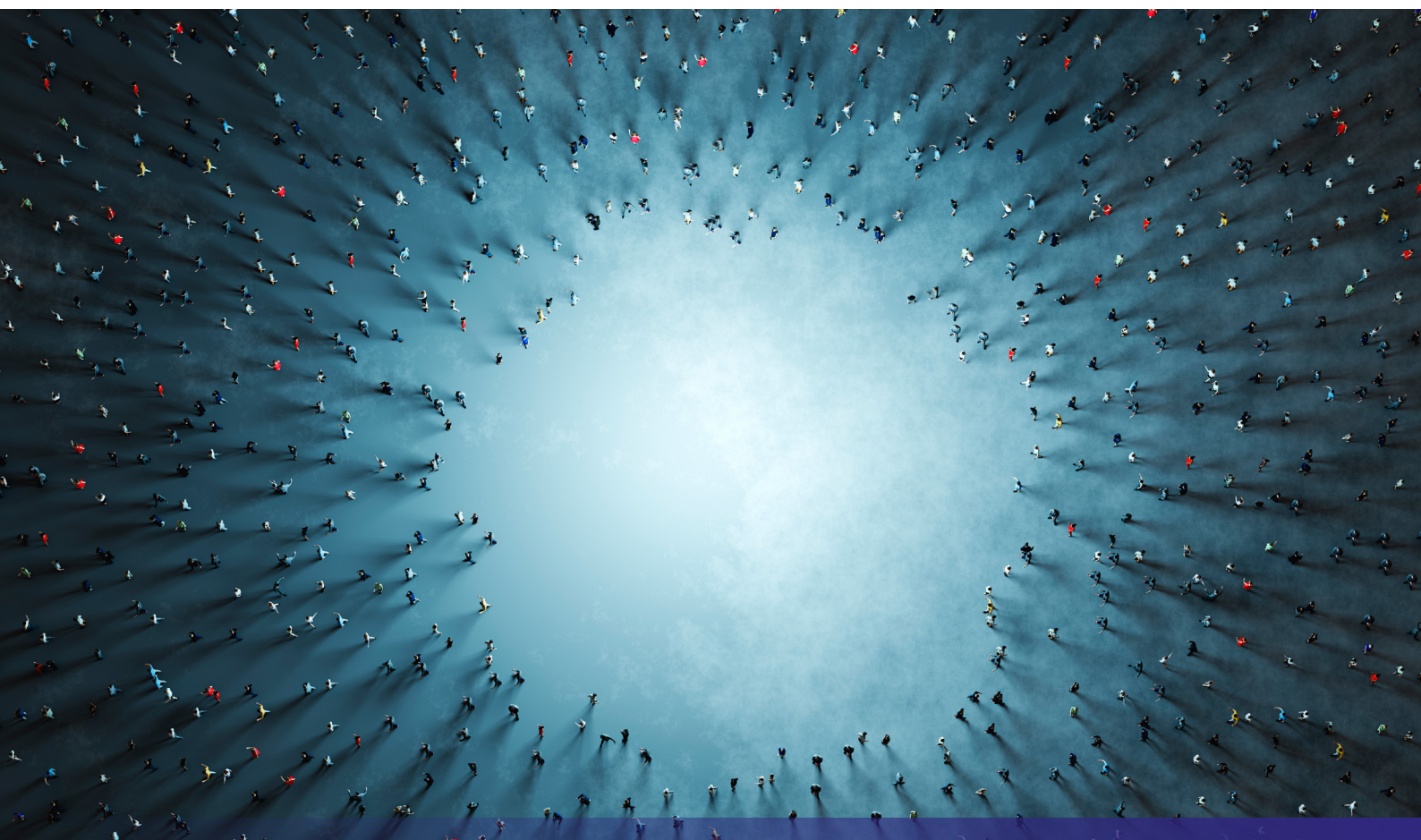


Offensive Weapons Homicide Review Oversight Board:

End of pilot report



March 2026

Lives taken, lives ruined: An opening quote from a victim's family

The following statement is from the sister of a victim of a homicide caused by an offensive weapon (Harrow OWHR). They reflect the emotion, tragedy, and loss from the perspective of family members, and help place the importance of learning from such awful events.

