

OWHR Draft Review Report (England)

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

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

Birmingham City Council- Community Safety Team

Case Reference Number:

OWHR012

Pseudonym 1:

Please copy and paste the appropriate number of pseudonyms.

Victim 1

Mr A

Pseudonym 2:

Alleged Perpetrator 1

Mr B

Choose an item.

Date of incident which led to the Review:

Winter of 2023

Date of death where applicable:

The date of death has deliberately not been specified, as this may lead to the identity of the parties involved in the homicide review being inadvertently disclosed.

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

Review completion date (approved and signed off): Click or tap to enter a date.

Publication date: Click or tap to enter a date.

The Review start date commenced in November 2023; However, the first meeting took place in January 2024, further meetings took place throughout 2024, There were some delays in establishing contact with the victim's family. It is unfortunate that ill health and a bereavement on a close family member of the report writer caused delays in the completion of this report.
TClick or tap here to enter text.

Outline of circumstances resulting in the Review:

1. This Offensive Weapons Homicide Review was commissioned by Birmingham Community Safety Partnership in accordance with the OWHR Statutory Guidance. The death of Mr. A met the criteria for the Review are met under Section 24 of the Police, Crime, Sentencing and Courts Act 2022.in that at the time of his death an Offensive Weapon was used, and the victim was found deceased at a property in Birmingham, which was an exempt House in Multiple Occupation.
 2. The initial scoping exercise identified that Mr. A, and Mr. B, the alleged perpetrator, were known to several agencies prior to the homicide. It identified that there was potential learning which could be beneficial to the agencies involved. It was also identified that it might be appropriate for agencies to act in respect of those lessons learned.
 3. In addition, the scope of this exercise was chosen to identify factors that may have made it harder for local professionals and organisations working with Mr. A and the alleged perpetrator, Mr. B, to reduce the risk of violence. It also aimed to identify what can be done differently at both agency and system levels to prevent future homicides and reduce serious violence. The purpose of the review is also to identify areas of good practice and successful interventions which could be incorporated into general processes and system responses.
-

Notification

4. In November 2023, West Midlands Police informed the Birmingham Community Safety Partnership (BCSP) of a death that met the criteria for an Offensive Weapons Homicide Review (OWHR).
5. The Birmingham Community Safety Partnership notified the Home Office by letter on 10 November 2023 that it was under a duty to undertake a review pursuant to Section 27 of the Police, Crime, Sentencing and Courts Act.
6. On 4 December 2023, the Birmingham Community Safety Partnership formally notified the Home Office by letter of its decision to conduct a review pursuant to Section 27 of the Police, Crime, Sentencing and Courts Act.

Methodology

7. The review followed the core components of an OWHR as set out in the statutory guidance. It was led by the Independent Chair, assisted by a panel of designated professionals from each of the key agencies involved with Mr. A (P1) and Mr. B (P2). The full methodology is included as Appendix 1.
8. The panel members had no direct contact or management involvement with Mr. A or Mr. B and were not the authors of the Individual Management Review (IMR) reports submitted by their organisations.
9. All the agencies initially approached responded within the set period and provided factual information. This was compiled into a single document used to confirm that the criteria for an OWHR were met, to identify the agencies involved in providing services to Mr. A. and Mr. B, and to formulate the Part B questions.
10. The review process began with a meeting to determine the scope of the review, including the scoping period and identification of relevant agencies. Following the second meeting, scoping questions were sent to the identified agencies.
11. Requests for IMRs were sent incorporating the Part B questions. The individual agencies compiled a comprehensive chronology of

agency involvement and IMRs which identified single-agency learning.

12. The Report Writer was grateful to the agencies for completing the IMRs.

13. A sub-meeting was held with those involved in housing within Birmingham on 31/3/24 to enable the Chair to understand the issues related to the decisions that led to the housing of Mr. and Mr. B, and whether there was any correlation between the homicide and the nature of their accommodation.

14. Upon receiving information about Mr. B, the report writer noted that Mr. B's family lived abroad and that he had been separated from them for a number of years. Given this, it was deemed impractical to seek information from Mr. B's family. Mr. B was reported to have been assessed as a suspected victim, by the Modern Slavery Unit. The Chair sought to interview those involved in the Modern Slavery Unit (MSU) to clarify points or seek additional information from the agency tasked with supporting Mr. B once he had been identified as a potential victim of modern slavery.

15. The Modern Slavery Unit of the Home Office provided additional information, including helpful links to the statutory guidance underpinning decision-making.

16. The Chair also sought information from the CPS in relation to the alleged perpetrator, Mr. B. Originally, his trial was scheduled for May 2024, however it was postponed allowing the CPS to seek a psychiatric evaluation. Mr. B's trial was rescheduled for November 2025. The latest information was that there was a deterioration in his mental health. At the time of drafting this report, Mr. B had failed to cooperate with the assessment. Mr. B remains the alleged perpetrator, and there was sensitivity in approaching those who represent him and his family, as he had not entered a plea.

17. Full details of the agencies involved in the review are provided in the appendix.

- A pre-meeting was held in December 2023, followed by a meeting with the liaison officer from West Midlands Police on 24.1.2024. An initial scoping meeting took place on 8 February 2024, and a further one on 5 March 2024, telephone contact with Family liaison officer on 23 April 2024, a sub-meeting for the Housing Agencies and a meeting to review the report for factual accuracy and its recommendations took place on: 7 November 2024

Circumstances Resulting in the Offensive Weapons Homicide Review
Background

18. In the winter of 2023, a report was made to West Midlands Police that a body had been found at an address in Birmingham, in exempt accommodation occupied by three separate households. The report was made by a support worker who had visited the property. At the time, the property was occupied by three residents: Mr. B (the alleged perpetrator), Mr. A (the victim), and another resident whose name was unknown.
19. The support worker had attended the property in her role of visiting the residents and identifying any support needs. She was told by Mr. B that Mr. A had gone to Scotland. Mr. A, was originally from Scotland, had a girlfriend there, so it was feasible that he was away visiting. However, as part of her duties, the support worker decided to check Mr. A's room. Mr. B insisted that she should not enter the room as it was messy. Upon unlocking the door, she found evidence that Mr. A was deceased and lying on the floor, his body covered by a sleeping bag. She left the room and called 999. Both West Midlands Police and ambulance services attended the scene.
20. The injuries appeared to have been caused by a baseball bat and a knife. Death was confirmed at 13:28 on the date his body was discovered. A bank card belonging to Mr. A was found in the possession of Mr. B, who was subsequently arrested.
21. Mr. B and Mr. A were connected as tenants living in the same accommodation. There appeared to have been a pre-existing relationship, possibly a friendship. Mr B had experienced difficulties maintaining accommodation due to his behaviour, which led Mr A to recommend him as a tenant to his housing provider.
22. Part of the agencies' enquiries focused on trying to understand how this friendship evolved, whether there were warning signs of vulnerabilities or risks posed by Mr. B to Mr. A, and whether the relationship was exploitative. However, it proved difficult to obtain detailed information.

Review Scope and Considerations

23. The scoping period of the review was set as the three-year period from 2020, beginning with Mr B's arrival in the UK. Mr A, a Portuguese national, also arrived in the UK in 2020. He first came to the attention of the Home Office as a potential victim of modern slavery and self-reported suffering from Post-Traumatic Stress Disorder (PTSD), linked to a violent incident during his youth. The review sought to consider how these factors were addressed by the agencies and organisations that came into contact with him, and whether they were relevant to the alleged offence.

24. Additionally, the review considered whether Mr A had any vulnerabilities that made him a potential target for violence.

[Click or tap here to enter text.](#)

Equality and Diversity:

25. The equality and diversity issues as they relate to both Mr. A, and Mr. B was considered below.

26. **Age:** Mr. A was aged 42 at the time of his death, there were no issues which related to his age. Therefore, his age was Not applicable as a factor.

27. **Disability:** Mr. A self-reported having learning difficulties. He identified himself as having difficulties with literacy and needed additional support to process information. Although he had no official diagnosis, his learning needs were confirmed by his brother (see below) as such, this was considered by the chair as a potential protected characteristic.

28. Mr. A also in the past reported potentially harmful use of alcohol which could be classified as hazardous or harmful¹, in that alcohol played a factor in his involvement in crime.

29. Mr. B's self-diagnosis of PTSD is a mental health disorder in the Trauma and Stressor-related disorder category in the ²Diagnostic and Statistical Manual of Mental Disorders. Choose an item.

