					

[likert matrix]

11. Are there any other factors that contributed to the successful implementation of OWHRs? Please describe:

[open-text]

12. To what extent have the following factors been *challenging* in the OWHR process?

	Not at all challenging	Slightly challenging	Moderately challenging	Very challenging	Extremely challenging
Time scales to deliver OWHRs					
Staff capacity within partner organisations					
Information sharing across partners					
Engaging with families / next of kin					
Establishing if the death is a qualifying homicide					
Commissioning an Independent Chair					
Accessing all necessary information to conduct the review					

[likert matrix]

13. Are there any other challenges that affected the successful implementation of OWHRs? Please describe:

[open-text]

14. To what extent do you agree that the funding from the Home Office has been sufficient to carry out OWHRs?

a. Strongly agree
b. Agree
c. Neither agree nor disagree
d. Disagree
e. Strongly disagree

[single code]

Emerging benefits of OWHRs

15. **To what extent do you agree with the following statements?** *[Subtitle: If not applicable to your involvement with the OWHR pilot, please select "not applicable".]*

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Not applicable
OWHRs are addressing gaps from other statutory reviews						
OWHRs are being used for homicides that previously did not qualify for a statutory review						
OWHRs are producing useful lessons learned and best practices						
Recommendations from the reviews are clear, realistic, and practical						
The recommendations from the reviews will help to prevent homicides in the future						

[likert matrix]

16. **In your view, are there any other benefits of OWHRs? Please provide some examples below:**

[open-text]

17. **Are there any other considerations or recommendations for a potential national rollout of OWHRs? Please provide your feedback below:**

[open-text]

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