'... You have not only ended his life by ending his dreams, his hopes, his whole future, his ability of raising his own family and being at peace. ... You have not only taken his life but you have ruined mine forever. ... Coming home and being all alone, not able to knock on his door and talk, never seeing his smile which lit the whole room and his contagious laugh. Michael was joyful and loving, in-fact he was the funniest person I have ever met. I have funny stories like when it was snowing and he made us all go out in the garden and covered me in snow, or when he sat on my school computer by accident and we tried hiding it. Whenever he saw me upset, he tried his best to make me happy and it always worked. ... Everyday ... I wake up with only memories left of him. Every day I wake up hoping miraculously he would be in the room next to me. Every day it hits me that it is not possible. ... He was smart with lots of potential for his future that you have taken away. ... pictures and videos are all I have now. My brother was like my best friend, my father figure, and my protector all in one. ... a whole year of grieving has robbed me of my ability to feel joy and continue doing even simple things Sometimes I don't know if I want to heal as the pain is the last link, I have with him. Every day I wish I could go back and have one last day with Michael. Do you wish you could go back and change what you have done? ...

Foreword from the Offensive Weapons Homicide Reviews Oversight Board Chair

On behalf of the Offensive Weapon Homicide Review Oversight Board, I am pleased to present our first annual report. The role of the Board is to monitor the implementation of the OWHR pilot and to ensure that when a qualifying homicide occurs, local relevant partners carry out a high-quality review, in line with published statutory guidance, and carry out action and embed learning for future prevention of homicide.

Homicide has far-reaching and profound impacts upon the lives of individuals, families and communities and these impacts endure over many years. I have been struck by the feedback generously given by victims' families and highlight just a couple of poignant sentences from the above quote:

“... My brother was like my best friend, my father figure, and my protector all in one. ... a whole year of grieving has robbed me of my ability to feel joy and continue doing even simple things ...”

The Board understands the complexities surrounding homicide and acknowledges the exceptional work by Relevant Partners in commissioning, directing and governing OWHRs across the pilot areas to a consistently high standard. Much learning has already been taken both locally and nationally through these contributions and our research partners have now completed a detailed and meaningful evaluation.

In am grateful to the Board members for giving their time and extensive experience in providing meaningful oversight and constructive feedback to local partners and for the exceptional support to the Board by policy leads in the Home Office.

James. R. Vaughan QPM, MSt (*cantab*)

Chair - Offensive Weapon Homicide Review Oversight Board.

Context for Offensive Weapons Homicide Reviews & role of the OWHROB

As part of the accompanying statutory guidance¹ to support the primary legislation, a requirement was set out to have an Oversight Board to support and monitor the implementation and delivery of the pilot. Additionally, Ecorys, a research and consultancy organisation were commissioned by the Home Office to conduct a process evaluation of the pilot in partnership with the University of South Wales and the University of Hull. This report, which should be viewed alongside the Ecorys evaluation report, provides a summary account by the Offensive Weapons Homicide Review Oversight Board (OWHROB) during the pilot phase. As the first report by the Oversight Board, it sets out the activities of the OWHROB and early findings from the pilot OWHRs; it is hoped that this will inform future Government thinking and plans.



The purpose of OWHRs is to ensure that when a qualifying homicide takes place, local partners identify the lessons to be learnt from the death, to consider whether any action should be taken as a result, and to share the outcome. The intention is that these new reviews will improve the national and local understanding of what causes homicide and serious violence, better equipping services to prevent weapons-enabled homicides and, in so doing, save lives. Appendix 1 provides a brief policy and legislative context.

The stated purpose of OWHRs aligns with the ambitions of other public protection type reviews, such as Child Safeguarding Practice Reviews and Domestic Homicide Reviews. These reviews have demonstrated, over many years, added value, by capturing and raising the profile of important issues that can, and have been used, to improve the quality and effectiveness of the multi-agency response to abuse and neglect. Through systematic analysis of agencies and services contact with individuals, whether that be children or adult victims of abuse, themes have been captured that enhance sector knowledge which, in turn, allow improvements to be made. Examples include:

¹ Home Office, Offensive Weapons Homicide Reviews Statutory Guidance March 2023.

firstly, qualitative analysis of Domestic Homicide Reviews² enhancing our knowledge and understanding about risk and vulnerability factors of both victim and perpetrator; and secondly, examination about what, and how the best learning can be acquired through the review process, and how learning might be effectively embedded into system learning³.