¹ National Library of Medicine

² The Diagnostic and Statistical Manual of Mental Disorders

30. **Race:** Mr. A was bi-racial, he was Indian and White British
31. Mr. B is a Portuguese National.
32. **Religion or belief:** Mr. A was a Muslim; the alleged perpetrator Mr. B's religion is Not applicable
33. **Sex:** Both the victim and alleged perpetrator are Male, there is some evidence that being male is a factor which increases the likelihood of being a victim³
34. **Socio-economic disadvantage:** Mr. A's circumstances growing up put him at a socio-economic disadvantage, in that he was placed in care early in his childhood.⁴ Studies such as "Who cares about care leavers? The Centre for Longitudinal Studies University College London identified that care leavers are more likely to: live in poverty, have no or lower levels of educational qualifications and as such are more likely to suffer from mental health issues. The Children's Commissioner's findings on the disadvantage to care leavers, reported that half of children in care had a criminal conviction by the age of 24.
35. A further study from the University College London which used census data from the Office of National Statistics which considered the lives of 670,000 children some of whom had been in the care system, and some who had not, (between 1971 and 2001) found that whilst Black Children tend to be over-represented among the care population and those from an Asian background under represented, a key finding was that there was a clear link between self-reported health issues and a history of social care for both the white and South Asian Group, of which Mr. A would have been a subset.
36. The report writer understands that within the context of Birmingham City Council, care leavers, are a protected group. However, it is unclear whether this would have provided any additional support to Mr. A, given his age and the passage of time from his leaving care to his residence in Birmingham.

³ Crime in England and Wales, Victim characteristics year ending March 2023

⁴ Who Cares about Care Leavers? The Centre for Longitudinal Studies University College London 7 February 2024

37. Mr. B was an alleged victim of modern slavery.⁵, it has been noted that victims of modern slavery are at a high risk of becoming destitute and homeless.

38. Both the victim and the perpetrator lived in Supported Exempt Accommodation (“SEAs”) which is a possible factor indicating socio-economic disadvantage. SEAs are known as exempt supported housing, as they are exempt from the usual Housing Benefit cap which limits the amount of benefit that people can claim for housing. The housing is provided for

- People who are homeless
- People recently released from prison
- Survivors of domestic abuse
- People with substance dependencies
- refugees

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

39. The information concerning the victim Mr. A, who was from Scotland, was taken both from information provided by him, to his support worker at the SEA recorded in his Support Plan for his exempt accommodation, prior to his death, and from information that was provided by his brother and niece.

40. Given that some of the information about his past and his experiences were provided by him to his support worker (although the accuracy of this information has not been independently verified) it is the nearest that we have to his own voice.

41. Mr. A identified his Brother Mr. J, as his next of kin. He also provided contact details of a girlfriend, who lived in Edinburgh. Although there were details of her name and phone number provided to his support worker, the police family liaison officer did not contact her. No information was provided as to the rationale for this, however as she was not supported by family liaison, a decision was made by the report writer that it would not be appropriate to contact her in the absence of information about the status of the relationship at the time of Mr A’s death, and without knowing whether there was appropriate support mechanism in place to provide her with support.

⁵ Victims of Modern Slavery report to Parliament Twelfth Report

7. [What is supported exempt accommodation?](#) | [Supported exempt accommodation](#) | [Birmingham City Council](#)

42. Mr. A also provided information that he had a daughter. However, at the time of his death, he was not in an on-going relationship with his daughter with whom he was believed to have lost contact.

Mr. A

43. Mr. A appeared to have enjoyed a good relationship with his brother however, Mr. A was taken into care at a young age, this meant that he did not have the opportunity to grow up with his brother and this may have affected the degree of contact he had with his family over the years.
44. As part of the review process, there was liaising with the family liaison officer who provided information to Mr. A's brother and niece about the review process, after a brief telephone discussion with Mr. A's niece, she indicated that her father would be happy to have a telephone discussion whereby they could decide whether he wished to provide information about Mr. A.
45. Mr. A's brother confirmed that he was happy for Mr. A to be anonymised as Mr. A, and that he did not require a more personal non de plum.
46. Contact was made with Mr. A's brother and his niece, via the family liaison officer, who was provided with a letter informing them about the nature of the review and its purpose and explaining to them that their involvement would be welcomed if they wished to be involved.
47. The Liaison officer provided details of their availability; however, it was not possible to find a mutually convenient date and time until 15 January 2025. The contact was established by telephone. Mr. A's brother confirmed the accuracy of the information provided by Mr. A to his housing support worker. Mr. A's brother provided additional information about Mr. A. He explained that the family had experienced trauma due to the loss of their father as a care giver, due to his death by suicide with the added trauma of both brothers discovering his body.
48. Their mother was not being an appropriate care giver, due to risks from safeguarding issues that her behaviour presented. Given this the brothers were placed into care. It is unfortunate that both brothers were placed in different care homes. On leaving care Mr. A lived for a brief period with his sister (whose identity has not been confirmed) before moving into a hostel.
49. Mr. A's brother and niece spoke fondly about Mr. A, his brother recalled that he was hyperactive as a child, and that Mr. A struggled academically and was supported by a placement in a special school. He described Mr. A as "a good guy." He explained that Mr. A had a real sense of what he considered to be fairness and injustice, and that this presented a trigger for him when he perceived unfairness in his treatment. This could lead to him

responding inappropriately to treatment, he considered unfair or if he considered that he was being treated negatively.

50. He told the report writer that Mr. A had started drinking from an early age and this had an impact on his behaviour.

51. His niece recalled that he liked the outdoor lifestyle and enjoyed fishing, woodwork, and caravanning.

52. The report writer was grateful for the willingness of Mr A's family to provide information which was useful in providing context and confirming much of the information which had been provided by Mr A himself to his support worker. Mr A's family wished to be kept information of the outcome of the review.

[Click or tap here to enter text.](#)

Contact with the Alleged Perpetrator's Family

53. There was no contact made with either Mr. B or his family for this review, this was a deliberate decision pending the criminal trial.

54. The report writer was made aware that there were questions about Mr. B's fitness to plea and mental health prior to the trial. Given this, there was sensitivity around contacting Mr. B prior to his trial, as any information provided by him would be potentially disclosable at trial.

55. Given this, the report writer considered contact with him to be inappropriate.

56. His trial date was originally set for May 2024, and subsequently postponed to November 2024, and further postponed until November 2025.

57. The Trial commenced on 3 November 2025 and lasted for two weeks. Mr. B was found guilty of Murder and sentenced on 15.12.2025. to live imprisonment with a minimum sentence of 13 years and 9 months.

[Click or tap here to enter text.](#)

Family History and/or Contextual Information:

58. Mr A provided the following information about his family. He was born in Glasgow to an Asian father and a white British mother. He had five sisters (including a half-sister) and one brother, he was the second youngest. His parents both died whilst he was a baby. Mr A was raised [both] by foster carers and was also placed in children's homes. He informed his support worker that he was in touch with his brother by telephone, however, it had been "years since he had seen any of his siblings face to face..."
59. West Midland Police provided further contextual information, in their IMR, it was noted that Mr. A had been a victim of familial violence, he had also experienced the trauma of his father having died by suicide, and Mr. A along with his brother had discovered his body. His brother told his family liaison officer that Mr. A had learning difficulties and was easily led, and that this resulted in Mr. A getting into trouble with the police. He also reported that Mr. A had had a drinking problem.
60. Mr. A was known to the police, as a result of having had a history of offending, which had led to several convictions and also periods spent in custody.
61. In 2017, Mr. A started a relationship with his girlfriend Ms. W. West Midland Police reported that they lived together until Mr. A moved to Birmingham in July/August 2022.
62. There had been one recorded incident of domestic abuse between them; (This information was provided by West Midlands Police) However, his girlfriend did not support prosecution and, despite the alleged assault and Mr. A's move to Birmingham, they continued to maintain a long-distance relationship. Mr. A provided information to his support worker that they would take it in turns to visit each other with Mr. A, travelling from Birmingham to Scotland.
63. When Mr. A left Scotland, prior to his settling in Birmingham he briefly settled in Kings Norton for a very short period of time, although there was no information as to why Mr. A, originally left Scotland or Kings Norton, a relevant factor may have been that he was in breach of bail condition, relating to an alleged offence in Scotland, which was not an arrestable offence in England.
64. The West Midland Police reviewing supervisor noted that a decision was made that it was not in the public interest to pursue action against Mr. A in relation to the alleged offence as the investigation was not sent to WMP until five months after it was reported.