Currently, for each homicide caused by an offensive weapon there is no formal review process which sits outside of any process to determine criminal culpability. The Coroner's Inquest serves as a fact-finding process, not one which provides statutory agencies an opportunity to formally reflect on any contact they had with either victims or perpetrators, be scrutinised or examine accountability for such events, do not exist.

Given the current absence of a formal review process, it is anticipated that OWHRs could have the same impact on learning and sector improvement, as Child Safeguarding Practice Reviews or Domestic Homicide Reviews. It is our view that OWHRs can fill a significant gap in knowledge, as well as provide learning and improvement opportunity, by gaining insights into the circumstances and events following such tragedies. We also see there to be a continued need for an oversight mechanism, such as the OWHROB, and like that established for the other review processes referred to above to disseminate and promote learning regionally and nationally, monitor improvements, and advise Government.

For the pilot, an OWHR Oversight Board was established as a non-statutory committee composed of professionals with significant experience in safeguarding, preventing homicide, serious violence, public protection and how public sector bodies operate; their role was to oversee the local delivery of the OWHRs and consider whether lessons could be learned from reviews, and shared locally and nationally. The core functions of the Oversight Board, which at the pilot stage were agreed as needing to operate at a skeleton and proportionate level, were also set out:

- a. to review each OWHR report against the guidance document and templates provided and to provide feedback to the relevant review partners/lead agency/independent chair if appropriate to improve future process or to recognise examples of good practice;
- b. to develop collaborative relationships with local review areas, enable open dialogue to aid in resolving any issues that arise during the OWHR process which are unable to be solved locally and to provide expert challenge of local approaches and solutions;

² Domestic Homicide Reviews Quantitative Analysis of Domestic Homicide Reviews October 2022 – September 2023.

³ Child Safeguarding Practice Review Panel Learning Support and Capability Project, Research in Practice, in partnership with the University of East Anglia and Vulnerability Knowledge and Practice Programme May 2025.

- c. to conduct quarterly reviews to monitor the delivery of report recommendations within local action plans;
- d. to produce an annual OWHR report inclusive of an analysis of number of OWHRs completed, adherence to timeframes, delivery of recommendations and thematic analysis of key issues identified. This should be supported by a policy statement as to how cumulative findings will influence policy development; and
- e. To deliver professional curiosity, keeping updated with relevant legislative, policy and societal developments in the areas of safeguarding, homicide prevention, serious violence and public protection and incorporating this learning and expertise into discussions and thematic analysis.

Membership and activity of the Oversight Board during the pilot

The pilot ran from April 2023 to December 2025. During this time, the Oversight Board consisted of four individuals who brought experience from across different, but relevant sectors, including Policing, legal services, social work and children's services, health, and finance. Combined, their experience and knowledge covered multi-agency working, systems stewardship and leadership, and public protection. See Appendix 2 for further brief biographical details. All were appointed by the Home Secretary and were subject to stringent recruitment and vetting processes, and bound by the Code of Conduct for Board Members of Public Bodies.



Our activities, and learning have included:

We have met as a Board, mostly virtually, every six weeks, to allow for updates to be shared, but also collectively review OWHR reports received. Whilst this frequency of meeting and model for reviewing reports has worked effectively during the pilot, we envisage a greater workload should OWHRs be rolled out across England & Wales. On that basis, an alternative operating model and supporting administrative processes would be needed to match demand.

We have attended quarterly networking meetings with pilot area Partnerships and representatives, which has allowed networking opportunities, sharing of best practice as well as challenges faced when carrying out reviews. Best practice examples include, sharing and dissemination events taking place in Wales following the completion of OWHRs, the production of best practice guidance in carrying out OWHRs created by Birmingham and the West Midlands region, including the testing of a rapid review model. Examples of challenges faced have included, issues relating to information governance particularly in respect of acquittals and what information to include in an OWHR report, and commissioning arrangements for Independent Chairs. Going forward, should a decision be taken to continue with OWHRs, we would recommend these forums be offered and maintained certainly whilst all areas become accustomed to expectations and until the review process is fully embedded.