65. Whilst he was in King's Norton, there was a crime report incident, involving Mr. A in October 2022, when he was reported as having attended an address and threatened to kill a resident at shared accommodation, whom he suspected as having stolen his watch. Although the police were called, the resident was temporarily removed from the premises and Mr. A subsequently left and no further action was taken against Mr. A.
66. The, the availability of accommodation and its locality may have been a factor in Mr. A ending up in accommodation in Birmingham as he provided no information about having friends or family in the area.
67. While attending the housing sub-meeting, anecdotal information was provided that it was not unusual for other local housing authorities and probation workers in other localities to refer vulnerable people to Birmingham as it was an area that was known for having a large and readily available supply of social exempt accommodation. This meant that there is a large transitory population, who have moved from other locations in the UK due to the relative availability of housing and that although housing was available, they would lack immediate access to support from probation and social services.
68. A recent article in the *Guardian* dated 28 December 2025, on social exclusion⁶ examined the issues raised from the perspective of those in supported exempt accommodation. The article reported that it was estimated that there were 258 people living in 55 exempt accommodation properties, concentrated in a small area.
69. There were concerns expressed that this had led to people being housed in properties with others who had different needs and conditions and that this led to conflict and an increase in the locality to anti-social behaviour, including drug dealing and violence.
70. The article also noted that service users experienced being housed in multiple exempt accommodations over a relatively short period of time as placements may break down without adequate support being in place.
71. Mr. A was reported to have lived at 5 different addresses whilst resident in Birmingham, including the address at which he died. Although it was not known how Mr. A, and Mr. B first came into contact, and it has not proved possible to find out further details of this it was clear that both knew each other prior to Mr. B, being accommodated at the property.

⁶ 28 December 2025, on social exclusion titled: *Vulnerable people 'set up to fail' in Birmingham's streets of unregulated 'supported housing*

72. The subject property was a multi-occupied, and consisting of three bedrooms, a communal living room, a communal kitchen, and a communal bathroom. The layout of the property was over two floors. A third tenant also resided at the property. However, the third tenant (whose identity was unknown to the report writer) has not been asked to provide information as part of this review.

73. The information held about Mr. B, was also provided by him to his support worker. Mr. B is a Portuguese national, who was born in Portugal. However, he reported that he lived in Canada during his childhood and adolescent, where he moved with his mother as a small child.

74. Mr. B also has two stepbrothers. In 2015, Mr. B reported that he was deported from Canada to Portugal, due to drug-related offences. It is unclear whether this information was known to the Home Office, and it is important to note that no decision had been made as to whether Mr. B would have been given permanent settlement prior to the homicide.

75. The context in which Mr. B became known to the authorities was as a potential victim of modern slavery.

76. There was no independent information about Mr. B's drug use other than what was disclosed by him. However, one possibility is that he may have already formed an early pattern of drug use and involvement prior to leaving Canada. He provided information that he had been shot whilst in Canada, prior to his deportation. He cited this as a possible cause for his self-reported PTSD

77. On being deported to Portugal he lived with his father and grandmother for four years prior to coming to the UK. His relationship with his father was reported by him as being strained. At the time he provided the information to his support worker, he described himself as being occasionally in touch with his grandmother by telephone, but other than this, he disclosed no contact with other members of his family.

78. Information was sought concerning Mr. B's family via West Midlands Police/ CPS. No information was provided within the time frame of the review.

79. Mr. B drug use was also a notable factor in his alleged modern slavery, as Mr. B was allegedly paid in drugs for the work undertaken in the UK.

Agency Timeline and Terms of Reference:

80. In March 2024, the OWHRO12, agencies group met, and the terms of the scope of reference were agreed which were set out as follows:-

81. For the purpose of this Review the key lines of enquiry are as follows. The scoping period of 3 years was considered appropriate. The panel has identified that the perpetrator Mr. B, came to the UK via Portugal from Canada approximately 3 years ago. Information was if there were grounds to suspect that he may have been a victim of modern slavery.

82. The Housing partners were concerned that there was a lack of regulation within this type of accommodation. This meant that at the time of the offence there was and currently there is no requirement for the sharing of information between accommodation providers and key agencies which might assist in identifying risks and take steps to address those risks. (iii) The panel identified that Mr A, has been identified as having different dates of birth and spellings of his name, this meant that in order to respond effectively to the review it was necessary for agencies to ensure that information was been checked against all the names. No information was obtained about why this discrepancy exists. Set out below is a succinct summary of key significant events, within the agreed timeline.

Mr. A's Chronology (linked to the agreed timeline)-

83. **August 2022-** He contacted the police, reporting that he was a victim of an assault from a resident at his accommodation, he was taken to hospital. He was reported as sounding intoxicated during the telephone call. He was taken to hospital. Mr. A later discharged himself from hospital, attempts were subsequently made to contact him however he did not respond.

84. **September 2022-** Mr. A left Glasgow, Scotland following breaching bail conditions following the grant of a non-molestation order.

85. **October 2022-** Mr A [He] is the subject of a police report in Kings Norton, following this he was evicted from his accommodation in Kings Norton.

86. **November 2022-** Mr. A moved into exempt accommodation in Birmingham.

87. **28.06.2023-** Mr. A moves into the subject property.

88. **03.11.2023-** An incident takes place in his accommodation where the communal TV is alleged to have been stolen by **Mr. B.**

89. **End of November 2023-** Mr. A is found deceased at the Subject Property.

90. Very little was known about Mr. A's time in Birmingham and there was no information that he had accessed or been provided with support from any agencies. This could be indicative of Mr. A enjoying a period of relative stability.
91. However, it could be indicative of missed opportunities to provide him support around his perceived vulnerabilities around his alcohol use, social disadvantage (as a previous care leaver) and his learning difficulties. It is of some concern that he moved between SEAS, and the reasons for this are largely unknown.

Mr. B's Chronology

92. **12-05-2020**- Mr. B was referred by the Metropolitan Police to the Single Competent Authority as being a potential victim of Modern-Day Slavery ("MDS"). (the following information was provided by Birmingham and Solihull Integrated Care Board ("BSICB"))
93. **18/05/2020** a positive "Reasonable Grounds" decision was made as it was considered there were reasonable grounds to suspect that Mr. B was a victim of modern slavery. He was granted a "reflection and recovery period" up until 29.06.2020.
94. **16 July 2020**- Mr. B completed an application for settlement in the UK. He made an application under the European Union Settlement Scheme through his EUSS application.
95. **4-08.2020**- a witness statement was requested from Mr. B in relation to the allegation that he was a victim of modern slavery.
96. **18.08.2020**- Mr. B was reported as being unhappy at the request to provide a further statement, resulting in his threatening to leave his accommodation. His unhappiness stemmed from the fact that he had already provided a statement to the metropolitan police, and as such did not want to repeat information that he considered had already been provided.
97. **31.08 2020** – Mr. B was granted limited leave to remain (also known as 'pre-settled status').
98. **March 2021**- Mr. B approached his GP around his drug use, he expressed an interest in being treated for his addiction. He was referred to Change Grow Live.
99. **16.08.2021**- Mr. B Applied for accommodation via Birmingham City Housing, he was reported as having failed pre-qualified checks

although no information is provided as to why this was, it may have been due to his immigration status.

100. **October 2021-** A letter from Change Grow live confirmed that Mr. B was being treated for Heroin addiction.

101. **20.04.2023-** Mr. B re-applied for accommodation via Birmingham City Housing, on the grounds that he was scared to live at his accommodation. He stated that he worked full-time and had lost the funding for his accommodation and that he was no longer able to afford it.

102. **21.04.2023-** Mr. B again approached the housing department on the grounds that he had severe mental health issues and paranoia and that there was no room available at his exempt accommodation.

103. **5.06 2023-** Mr. B assaulted a tenant at his accommodation. The context of the assault was relevant in that the tenant reported that Mr. B had been smoking crack since 9am that morning and was having a 'psychotic episode'. He described Mr. B as trying to 'gouge' him. However, it is fortunate that the victim of the assault was physically stronger than Mr. B and given his had been able to restrain Mr. B and had then proceeded to lock him out in the back garden.

104. The tenant described Mr. B as "...going 'nuts'" and saying that Mr. B thought that the people in the house were going to kill him [Mr. B]. Officers attended the property at 18:12hrs and both the victim and Mr. B were present at the address. Both were spoken to and stated that they were friends again. The victim had no injuries and no longer wished to make a complaint. *Words of advice* were given by officers. During this interaction Mr. B asked for help with his drug abuse. ***See practice and organizational learning points***

105. The police made a referral to *Change Grow Live* for support to be provided to Mr. B around his drug use and mental health.

106. **06.09.2023-** Mr. B approached as homeless, as he had lost his place at his exempt accommodation. He had been staying temporarily at the subject property.

107. On or by 20.09.2023- Mr. B had signed an agreement at the Subject Property.

108. **24.09 2023-** The West Midland Police received a report that two males were trying to gain access to the premises, where Mr. B lived and had smashed a door.