We have attended quarterly meetings with Independent Chairs. Again, similar networking and sharing opportunities existed. Examples of issues discussed have included challenges faced by Independent Chairs in obtaining and accessing information about cases subject to review, dealing with delays from the local Partnership governance processes, and challenges of explaining their independent roles to members of the victims' families. Again, moving forward, we would recommend that these opportunities are offered and maintained for a period to promote consistency and quality.

We have remained mindful about our role not being that of a quality assurance mechanism. At times that has been challenging and certainly we have considered it remiss of us not to highlight more general issues in individual reports where there has been an obvious need for greater and stronger local quality assurance and oversight. Going forward, we maintain the view that the Oversight Board should not have an explicit quality assurance function and that responsibility for this should rightly sit with the local commissioning body. However, we would anticipate still highlighting issues about quality where obvious and necessary to do so.

A suggested OWHR report template has been provided in the statutory guidance. Despite this, report formatting, style, and approach has varied considerably; consistency of structure, format and style should be encouraged to make reports as accessible as possible, but also allow for data capture.

Due to the inconsistency of action plans being submitted by commissioning Partnerships, and timeframes, we have not been able to conduct quarterly reviews to monitor the delivery of report recommendations within local OWHR action plans, as part of this pilot.

The Board has been supported by a Secretariat. As well as leading on supporting local areas with reviews, providing the administrative function and communications, the Secretariat has taken responsibility for collating data captured from reviews thereby enabling themes to be more easily captured. As a pilot, opportunities to demonstrate impact have naturally been limited; nevertheless, the support by the Secretariat has been critical and invaluable, and we would anticipate this needing to be bolstered if there is a national roll-out to support further development of engagement, monitoring, thematic analysis, and communications.

Our observations from reviews completed so far

As of December 2025, we have reviewed 15 OWHR reports that have been completed, out of a possible 26 commissioned at the beginning of the pilot. Pilot areas for the 26 OWHRs included specified areas in London, West Midlands, and South Wales, and we have reviewed reports from across all these areas. To date, nine reports have been published from across all of the pilot areas, and these are available at: [Offensive weapons homicide reviews - GOV.UK](#)

Given both the limited number of reviews commissioned for the pilot, and the even more limited number of reviews from which data has been captured, some caution should be exercised in extrapolating findings and forming views.

By examining review reports to date, we make the following observations about the process of carrying out a review:

A proportion of reviews clearly consisted of events and circumstances involving a victim and a perpetrator that were less complex i.e. in terms of background history of individuals involved which had been gathered from agency records or events which were seemingly unplanned acts of fatal violence and had no identified pre-determinants. Our view is that these scenarios would have lent themselves well to a timely and robust rapid review style approach to capturing learning, rather than undertaking a full, more time consuming and costly review exercise. The use of a rapid review approach has been very successfully implemented with Child Safeguarding Practice Reviews, and we would endorse a similar expectation and format (albeit with a longer timeframe for conducting a rapid review).

The length of time to complete full reviews during this pilot has been an issue, with most reviews seen by the Board taking well over the indicative 12-month timeframe suggested in statutory guidance. Although not intended to prevent the continuation of a review, this has been mostly due to protracted criminal and legal processes. For some reviews, the governance and sign-off process appears to have been unusually long without explanation. The worry with such delays is that it lessens the impact of any learning and improvement opportunities identified. This is another reason for us supporting the use of a rapid review approach under appropriate circumstances.

The quality of reporting overall, was good, showing robust analysis, capturing relevant learning, and culminating in useful and appropriate recommendations. However, many reviews in our view were unnecessarily lengthy resulting in a report that was less accessible to a wider and more diverse audience, containing broader and less focused recommendations and lacking in focus.

This highlights for us, the importance of four factors; firstly, the need for suitably experienced, capable and well-trained Independent Chairs being commissioned to conduct and write review reports; secondly, having clear and concise terms of reference / key lines of enquiry that focus the review and all involved, thirdly, Community Safety Partnerships, as the commissioning bodies who were designated locally for OWHRs during the pilot, having clear and robust expectations about the final output of the review process, maintaining oversight of quality; and finally, providing a more streamlined set of expectations in statutory guidance about reporting templates, and promoting reports that are accessible to a range of audiences.