109. **3-11.2023-** an ambulance was called as Mr. B had been stabbed in the back with a razor blade, which had been placed on a handle. He was reported as having 7 wounds to his back, he was

noted to have a deep wound to the right- hand side of his spine and 1 to his right upper arm and left wrist. He was found by the ambulance outside in the street, conscious and breathing he had 27 sutures in total. (In his GP notes it was recorded that Mr. B had been assaulted in his own home.)

110. He stated that the suspect had left the scene. Although the suspect was known to Mr. B he refused to cooperate with the police and provide this information.

111. No information concerning this assault was provided by him to his support worker.

112. **7.11.2023-** There was an entry in Mr. B's support plan that he had taken, the TV which was in communal area of the subject property. To sell it to get some money, possibly linked to his drug use. He was asked to return the TV to the property. This incident was reported by Mr. A, who later reported that the TV had been returned.

Mr B's drug use and the involvement of Change Grow Live

113. As Mr B's Chronology shows a consistent involvement with *Change Grow Live*, which proceeded his moving to Birmingham, it is appropriate to consider the role of the agency, and effective practice and lessons learned which are considered below.

114. Mr B was referred and made several self-referrals to Change Grow Live ("CGL"). The scope of their work is set out in their IMR at paragraphs 2.1 and 2.2 in which they stated:- "2.1 Change Grow Live have been providing substance misuse services in Birmingham since 01/03/2015 after being awarded the contract to deliver services by Birmingham Public Health Team.

115. CGL is a registered charity, that delivers community-based services across England, Wales, and Scotland. Services provided include prescribed opioid substitution therapy, alcohol detoxification, psychological therapies, and social and harm reduction interventions.

116. 2.2. Change Grow Live is a voluntary sector organisation, working with adults and children/families who have been affected by substance misuse. Attendance is voluntary unless ordered by the courts within the criminal justice system."

117. Mr. B was first referred to Change Grow Live (CGL) by Modern Day Slavery Service. The initial contact and referrals to CGL took place on the telephone due to the Corona Virus Pandemic (Covid 19).

118. Although there were reports of Mr. B providing background information and engaging well with the online calls with support workers from CGL there was a gap in the further provision of

support which appeared to result from Mr. B changing accommodation.

119. On 9.11. 2020, CGL attempted to contact Mr. B via his support worker who informed CGL that he had left his accommodation and had changed support worker. The support worker agreed to provide details of his new address and support worker. However, nothing was received by CGL, who eventually closed their file. **See Organisational learning**

120. There were further self-referrals to CGL, and one referral from the West Midlands Police where the file remained open during the periods 14/09/2021 – 31/03/2022, 25/07/2022 – 23/07/2022, 09/08/2023 – 13/09/2023 and 03/10/2023.

121. The last self-referral was on 09/11/2023 when Mr. B made an appointment to re-start the drug rehabilitation program, this program was due to restart on 13. 11. 2023. This did not take place as by that date Mr. B was in custody due to the homicide.

122. Prior to the homicide there was also a referral from West Midland Police to CGL, on 7.06.23, which appears to be directly linked to the incident on 5 June 2023, when Mr. B had assaulted a tenant at the accommodation occupied by him, prior to his moving into the Subject Property.

123. There was some evidence of good practice by the officer making the referral appeared to directly link Mr. B's behaviour to his drug use, and this was evidence of good practice, although it is unfortunate that there was no further action was taken. The incident on 07.06.23 was rightly linked to Mr. B's drug use. This highlights one of the difficulties of continuity of service to Social Exempt accommodation users, in that on two occasions, Mr. B was not able to be supported by CGL, who were unable to follow up as he had changed accommodation.

124. The information provided to CGL from Mr. B concerned his alleged modern-day slavery. This is useful given the lack of evidence about this aspect of Mr. B's history from the Metropolitan Police.

125. Mr. B provided the following information concerning his alleged modern slavery to support workers from CGL; -: "Mr. B states he was previously living in Portugal and was offered a job in England as a painter and decorator and his wages were being paid into someone else's account, and he did not receive his money."

126. In his first triage call on 20/05/2020 he told his ⁷CGL support worker that "...he was a victim of MDS and was paid in Heroin, that he sniffs 2g heroin daily..."

127. Mr. B, on being supported following his alleged modern slavery, initially lived in London. There was an absence of information on when, why and how Mr. B left London and went to live in Birmingham. However, given the information which was available about Birmingham operating as a magnet, for those seeking social exempt accommodation it is considered that the prevalence of the ready supply of accommodation may have been a factor.

Mr. A

128. Mr. A's formative years were punctuated with difficulties, [in that from early in his childhood he experienced traumatic incidents. *Trauma and Mental Health Young Minds*⁸ acknowledges that the suicide of a parent and experiencing violence within the home are traumas which may have a significant and lifelong impact on a child.

129. There is nothing to indicate that support was given to Mr. A, at an earlier stage in his life to deal with the trauma however, no conclusions can be drawn from this as this as Mr. A's formative years were outside the scoping period, and involved his time in Scotland, and as a result no information has been requested or received for the review from Scottish agencies.

130. Mr. A however in his responses to his support worker, appeared to have good insight into his needs and the support that he required in respect of his learning difficulties.

131. There is a degree of caution which needs to be applied when ascribing a diagnosis of learning difficulties to Mr. A, however, the report writer considers that Mr. A may have met the classification for having a learning difficulty. *The National Institute for Health and Care Excellence*, advise that a learning disability is defined by three core criteria (1) Lower intellectual ability, (2) Significant impairment of social or adaptive functioning, (3) onset in childhood.⁹ Mr. A met at least two of the three criteria, in that he had significant impairment of adaptive functioning, which was identified in childhood which led to his being educated at a special school. The Report writer recognizes that a degree of caution has to be applied as it is not her role to make a diagnosis.

132. He self-reported as having difficulties with reading and writing and needing help with reminders of the need to attend to his

⁷ IMR Change Grow Live

⁸ Trauma and adversity Young Minds resources

⁹ Nice Institute for Health and Care Excellence Learning disabilities: What is it? Last revised in April 2025

hygiene. Given this the report writer is comfortable with concluding that Mr. A had a learning difficulty, and as such he was potentially vulnerable and open to exploitation.

133. There is no information that he was involved in criminal or anti-social behaviour in the months leading up his death and this may be indicative of Mr. A having a relatively stable period in his life prior to the homicide.

Statutory Guidance

134. To fully consider the Management Reviews, contextual information is provided concerning the statutory framework for both Modern Slavery and Supportive Exempt Accommodation (SEA)

135. **Modern Slavery and the statutory guidance for England and Wales** *and the National Referral Mechanism and standards of care*

136. The Home Office guidance on Modern Slavery Statutory Guidance for England and Wales

137. Paragraphs 1.2 and 1.3 of the guidance set out that:- “1.2 Identification, protection, care and support for victims of modern slavery is at the heart of this Statutory Guidance. Professionals should work proactively with a view to preventing modern slavery in all its forms. They should be trained to take appropriate action and provide possible victims with appropriate protection and support, based upon their individual needs. It is essential that professionals recognise that survivors of modern slavery may be at risk of re-trafficking and further harm. 1.3. Collaborative partnerships, multi-disciplinary and multi-agency working are fundamental to ensure that victims are identified, protected and safeguarded. Activities should be carried out in partnership with other agencies to provide victims with integrated support and access to their rights and entitlements.”

138. The Guidance at paragraph 2.77, provides a definition and the circumstances of modern slavery.

139. Mr. B by the definition was a potential victim of modern slavery. He set out in a telephone conference with a case worker for Change Grow Live, that he received no money for his work, and was paid in drugs. In accordance with the guidance the Metropolitan Police are one of the bodies who act as First Responder in identifying those who might be a victim of modern slavery.

140. The Key Points set out that:-

141. “Following referral from a First Responder Organisation, the relevant competent authority will make a Reasonable Grounds decision to determine whether an individual is a potential victim of modern slavery. This decision should be made within 5 working days of referral, where possible. Following a positive Reasonable Grounds decision, a potential victim will receive a Recovery Period of at least 30 calendar days and will be able to receive support as set out in the Support section.

142. The relevant competent authority will make a Conclusive Grounds decision at least 30 calendar days after the ‘reasonable grounds decision’, to determine whether ‘on the balance of probabilities’ there are sufficient grounds to decide that the individual is a victim of modern slavery. In many cases a decision will take longer, as all relevant information must be shared and made available to the relevant competent authority to inform the decision, which can often take interested parties significant time to provide.

143. Following a positive Conclusive Grounds decision, victims will be exit-ed, from support *only when appropriate to do so*. Victims with a positive Conclusive Grounds decision will receive at least 45 calendar days of support during the move-on support period.”