Of the review reports seen to date, the strongest ones were:

- those that contained a concise and accessible timeline and account of relevant history and agency contact with both the victim and perpetrator;
- those that benefited from a tribute or reflective statement from members of the victim’s family which brought the report to life by ensuring the victim, and impact of the tragedy on family members, remained central;
- those that equally examined the perpetrator’s history and timeline, and;
- those that provided a concise and pithy analysis, capturing and articulating clear learning, which culminated in recommendations that were expressly linked to the analysis and learning. Examples of good recommendations were those that were focused on system learning (either local, regional, or national), and were accompanied by clear action plans. Report length varied between 20 - 80 pages.

Key messages emerging from reviews with implications for policy, procedure, and practice

Early analysis of national and local recommendations highlights clustering of recommendations in the following areas: Housing, health related issues, drug related issues, local practices and processes, work with the community, crime prevention, Probation Service, Court decisions, Adult Social Care, Policing,



immigration and asylum, young people and, modern slavery. Given the limited data set to date, further evidence will be required to offer more conclusive findings. However, these early findings do provide insights into the potential for using OWHRs as a vehicle to drive change and improvements at both local and national levels, and take steps to reduce the likelihood of recurrence.

Some caution should be exercised about extending these early, and pilot findings, to a potentially wider cohort of reviews, nevertheless, we highlight these as they resonate with findings made in other thematic analyses or research.

Examples included:

There were numerous examples in reports completed so far, of recommendations made in local reviews that were likely to be highly relevant, of interest, and directly transferable to many other areas. This highlights the importance of findings and recommendations being effectively disseminated beyond the local commissioning area. Examples include recommendations such as the use of joint working protocols when considering conditions attached to bail and tenancies, the development of practice guidance covering all forms of adult exploitation, strengthening transition arrangements across services, and extending an early help style of support to young adults up to the age of 25 years.

The recognition and response by agencies to escalating offending behaviour, often during a time of transitioning, such as moving away from professionals working in child-based services where there may be a greater intensity of professional effort to work with a child / young person, into adult based services. This area highlights the importance of robust and dynamic, and multi-agency risk assessment, timely and effective information sharing, and coordinated services to support risk management.

The importance of engaging with housing providers – at both strategic and operational levels - to aid with the identification of individual need and risk, and promote multi-agency working.

For many victims and perpetrators information confirmed they had experienced difficult, abusive, or neglectful childhoods, resulting in them being diverted onto a pathway to further harms and increased risks. This highlights the importance of early help and intervention in children's lives when vulnerability and adversity is identified, but also effective transfer of support from children's to adults' services.

Similarly, findings can be made about the importance of early help for adults with recognised neurodivergence transitioning from children's services to adult services (or not), mental health difficulties, and problematic drug/ alcohol use. These characteristics were common in reviews.

Characteristics and profile of the victims: common features

All victims were male, with an age range of 19 years to 73 years and the most common age group being 40 – 45 years. Victims mostly were alone having either been married but divorced or having a previous partner or being estranged from a partner. Government data⁴ highlights that 41% of homicides involving offensive weapons were committed against victims in the age range 18 – 34 from

⁴ Government data – Executive Summary of Adult homicide in 2023/2024



April 2023 – March 2024, with 75% of homicides involving an offensive weapon involving male victims; this age group were victims of just 30% of total homicides. 8% of homicides involving offensive weapons were committed against victims aged 16 and 17 years, who were not eligible under the current pilot criteria for an OWHR to be undertaken.

Protected characteristics were often not known or not recorded making it difficult to extract reliable data. Where it was recorded, the characteristic of race was diverse; including Asian, Chinese, Black British, African, White British, Southern European. It is too early to make a finding about whether nationality is an emerging theme. Religion, when recorded, included Muslim, Rastafarian, or Christian. Sexual orientation was mostly recorded as heterosexual or not known. Disability for 10 victims was not known or recorded, with four having identified neurodivergent characteristics – in three, it being dyslexia, ADHD, or autism. Most victims had previous contact, or varying degrees, with mental health services, but minimal with drug & alcohol services.