144. As a *Reasonable Grounds* Assessment had been made in Mr. B’s case Paragraph 8.20 stated:- Following a positive Reasonable Grounds decision, adult victims will be provided with a *Recovery Period* of at least 30 calendar days. This period begins on the day the *Reasonable Grounds* decision is made. During this period, support and assistance will also be provided on a consensual basis and potential victims will not be removed from the UK.

145. The support and assistance to be offered is as set out in paragraph 8.19 of the Statutory Guidance.

146. “The purpose of the Needs-Based Assessment is to identify the detailed support needs of the potential victim or victim (and their dependents), whilst they are in Modern Slavery Victim Care Contract support which considers:

- physical (including sexual) health needs.
- psychological and emotional needs.
- cultural and spiritual needs.
- practical needs, such as but not limited to the need for material assistance, interpretation services.
- if there is a requirement to access legal advice and representation.
- if there is a requirement to access other advice and assistance.
- arrangements for meeting welfare needs and payment of subsistence.
- if any dependents should be referred to the NRM in their own right.

- access to education for school-aged dependents; and
- the production of a journey plan with the potential victim or victim.

147. Mr. B was provided with access to support. The agency providing that support was the Salvation Army. No information has been provided by them as to the decisions made concerning the level of support to be provided to Mr. B during his *Recovery Period* or his *package of support*.

148. The last information from the Home Office Single Competent Authority was that Mr. B applied for pre-settled status on 31 August 2020 this related to his application to the European Union Settlement Scheme. In respect of the decision related to whether it was accepted that he was a victim of Modern Slavery No *Conclusive Grounds* decision was made prior to the Homicide as that decision was at that point of the Homicide still outstanding.

Supportive Exempt Accommodation (SEAs)

149. The statutory which underpins this accommodation is considered further in the recommendations.

150. Both Mr. B and Mr. A lived in supportive exempt accommodation (also referred to as exempt accommodation), as such this is considered to be a factor of some significance, as it played a part in bringing both Mr. A, and Mr. B together and the events which led up to Mr. B's death which have been explored.

151. There were certain factors in common that both the victim and perpetrator shared; they had tenuous family links, a history of substance abuse, and criminal antecedents. However, neither Mr. B nor Mr. A had any social links that have been detected, such as family or social ties to Birmingham. Accordingly, the reason that they were living in Birmingham requires some exploration. At the Housing sub-committee meeting, it was noted that: although vulnerable homeless could be housed by the housing department there were over 150 organisations in Birmingham and 9000 units of supported exempt accommodation. Birmingham is one of the largest providers of supported accommodation in the country.

152. In order to understand what exempt accommodation is, a helpful definition is provided by **Insight Housing The provision of Exempt Accommodation**

153. ¹⁰:- "Exempt accommodation is shared housing that is not funded or commissioned by local authority or social care funding. It is often used as accommodation for people with very few other housing options, such as prison leavers, rough sleepers, refugees

¹⁰ *Insight Housing: The story explained: What is exempt accommodation? (03.12.21)*

and migrants, and those experiencing substance abuse issues. There is also a small element of care, support and supervision provided to claimants, which means it is exempt from Local Housing Allowance (LHA) caps, hence the use of the term 'exempt'.

154. The type of accommodation may also be described as Houses in Multiple Occupation (HMO's) which is defined as a property in which the following applies, at least three tenants live within the property forming more than 1 household, in which facilities such as toilet, bathroom or kitchen facilities are shared with other tenants.

155. Exempt accommodation in most cases, as well as not being subject to the licensing provisions of the Housing Act 2004, attract higher levels of housing benefit payments as services are normally provided to the tenants/ licenses. It is significant that the purpose of the licensing regime is to ensure that residential accommodation within the Private Rented Sector (PRS) is safe, well managed and of good quality with a particular focus on safety. Part of this review has considered, the role that living in such accommodation may have played in providing the circumstances for the OWH to occur.

156. *A report in Inside Housing:*¹¹ stated that -:

157. "There are now more than 21,000 claimants in Birmingham, 15% of all the 150,000 UK claimants. Birmingham houses 6% of the UK population.

158. And most of these homes, and the providers that supply them, provide desperately needed accommodation with essential support.

159. Birmingham has provided fertile conditions for this growth. The city has its own constant demand for housing, with a housing waiting list of 17,000 households – including its large Victorian properties, which are ripe for conversion into HMOs, the ideal type of housing for EA. But it is the council's housing benefit regime that has really fueled this growth."

160. "People came to Birmingham because housing benefit was easy," says one person in the exempt sector who has worked for managing agents and housing associations. "If you go to neighbouring councils, like say Walsall and Dudley, you can't get anywhere near the rates that you can in Birmingham."

161. As part of the sub-housing group meeting, the issue of the growth of exempt accommodation in Birmingham and the effect that it might have played as the backdrop to the Offensive Weapon Homicide was part of the discussion. With its central location and links to other parts of the UK it is understandable that those who

¹¹ *How Birmingham became the centre of a supported housing controversy dated 12.08.2022*

are homeless and vulnerable may gravitate to Birmingham in the same way that both Mr. B and Mr. A appeared to have gravitated towards Birmingham.

162. Both Mr. A, and Mr. B had a period of instability within their previous exempt accommodations prior to their tenancies at the subject property.
163. Mr. B was linked to 10 separate addresses including the subject property. Whereas Mr. A was linked to 5 properties within the Birmingham area. An IMR was sought from the providers of previous accommodation. However, at the time of the draft report, no further information had been provided from any of the social housing providers.
164. Mr. B was involved in a serious and significant incident in which the police were called (see the chronology on 5 June 2023). Mr. B was linked to an incident where a tenant was assaulted, and the assault was linked to Mr. B's drug use. It was reported that this incident only ended when the tenant who was assaulted managed to push Mr. B into the garden. This was an incident which had the potential for a serious violent offending. Mr. A was also the victim of an assault at a previous property (see August 2022).
165. However, neither of these incidents, which reveal potential risks and vulnerabilities are contained in the tenant's background information provided to the support worker.
166. Both tenants appeared to have been asked to leave their previous accommodations when problems arose and there was no obligation on the exempt accommodation providers, to provide any information to the LA or any future housing provider.
167. As the previous SEAs providers have not submitted information for review, the type of tenancy agreement, and the rights that both Mr. A & Mr. B had as tenants/licensees are unknown and whether these were explained to them and whether they were asked to leave using informal means rather than a Notice of Seeking Possession or whether they made the decision to seek alternative accommodation is an unknown factor. If they had been granted tenancies, they may not have understood that there were legal safeguards in place such as being able to remain in the property prior to court proceedings and an order for possession having been granted.
168. It is significant that the tenancy agreement at the *subject property* was a Shorthold Assured Tenancy, which attracted rights not to be evicted without legal proceedings.
169. Birmingham City Council has recognised the potential for Anti-social behaviour as it was part of the national pilot scheme launched in October 2020 to address the standards around such

housing. As part of the agencies which contributed to this review, information was provided of a pilot project in Birmingham which has been put in place to improve the standard of exempt accommodation. This includes the availability of a seconded police officer, who had a role in supporting exempt accommodation providers with anti-social behaviour.

170. As part of the review, the chronology revealed that both Mr. B and Mr. A had experienced problems with violence in their previous accommodation, both being identified as victims and perpetrators of violence. However, it was noted that the information provided to *Sustain UK* (which was within their support folders) was provided by Mr. B and Mr. A, and as such it was self-selected and did not reveal any of this previous housing history. There was no requirement for any independent verification of information provided by the tenants.
171. This review revealed that there was no independent mechanism for information to be shared between providers, the only potential organisation which may have been able to take the role of collator and provider of information was Birmingham City Council as a housing provider, with a duty under the Housing Act 1996 and the Homelessness Reduction Act 2017 which included making assessments and developing a personalized plan for those at risk of homelessness.
172. It has also been a feature that any mechanism for information sharing must conform with the UK General Data Protection Regulation (UK GDPR) and the Data Protection Act 2018, in that there must be one of six lawful bases to share data. The framework within which this sits in relation to prevention of violence in and around SEAs is considered as part of the National Recommendations.
173. No criticism is made about the role of the providers of the *subject* SEA to both the victim and perpetrator. The subject SEA provided information that included a copy of the tenancy agreements, the support file for both Mr. B and Mr. A, which included details of a support plan for each of the occupants and the services which they required.
174. A careful review of the information confirmed that both Mr. A, and Mr. B were provided with a support plan which on review included personal details such as next of kin and background, criminal convictions, and information on the level of support which was to be provided.
175. Sustain UK made information available to the tenants and formed the rights which the tenancy provided such as their Safeguarding Policy, a Charter of Rights, and a Housing Rights: Statement of Rights.
176. Mr. A, and Mr. B received regular visits from their support worker, and within the confines of the information provided by the tenants an appropriate level of support was provided.

177. The key worker engaged with both Mr. A, and Mr. B and that there was evidence of good practice. (For example, albeit traumatic for the worker concerned, they used their professional curiosity to investigate why Mr. B was reluctant for them to enter Mr. A's room in his supposed absence.)
178. The support plan enabled the tenants to self-identify the required level of support. However, details of mental health needs and addiction were largely left for the tenants to self-report which is a possible weakness of the system. The support worker was not trained to identify mental health needs, neither did there appear to be a role for them to determine whether such needs required further intervention, and if so the plan to escalate the needs so that further support could be provided. -
179. The files contained a risk assessment, and daily records, together with a review of the plan at the one- month mark.
180. There was more detail in Mr A's plan which is reflective of his longer period of tenancy. In respect of the risk assessment for Mr. A, it was identified that a particular trigger point and warning for a change of behaviour, was when Mr. A smoked [drugs] or drank more than usual. The last incident involving a change of behaviour was reported as being in May 2023. The risk assessment level was identified as high. However, it is not clear that there were suggested strategies for managing any change in Mr. A's behaviour. The assessment centered on the risks that his behaviour might present and as such did not appear to include a consideration of his potential vulnerabilities.
181. Although Mr. B's files contained similar information there was no risk assessment, this may have been linked to when he moved into the accommodation. However, there was a referral form, which covered some of the issues which would have formed part of the risk assessment had one been completed.
182. The referral included information that Mr. B had convictions for the supply of drugs, was a drug user, and had problems with sleep issues, anxiety, and PTSD. He was described within the plan as managing his addiction by "having gone cold turkey". In his support plan Mr. B was identified as having served an 18-month sentence [for] for aggravated assault with a weapon. There was no information of possible weapons awareness or prevention work having been undertaken. Neither did there appear to be any method for verifying whether he was using drugs at the point of his moving into the subject property.
183. The daily support records recorded an appropriate level of support, which was accorded with the tenancy agreement. There were issues concerning the level of benefits that were payable for accommodation for Mr. B, this accorded with the daily notes, as

before coming to the subject property, Mr. B had an overpayment of housing benefit which was recoverable by reducing the amount paid to the landlord.

184. There were several stressors on Mr. B, such as financial, and mental health there was some evidence that may suggest possible escalation in his mental health prior to his admission to the subject property, (based on separate information from West Midlands Police). There was also a concern as to whether he had been open and honest about the extent of his drug use, and whether his claims to have “gone cold turkey” (Given up drugs by himself without additional support) should have led to further investigation. However, it is important not to apply hindsight when considering what occurred.

185. This section considers the Individual Management Reviews (IMRs) and Information

186. Reports were completed by the individual agencies and the panel’s contribution to their analysis, focused on the response of agencies to the presenting issues, the effectiveness of information sharing between agencies, why decisions were made, and actions taken or not taken.

187. The Panel was mindful of hindsight bias and has attempted to view the case and its circumstances as it would have been seen by individuals at the time, not with the benefit of hindsight. Further, the findings of the review must be set in the context of any internal or external factors that were impacting on the delivery of services and professional practice during the period covered by the review and one such factor that is highly significant is the coronavirus pandemic and the impact which this had on services.

188. The IMRs that have been reviewed predominantly deal with Mr. B’s contact with agencies, this does not mean that Mr. A is less important. Information was provided about Mr. A from his support file. In hindsight he could have been viewed as being clearly vulnerable, in that he needed on-going support for his daily living in keeping with his self- reported, though undiagnosed learning difficulty.

189. It was confirmed by his brother that Mr. A had attended special schools as a child. He also has issues with alcohol misuse which was reported as being a factor which influenced his behaviour and led to, it is possible that these factors could also have rendered him vulnerable to exploitation and less able to defend himself. As such this may have been a factor in the circumstances which led to his death.

190. It should be noted that although West Midland Police did have some contact with Mr. A, ~~this was~~ as both a potential victim and perpetrator (of previous threats). The incident in which he was a victim occurred in August 2022, he was the subject of an assault whilst he and the perpetrator of that assault were under the influence of alcohol.
191. Although, the assault was serious, it was not considered to be life threatening, however, it was reported that the assault resulting in his being taken to hospital. There was no information about the extent of the injuries he sustained available from West Midlands Health Trust, this could be due to his using an alias at the time of the injury as the police record states that the caller who made the call, although believed to be Mr. A used the name "Paddy". He was reported as "sounded very intoxicated, he was talking slowly and was difficult to understand."
192. One concern about the information held by agencies concerning Mr. A, was the fact that it was known that he used a number of aliases, given this there is a possibility that information may be held about Mr. A under an unknown alias

Housing- Support agency

The Salvation Army

193. Mr. B was initially provided with accommodation by the Salvation Army during his recovery period once his reasonable grounds decision was made (see the information on modern slavery given above). From the information provided Mr. B was receiving some support up to August 2020.
194. The Salvation Army provides specialist support to protect and care for all adult survivors of modern slavery in England and Wales through a government contract which was first awarded in 2011 and was extended in 2021. The specialist services are able to provide access to a safehouse, or outreach support which is not limited to confidential legal advice, health care, counselling and support in obtaining employment and housing.
195. However, no information was provided by the Salvation Army concerning the level of support provided or the circumstances of Mr. B's accommodation ending, or whether there was a risk assessment or any other circumstances which caused concern during his occupation.
196. This has proved to be a real weakness in enabling the panel to understand whether there were potential red flags which indicated deterioration in Mr. B's mental health or evidence that he represented a risk to others due to his behaviour. *See Practice and Organisational Learning below.*

197. *Birmingham City Council, City Housing*

198. The IMR provided by City Housing stated that:- “There was no agency involvement with the victim, [Mr. A].

199. The alleged perpetrator, [Mr. B], was determined as ineligible to join the Council’s Housing Register in October 2021. He sought homelessness assistance again in April and September 2023. Advice and assistance were provided in securing Exempt accommodation.

Sustain (Registered Social Landlord)

200. Detailed information has been provided above, concerning the interventions of both Mr. B and Mr. A’s support worker, who was provided by Sustain UK, as such it is not intended here to separately analysis their responses and the organisational decisions taken, although information has been provided as part of the learning for the review. Practice and Organisational learning in relation to the support given to both Mr. A, and Mr. B is considered below.

Health Care

Sandwell and West Birmingham NHS Trust

201. An Individual Management Review was prepared by the Senior Adult Safeguarding Nurse Sandwell and West Birmingham NHS Trust- “The Trust identified that the first contact with Mr. B was on 1.05.2023. He was brought in by ambulance to A and E where he was assessed by the Trauma Orthopedic team with injuries to his knee, spine, and pelvis. He reported that he had jumped out of a window because “someone was chasing him.”

202. His medical history revealed that he had received injury due to having been shot in his right arm in 2005. While he was in the hospital, he fell out of bed, he reported that he was having nightmares. He told staff that he lived in shared accommodation and did not have anyone to look after him.

203. The Safeguarding Nurse identified all these factors as indicating vulnerability. In addition, in the report, it was noted that:- “[Mr. B] was referred to the Surgical Assessment Unit after an X-ray showed shattered calcaneal fracture. *Noted to be a Heroin user.*

204. No further enquiry was made into why [Mr. B] lived in a shared accommodation/ who he thought may be chasing him / no link made to [a] previous bullet removal whilst in Accident and Emergency.[Mr. B] was moved to the Surgical Assessment Unit in the early hours of 02/05/2023 whilst awaiting a decision re - surgery on their ankle and again it was noted that he lived in shared accommodation with a support worker and was a heroin

user but no further assessment took place and Mr. B was transferred to a T & O ward on the evening of the 02/05/2023.”

205. The IMR also noted that Mr. B had been noted to be a Heroin user.

206. He was discharged but re-admitted to A & E with a previously undetected ankle fracture. At the pre-operation assessment completed on 18/05/23 it was noted that he was [on] Heroin until 2 weeks prior to his admission to A & E, however, Mr. B refused referral or help/support for this. He was discharged the next day. Although Sandwell and West Birmingham NHS Trust policy supports drug addicts by providing access to support to substance misuse support services, this involves directing patients to services, and the support given would appear to be reactive, in that the user would need to identify as someone who needed support with their addiction. It is not clear that Mr. B was directed to support, or that there was any overview of his mental health needs. *See Practice and Organisational Learning below.*

Primary Care- (GP Services)

~~207.~~ *The Birmingham and Solihull Integrated Care Board (the ICB)*

208. Mr. B’ had contact with GP services, the Primary Care services were not aware of any potential violent behaviour, however, Mr. B was referred to Change Grow Live, by his GP.