The victim's relationship to the perpetrator ranged from their being no relationship known, or them being strangers, to victims living in shared housing, being friends or associates, or somehow connected through an illicit drug network. Links for victims to gang networks was not always a factor. The use of illicit drugs featured in most victims' lives alongside selling drugs, with half also having problematic alcohol use and identified mental health difficulties i.e. depression, self-harm, and previous suicide attempts. Identified housing needs i.e. homelessness, living in shared accommodation or no permanent address, was also a common factor. Almost half were either unemployed or not working, with two victims being students. Pre-disposing vulnerabilities or adversity was a common feature, for example, information about either being an abuser, or having witnessed abuse as a child, as well as having experienced some degree of trauma as a child.

For all but three victims, there was a history of criminal record and contact with law enforcement agencies.

The findings set out above highlight the importance of collecting accurate data about the individual characteristics of victims, such as race, religion, disability, to help us better understand vulnerability.

A review into Michael's death – what have we learned?

Michael was born in Romania but grew up in England. From early in 2020, Michael, aged 16 years, started to come to the attention of the Police and other agencies – concerns included him going missing, family tensions, exploitation, and low-level offences. Concerns escalated over the following months with agencies being involved and offering support. Information indicates that Michael was being targeted; he sometimes lived with his family, and at other times becoming homeless.

In July 2023, Michael was dealing drugs in his local area by car. At one stop, five men approached Michael's car, with one inflicting a single stab wound to Michael's chest. Michael died, aged 19 years shortly after this incident. One person was charged with murder however the outcome of the trial was that he was found not guilty on the grounds of self-defence, but was convicted for possessing an offensive weapon.

In April 2024 a local Review Panel was formed, having determined that the criteria to conduct an OWHR was met. Key lines of enquiry were established, and information reports were obtained from key agencies along with further information being gathered. Michael's family contributed to the review.

A summary of learning points captured from this review are set out, and which clearly may be of interest and relevance to all Partnerships nationally, given the transferability of findings:

- Opportunities to review local risk assessment processes to see whether identity, status, respect, and trauma are defined risk factors, within their contextual safeguarding processes.
- Agencies not fully recognising cumulative risks, and seeing non-engagement, as a reason to close engagement rather than as an accumulation of contextual factors. The victim was not 'hidden' to services, rather the agencies who were given responsibility to provide support, or intervene, did not find ways to engage him.
- The Violence, Vulnerability and Exploitation meeting should be recognised as good practice. The meeting could improve its overall impact by including a Contextual Safeguarding risk assessment process, particularly where cases are brought to the meeting on multiple occasions (on three or more occasions).
- The victim's family highlighted their concerns that partner agencies did not perceive the same level of risk that the family saw developing earlier; there is evidence that supports that view. The view of family, close relatives, or guardians and the individual should be a fundamental part of any risk assessment.

- Partner agencies need to be more aware of adultification and the potential for adultification bias, particularly in terms of children in adolescence.
- The need to strengthen quality assurance processes on risk assessments carried out on individuals.
- How service provision fundamentally changed for the victim once he became 18 years of age, highlighting the importance of a national approach to define for child, young person, adolescent, and young adult to better align how vulnerability is considered – this may reduce the current cliff edge of support that exists at the age of 18 where services are reduced or withdrawn based only on age.
- The importance of involving local Trading Standards Services to support the Partnerships ambitions of reducing serious and violent crimes, in providing age-restricted advice to businesses on the sale of knives.
- The review concluded with national and local area recommendations. The national recommendations included:
 - Adopting clearer definitions of age ranges for the terminology of ‘child, young person and adolescent’,
 - Reviewing the safeguarding responsibilities of partner agencies for a young adult between the ages of 18-24, where there are recognised latent vulnerabilities, to ensure they receive the same level of support and protection as if they were under the age of 18.
- The 13 local recommendations reflected the learning points set out above, addressing policy, procedure, and practice aspects; with an action plan submitted that sets out how these were to be achieved.

Characteristics and profile of perpetrators: common features

All perpetrators, bar one, were male, with one female and one not recorded due to being found not guilty. The age range of those committing the homicides was between under 18 years to 43 years. The most common age grouping was 20 – 30 years (n:5), with 20 – 30 years next (n: 4), followed by 30 – 40 years (n: 3).

Records show that for six perpetrators there were no recorded disabilities, with five it not being known about, and for three having recorded disabilities of mental health difficulties, Post Traumatic Stress Disorder, Autism or ADHD.



As with the victim's, protected characteristics were often not known or not recorded making it difficult to extract reliable data. Where it was recorded, the characteristic of race was diverse, including Chinese, Albanian, Syrian, Black British, Asian, Afro-Caribbean, Black African, Mixed White Asian. Religion and sexual orientation were mostly not recorded.

Illicit drug use commonly featured yet problematic alcohol use was often not known about or recorded. Information was captured that highlighted educational needs for some; including experiencing a disrupted education due to, for example repeated exclusions, antisocial behaviour, or moving countries, or low educational achievement. However, this must be balanced with two perpetrators out of the cohort achieving well in terms of ability or qualifications i.e. university education or a vocational qualification. Information about previous adversity, such as experiencing abuse or neglect was captured for some. Housing needs featured, with instability, insufficient arrangements following prison discharge, living in semi-independent accommodation, secure or temporary housing being noted – with homelessness occurring within a short period of time and a return to crime. Information about involvement with either mental health or drug / alcohol misuse services was not reliably captured.

For 10 perpetrators there was information about either extensive criminality, repeated arrests but without prosecution due to a lack of evidence or witnesses not being prepared to give evidence, and criminal records, such as antisocial behaviour, drugs possession, knife or weapon crime, violence, assault, or threatening behaviour. As a result, the pattern of increasing risk was evident. For six perpetrators information indicated either explicit or possible links to drug networks or connections to influencing networks. The need for greater professional curiosity was evident in such scenarios.

In all but one, stabbing or the use of a sharp weapon i.e. a knife was the method of killing; one victim died because of being hit by a motor vehicle. Government data⁵ shows that offensive weapons were the method of homicide in 55% of all homicide cases. This is comprised of sharp instruments (45%), blunt instruments (6%), and shootings (4%). Other than offensive weapons the next largest method was hitting, kicking etc, without a weapon at 18%.

It is too early to reliably or accurately capture data or themes about the outcome of any criminal or legal process i.e. charging, length of time to proceed to trial, convictions, and sentencing.

⁵ Government data – Executive Summary of Adult homicide in 2023/2024

Recommendations

1. A process for a rapid review should be considered for those incidents that appear less complex and where it is believed that much of the learning could be gathered and shared relatively quickly. Such a process should be modelled on the current system used by the Child Safeguarding Practice Review Panel.
2. Clearer guidance to be issued to support Partnerships and statutory bodies with their decision making about when to commission an OWHR when there is a likelihood that another review may also take place i.e. Mental Health Review, MAPPA Serious Case Review, to avoid duplicated efforts.
3. If a decision is made for national roll-out of OWHRs Secretariat support should be strengthened to assist with engagement, monitoring, thematic analysis, and communications.

Appendix 1: Brief policy and legislative context.

Homicide rose by about a third between 2013/2014 and 2021/2022⁶, but have since fallen by 16% in 2023/2024. The cost of homicide is significant and is annually estimated to be more than £2.5bn in 2025/2026 prices. Homicides involving offensive weapons make up a large and growing proportion of all homicides, with analysis indicating 314 of 570 homicides in 2023/2024. Of the 570 offences initially recorded as homicides in 2023/2024 the Government estimates that 389 did not meet the criteria for an existing formal review i.e. a Domestic Homicide Review or Child Death Review, and that 203 of the unreviewed homicides involved an offensive weapon.

The Police, Crime, Sentencing and Courts Act 2022 introduced a requirement on the police, local authorities in England and Wales and integrated care boards in England and local health boards in Wales, to review the circumstances of certain homicides; those where the victim was aged 18 or over, and the events surrounding their death involved, or were likely to have involved, the use of an offensive weapon. Section 34 of the Police, Crime, Sentencing and Courts Act 2022 required a pilot to be carried out ahead of a decision to roll out the Offensive Weapons Homicide Review (OWHR) policy across England and Wales.