209. On March 2021, Mr. B consulted with his GP about his drug use, Mr. B was advised to refer himself again to CGL – and was provided with the telephone number and email as DB expressing interest in restarting drug treatment.

210. In October 2021 a letter was received from CGL that Mr. B had been seen by the service due to Heroin use. In May 2023, Mr. B had telephone contact by the GP due to a recent injury, the explanation offered was that he had slipped in the shower. The explanation provided by Mr. B to his GP was different from the detailed explanation given to A & E, however, this does not appear to have been information that was transferred from the NHS Trust Hospital to the GP. An important factor at the time was the effect that Covid had on GP practices and the fact that most appointments were not fully face-to-face. It may have been that Mr. B would have been more forthcoming at a face-to-face appointment, which may also have led to a wider discussion of his mental health and ability to self-manage his addiction.

West Midlands Police

211. The Chronology provides information of Mr B both being a perpetrator, in June 23 and a victim of assaults in November 23.

212. In early November WMP received a call from West Midlands Ambulance Service who inform them that they were en-route to a

report of a male having been stabbed in the back. He was outside in the street, conscious and breathing. He stated that the suspect had left the scene. Officers arrived and located Mr. B who had five deep wounds to his back and a stab wound to his chest.

213. He told officers he had been attacked outside his room within the *subject* property. Although the wounds were assessed to be life-threatening this was subsequently downgraded.

214. Mr. B told officers that he had been attacked by his drug dealer over an argument concerning the price of drugs. It is significant, and of some concern that there was no information about this within Mr. B's support file, given that his assault was reported to the police, who may have wanted to make enquires and notify his SEA of an identified risk, not just to Mr. B but potentially others within his exempt accommodation. Such a report may have indicated to his support worker that Mr. B, either due to his health or behaviour was placing both himself and potentially others at risk due to his drug use.

215. The next section of the report identifies individual learning points arising from the case, including effective and good practice. It sets out the changes that the organisations, have identified from the review, and also the areas noted by the report writer as being specific to the organisation. *See Practice and Organisational Learning below.*

Practice and organisational learning:

Sustain UK- Supported Exempt Accommodation Provider

216. In their IMR noted that -: "... there are barriers in general for us as an RP and our MAs in gathering relevant background information of potential tenants. If we were ... privy to background information/criminal history of tenants or potential tenants, this would make assessments and decisions much more beneficial to all parties. Including the housing history of a person as knowing all previous addresses, and length of time there, can be a very useful tool in assessing someone's ability to manage well as a tenant and/or to gather information on how they are as a tenant."

Increasing background checks and closer working with West Midlands Police Force

217. As a result of the OWHR Sustain intended to put the following organisational learning into practice. *"In light of this OWHR we have produced a document providing our MAs with a list of options they can take to seek additional background information on tenants and how they can improve their referral assessments, this is intended to be a reminder document for all MAs and something that they can refer back to with confidence that we as there RP are*

encouraging more professional curiosity at point of referral. We also feel that improving the partnership work between us our MAs and the Police, so that spot check visits and support from local police to manage ASB (which is more prevalent within our accommodations at times) would be beneficial to staff, tenants, and wider communities too.”¹²

218. It was clear that within the limits of the knowledge and information that there were many areas of good practice in that both Mr. A. and Mr. B were supported by their support worker on a daily basis, and the support worker who discovered that Mr. A was deceased, used professional curiosity and demonstrated concern which led to her investigating Mr. A’s absence. However, it is clear that very little information was cascaded down to them.

The SEAs identified a need for further support and information and The requirement for a dynamic risk assessment (see also national recommendations)

219. It was also noted that there needed to be a dynamic risk assessment undertaken. Which meant that the risk presented by tenants was being evaluated and updated and took account of matters such as escalating drug or alcohol misuse, threats of violence or actual violence and any identified concerns of deteriorating mental health

220. It was noted that Birmingham City Housing was aware of the potential impact of Supportive Exempt Accommodation in the increase of anti-social behaviour. This has led to a police officer being seconded to City Housing, primarily to deal with this issue. Having reviewed the IMR from WMP it appears that the information concerning Mr. B’s assault was not shared by WM Police with the seconded police officer.

Sandwell and Birmingham NHS Trust

221. Sandwell and Birmingham NHS Trust in seeking to identify individual learning point in this case considered the following issue:-
“Did the organisation have policies, assessment criteria and procedures in place for dealing with concerns about the emotional wellbeing of the perpetrator, their violent behaviour and vulnerability? Were these policies, assessments and procedures use?

222. It was noted in their IMR that the Trust have psych liaison and referral processed to psych. liaison however, Mr B’s vulnerability factors were not identified. It was considered that due to his history of being chased, previous gunshot wound, living in shared accommodation and having disclosed frequent nightmares. These factors ought to have been identified.

¹² Sustain IMR

223. Organizational learning identified was that Trauma informed practice was being promoted and was already within safeguarding training and part of safeguarding training strategy particularly around self – neglect”.

224. The IMR noted that “There is an acceptance that the NHS used a medical model for treatment and that a review of this case has concluded that a more effective approach would have been to adopt a more professionally curious approach together with a trauma informed approach.

225. The Trust also addressed the issues of lessons that can be learnt which have been accepted as part of this review they include-:

226. The Requirement for further professional curiosity

- **Requirement to raise practitioner awareness and understanding of trauma informed care and collate evidence of the application and impact of trauma informed care.**
- **For better information gathering and sharing from all relevant agencies involved with supporting patient needs.**
- **Requirements for making every contact count to aid in referrals to specialist services.**
- **The there was a need to raise awareness of trauma informed practice.**

Better information sharing of information with the GP

227. It was also accepted that more comprehensive information could have been provided to Mr B’s GP, and this would have included the background to his injuries and his reported nightmares.

228. There was also a recognition of the need for better information sharing with his support worker/ accommodation provider.

229. Mr B throughout the period of the review (2020-2023) was referred to CGL by several agencies, he also self-referred, this was evidence of good practice, however the referrals were around the issue of Mr B’s drug use, rather than because of his mental health.

230. The nature of support from CGL is by its nature consensual and any disengagement results in his file being closed. However, when Mr. B engaged, there was good practice in relation the level of detail contained within his notes.

231. Improvements in practice require that both the Trust and CGL should in order to improve their current practises provide more comprehensive information to GPs to enable decisions

to be made around the need for treatment for drug use and mental health

232. Although it is easy to use hindsight, the pattern of Mr B's behaviour suggest that this may have been evidence that his mental health was deteriorating and that this was coupled with persistent drug use, however this does not appear to have been shared with his social housing provider. This had the potential to put other tenants at risk. **This has been dealt with as part of the national recommendation.**

Modern Slavery and the role of the Salvation Army

233. This review has not been able to comment effectively on the extent of the support that Mr. B received as a person whom there was reasonable grounds to believe that he was a victim of modern slavery and the impact that this may have had on his mental health. Since no information has been provided from the Salvation Army who were tasked with providing support. This is significant as although Mr. B provided information to CGL and Sustain about his mental health he does not appear to have undergone an assessment.
234. Within this report there has been reference to Mr. B's mental health, this report has been unable to conclude on the extent, if any that this was a factor in the homicide, however there is a concern that Mr. B's deteriorating mental health may not have been dealt with effectively.
235. No information has been provided as to why he left his accommodation, and he may have no longer consented to the provision being offered. This means that any mental health issues that he may have had remained undiagnosed. The nature of support from CGL is by its nature consensual and any disengagement results in his file being closed. However, when Mr. B engaged, there was good practice in relation the level of detail contained within his notes.
236. **For improved practice and organizational learning it is suggested that as an organization who have a government contact to provide support to victims of modern slavery, it is disappointing that the Salvation Army did not provide any information for this review. It is recommended that in order to improve practice the Salvation Army should consider appointing someone tasked with responding to such reviews and providing information.**

Modern Slavery Unit

237. In respect of Mr. B's *Reasonable Grounds Assessment*, no *Conclusive Grounds Assessment* was reached within the time scale.
238. Although it is speculative it is possible that had a Conclusive Grounds Assessment been made, then Mr. B would have been provided with a Recovery/ and or Moving on Period as set out in the legislation.
239. Had Mr. B consented to this; it could have resulted in a personalised journey plan. Paragraph 8.24 provides that:- ¹³. A journey plan is a plan tailored to an individual's needs and circumstances, which keeps track of the potential victim or victim's recovery progress and details how they will move towards independence outside of Modern Slavery Victim Care Contract support. The journey plan will be informed by the Needs-Based Assessment and is developed through interaction with a support worker. The journey plan will consider the personal goals and aspirations of the potential victim or victim and what support they will require to help them recover."
240. Although the Modern Slavery: Statutory Guidance for England and Wales (under s49 of the Modern Slavery Act 2015) and Non-Statutory Guidance for Scotland and Northern Ireland at paragraph 14.124 does not provide a target period for making a Conclusive Grounds decision, the delay in making a decision had the potential to limit victims of modern slavery's access to further support.
- 241. For improved practice and organizational learning, it is suggested that during the 'reasonable grounds to suspect' period closer monitoring and support should be provided by the support agencies involved in providing this support.**
242. In order for this to be truly effective: The following recommendations should be put in place:-
- Recommendation 1**
243. **The role of the seconded police officer should be reviewed to ensure that the role profile / job description is proactive – namely that it supports reaching out to police colleagues at a local level, supporting the identification of criminal behaviour within SEAs.**
244. It is recognized that this officer's role does not displace the role of the local officer who has a responsibility for investigating crime,

¹³ Modern Slavery: Statutory Guidance for England and Wales (under s49 of the Modern Slavery Act 2015) and Non-Statutory Guidance for Scotland and Northern Ireland

however the seconded officer has an important role in raising the level of awareness.