⁶ All data provided in this section has been provided by the Home Office.

Appendix 2: Biographical details of the OWHR Oversight Board during the pilot.

Chair: James Vaughan QPM

James Vaughan spent 30 years as a police officer, serving in three different police forces across the South West and leading Dorset Police as the Chief Constable between 2018 and 2021. He served as an operational detective through the ranks and was the Head of Crime for Wiltshire Police before graduating from the Police Strategic Command Course in 2011. He was a member of the Homicide Working Group and was the national lead for child homicide. He completed a Master's at the Institute of Criminology, Cambridge and has published his research surrounding infanticide. James held chief officer roles in Wiltshire, Dorset and Devon and Cornwall Police and led the response to serious and organised crime in the South West. He was responsible for delivering major restructure, transformation, and change through ten years of significant police reform and economic restraint. James was the national lead for Forensics, driving forward a very challenging transformation programme in response to strategic and structural issues including: market sustainability, raising quality standards and meeting digital forensic proliferation. He was awarded the Queen's Police Medal in the 2018 New Year's Honours. He is currently the interim Chief Constable for Devon & Cornwall Constabulary.

Board member: Dale Simon CBE

Dale Simon CBE is a qualified barrister and an equality and diversity specialist who has worked in the criminal justice system for over 30 years. She began her career as a criminal defence barrister in 1986 and then moved into the public sector in 1992 where she held a variety of frontline, operational and strategic roles; specialising in equality and diversity and professional standards including the Head of the Office of Judicial Complaints and the Director of Public Accountability and Inclusion for the Crown Prosecution Service (CPS). In 2013 Dale was awarded a CBE for services to equality and diversity in recognition of her success in driving the CPS violence against women and girls' strategy and increasing the diversity and talent pipeline of the CPS. In 2014 Dale commenced a portfolio career and now runs her own management consultancy company specialising in organisational equality and diversity 'health checks', bespoke diversity and inclusion programmes and workplace mediation. Dale was a Non-Executive Director for the Parole Board where she Chaired the Standards Committee for 6 years, which has responsibility for advising the Parole Board on issues relating to the standard and quality of Parole Board work, and the support and development needs of Parole Board members. She is a former member of the Board and the Equality, Diversity, and Inclusion (EDI) Board sponsor for the Office for Legal Complaints. Dale is a member of the House of Commons Independent Expert Panel which deals with allegations of

sexual misconduct and bullying and harassment against Members of the UK Parliament and appeals from the Committee on Standards. She sits as a panel chair on Nursing and Midwifery Council fitness to practice hearings; and is also a former member of the National Child Safeguarding Practice Review Panel (NCSPR) which reviews the most serious safeguarding cases to share lessons and improve practice. In this capacity she led the first [NCSPR national review into the criminal exploitation of adolescents](#).

Board member: Kevin Ball

Kevin Ball has over 34 years of experience working across children's services ranging from residential childcare (local authority and charitable sectors), statutory social work and management (operational and strategic) to inspection, Government Allegations Management Adviser, NSPCC consultant, and independent consultant; having worked for a local authority, regulatory body, central government, and the NSPCC. Kevin has experience of working as a frontline practitioner through to board-level representation. His training and background as a social worker working with children and families, and then in more recent roles conducting Serious Case Reviews, Child Safeguarding Practice Reviews and Domestic Homicide Reviews, providing independent scrutiny and quality assurance, has resulted in him having a solid understanding, knowledge, and appreciation of the multi-agency landscape for public protection work.

Board member: Tim Goodson

Tim Goodson has over 20 years of experience as an NHS board member and system leader. Tim now runs his own consultancy company and is a qualified accountant with a proven track record of supporting and advising boards. During Tim's time in the NHS, he led a transformational clinical service review across Dorset securing millions of pounds of capital investment and was accountable for the £1.6bn health budget delivery. During this time Tim became a very well-respected Chief Executive Officer and Director of Finance and has the gravitas to navigate, influence, question, and support boards. Tim is also the deputy chair and trustee for a local hospice charity.