245.

Recommendation 2

Joint specialist training should be provided to both police officers and local authority officers (Environmental and noise nuisance and anti-social behaviour), in understanding identifying SEA accommodation and tackling anti-social behaviour.

It was recognized that there was further work to be done on the training needs of local police officers, and the agency workforce in general concerning Supportive Exempt Accommodation, and anti-social behaviour.

246.

This will support the duties that the local authorities have under Section 17 of the Crime and Disorder Act 1998 to take all reasonable steps to prevent crime and disorder in their local area.

Recommendation 3

247.

It is recommended that Birmingham City Housing should in making referrals establishing criteria to be used in matching tenants to SEAs. Any housing referrals should consider safeguarding and vulnerability of proposed tenants to ensure that they are matched to the most suitable accommodation which can meet their needs.

248.

It was noted by Probation Services that the council have an approved list of placements who provide services that vulnerable people need. (Birmingham City Housing should take a more proactive role in matching tenants to appropriate housing providers, (as currently practiced by the probation services)

249.

The report writer was provided with information that the Probation service in Birmingham only accepts transfers that are going to one of these approved addresses. The report writer recommends that if the system is partially in place in relation to probation, the system of an approved list of placements which identifies the specialism of SEAs can support appropriate placements.

250.

Recommendation 4

(iv) Tenant's agreements used by Exempt Accommodation Providers could be amended to require tenants to consent in writing to relevant authority's sharing information about them

which would mean that Data Protection would no longer prevent information sharing.

251.

The current system is reliant on potential tenants disclosing information about themselves. As part of the process of acceptance of a tenancy. Tenants should be asked to consent to checks and information sharing, to ensure that they are being provided with appropriate support.

252.

Where agreements are in place this would support the police and local authority in sharing information, where the tenant has been involved in incidents of anti-social behaviour or has been the victim of or perpetrator of serious anti-social behaviour.

253.

All reported incidents of violence involving tenants of exempt accommodation either as victim or perpetrator should be shared with the social housing provider.

254.

Recommendation 5

That applications for changes of Housing benefit to new SEAs should require information to be provided by the tenant as to the reason for changing SEAs/ with the option of the tenant being asked to consent to this information being shared.

255.

Recommendation 6

Risk assessments should be dynamic and support plans should be updated to include, plans to deal with changes in risk and behaviour with strategies, support and referral information set out within the plan.

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

257. To promote the learning from this case the review identified the following actions and anticipated improvement outcomes: The provisions of The Supported Accommodation (Regulatory Oversight) Act 2023 received royal assent on 29 August 2023. The purpose of the act was to requires the Local Authority to implement a supported housing strategy for the purpose of raising the standard of supported exempt accommodation.

258. The Act provided that the government will create new National Supported Housing Standards and for the introduction of Licensing Regulations. Although consultation has taken place, the government is yet to have published regulations, the Local Government Association has published guidance for local authorities (Supported Housing LGA Reference Code 5.204)

However as at the date of writing the recommendations there is no set date for the standards to be introduced and the standards have not been finalized.

259. From the discussions with the agencies, it is clear that there is a need for standards which address how supported exempt accommodation is allocated. A recent article in the Guardian Vulnerable People still living in Unsafe Supported Housing two years after the Law was passed, the article noted that one of the main concerns with the sector is that rogue providers are placing very vulnerable people in shared housing which can exacerbate addiction issues and mental health problems creating violence and anti-social behaviour and placing strain on emergency services.
260. Given the current constraints on local agencies and SEAs such as Sustain, who, although evidencing good practice; a noticeable difficulty was that without a full picture of the history of the tenants it was not possible to establish a dynamic risk assessment process. The added difficulty was that tenants appeared to self-select SEAs rather than a process of assessment and allocation, to SEAs who could provide specialist support around the tenant's main area of vulnerability. (although the report writer accepts that both the perpetrator and victim had complex and compounding vulnerabilities.)
261. Para 2.18 of the Government's consultation address the need for a person centered support standard which set out that a needs assessment and tailored support plan with agreed outcomes needed to be put in place for each tenant.
262. In order to facilitate this a national standard should require tenants to be provided accommodation in SEAs which are licensed to provide specialist support around the tenants main areas of vulnerability.
263. There is an urgent need for SEAs/ Local authorities who may have a role in facilitating placement to obtain and share information. Currently concerns around data protection may prevent information being shared with SEAs who are not statutory organisations.
264. The following national recommendations are suggested
- I. **The implementation of the National Standards**
 - II. **The person centered care standard to require SEAs to be licensed to provide specialist care for Mental Health Needs (including trauma and post-traumatic stress), Addiction, support for vulnerable adults and complex needs.**
 - III. **That specialisms shall require providers to demonstrate expertise by appropriate accreditation, training.**
 - IV. **That the National Standards should provide a limited exemption to the Data Protection Act 2018 to enable the sharing of information for the prevention of crime and safeguarding and protection of tenants.**

Dissemination

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

Date circulated to relevant policy leads: [Click or tap to enter a date.](#)

Organisation	Yes	No	Reason
Single Competent Authority	☒	☐	Click or tap here to enter text.
West Midlands Police	☒	☐	Click or tap here to enter text.
NHS Birmingham and Solihull Trust/ Sandwell and Birmingham NHS Trust	☒	☐	Click or tap here to enter text.
Change Grow Live	☒	☐	Click or tap here to enter text.
Birmingham City Housing/ Sustain Housing	☒	☐	Click or tap here to enter text.

OWHR process

A scoping meeting took place to examine the contacts between the persons subject to the review and the statutory agencies. The relevant period of scoping was agreed as the Three years prior to the homicide which was reflective of the length of time the perpetrator had been in the UK. However, were relevant events occurred prior to this they were considered in the report. Review partners submitted information gathered in the IMRs. Where considered necessary further sub-meetings were held. Following the information phrase a draft report was prepared for the agencies to consider. This identified organisational and policy improvements which could be made following the incident. The report was presented to Birmingham OWHR Strategic group which led to further suggested amendments and for further review and sign off.

[Click or tap here to enter text.](#)

Final confidence check

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

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

☐

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

☐

Statements of Independence

Statement of Independence by Chair:

Please read and sign the following statement. Consider the section on independence in the OWHR Statutory Guidance before completing.

Chair 1:

Statement of independence from the case

I make the following statement that prior to my involvement with this review:

- I have not been directly involved in the case or any management or oversight of the case.
- I have the appropriate recognised knowledge, experience and training to undertake the review. Therefore, I have met the criteria of an Independent Chair.
- The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference. I recognise that the purpose of this is to identify learning from the case, not to attribute blame to practitioners or agencies.
- I have read and understood the equality and diversity considerations and will apply accordingly.

Please set out below how you meet paragraphs 3.14 – 3.19 of the OWHR Guidance

The report writer who chaired the review, is a barrister, who worked for a London local authority for a period of 15 years, as an employed barrister. More recently she has undertaken regulatory legal work for the NMC and the East England Police misconduct panels, as well as being appointed by the MOJ as a fee-paid Tribunal Judge.

The chair has had no connection with the relevant review partners or local oversight process for this review. If they have worked for any agency previously state how long ago that employment ended:

Click or tap here to enter text.

Signature: *Ms Monica W Daley-Campbell*

Name: Ms M W Daley Campbell

Date: 29/01/2026

To be completed by the Home Office:

Please tick here to confirm that the Chair was appointed from the Independent Chairs List held by the Home Office:

☐

If the Chair is not a member of the Independent Chairs List, then please give detail to confirm how the alternative Chair fully meets the Competencies set out in the OWHR guidance.

Click or tap here to enter text.

Scope/Terms of Reference

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

Click or tap here to enter text.