Learning from tragedy?

The potential benefits, risks and limitations of Offensive Weapons Homicide Reviews

by Dr Susie Hulley
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CENTRE FOR CRIME
AND JUSTICE STUDIES

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Young adult safety project

Learning from tragedy? The potential benefits, risks and limitations of Offensive Weapons Homicide Reviews is part of the *Young Adult Safety* project at the *Centre for Crime and Justice Studies*.

This project aims to strengthen advocacy about key aspects of serious violence that affect young adults and is supported by the Transition to Adulthood (T2A) Alliance, a Barrow Cadbury Trust criminal justice programme and campaign.

Since 2009, T2A has been building the case for a distinct approach to policy and practice relating to young adults in the criminal justice system. By collaborating with criminal justice professionals, the voluntary and community sector, policy-makers and young adults themselves, T2A is building a body of evidence and good practice guidance. The T2A Alliance supports this programme of work - and consists of leading criminal and social justice organisations, including the Centre for Crime and Justice Studies. Alliance members collaborate on T2As reports and resources.

Previous publications in the *young adult safety* series have explored joint enterprise prosecutions and Serious Violence Reduction Orders.

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Executive summary

This report examines the potential benefits and limitations of Offensive Weapons Homicide Reviews (OWHRs), introduced in the Police, Crime, Sentencing and Courts Act 2022. It is part of the Young Adult Safety project at the Centre of Crime and Justice Studies (CCJS), a project which aims to explore effective and accountable policies and practices that could reduce violence involving young people (aged between 18- 25-years old).

OWHRs were introduced by the Conservative Government to address concerns that existing statutory homicide reviews were not formally capturing information about the 'growing proportion' of homicides involving offensive weapons (Home Office, 2023a). Like other homicide reviews, the purpose of OWHRs is to help national and local agencies understand the causes of serious violence, to better prevent homicides involving offensive weapons and 'save lives' (Home Office, 2023a).

OWHRs require that the police and local authorities (in England) or health boards (in Wales) review the circumstances of homicides involving adults (aged 18 and over) killed using an offensive weapon, which fit specific criteria. OWHRs were introduced into three pilot areas across England and Wales on 1st April 2023 (Home Office, 2024) and an 18-month evaluation was commissioned by the Government, with a report expected 'in due course'.[1] The outcome of the evaluation will determine whether OWHRs will be rolled out nationally.

Since findings from the evaluation of the OWHR pilot have not yet been published, this report was compiled from academic research, statutory guidance on OWHRs, Freedom of Information (FoI) requests, existing homicide reviews and inquiries, and other grey literature. Based on this information, the report concludes that despite the potential of OWHRs to achieve a number of benefits, set out below, they are unlikely to satisfy their key aims of reducing weapon-enabled homicides and saving lives. Therefore, to achieve such aims, we recommend that the Government invest in violence reduction programmes for young adults that are evidence-based. However, if they decide to roll out OHWRs nationally, it is important that the Government are clear and realistic about the aims and potential benefits of OWHRs, and that they set out how they will mitigate their risks outlined below.

The potential benefits of OWHRs are:

1. They serve a symbolic function, signifying to victims' families and the wider community the Government's commitment to taking offensive weapon-related homicides seriously, including those involving young adults.
2. They could provide a victim's family and friends with additional information about a homicide. This could help them to understand and cope with the death of their loved one.
3. They could offer valuable local and national data about offensive weapon homicides involving young adults that is not currently available. If collated in a national database, this could improve knowledge and understanding and the development of initiatives to reduce such homicides (but see risks below).
4. They have the potential to help local and national agencies develop policies and practices to address weapon-related homicide among young adults, if the risks outlined below are mitigated.

However, this report also identifies several risks and potential limitations of OWHRs:

1. Evidence suggests that existing homicide reviews have not reduced homicide rates, and that OWHRs may not be effective in preventing future weapon-enabled deaths and saving lives;

2. There is a risk that local and national agencies will not engage with or act on the findings from OWHRs, particularly given the lack of a statutory duty or resources to do so;
3. OWHR panels may apply 'hindsight bias' in their reviews of offensive weapon homicides, oversimplifying the (often complex) story of a homicide and misidentifying causes;
4. The current selection criteria of OWHRs may generate misinformation about offensive weapon homicides involving young adults, potentially reinforcing existing racialised stereotypes about the involvement of young men from black and mixed ethnic backgrounds in weapon related violence.

Therefore, while OWHRs may offer symbolic assurance to secondary victims and the general public and could provide information to victims' families about their death, they are unlikely to prevent weapon-enabled homicides involving young adults and save the loss of future lives. In light of these findings and the government's ambitious target to halve knife crime over the next decade, we urge them to reconsider the cost effectiveness of a national rollout of OWHRs, and to instead focus on well evidenced interventions that reduce serious violence and support young adults to flourish.

However, if OWHRs *are* expanded nationwide, this report makes five key recommendations to mitigate the risks it has identified in relation to homicides involving young adults and weapons:

1. Remove the OWHR criteria that requires that the victim or perpetrator is known to agencies. This would ensure that any insights derived from OWHRs are as inclusive as possible, allowing for local and national learning from *all* homicides involving offensive weapons (outside existing homicide review frameworks).
2. Ensure that the chair and members of the review panel are culturally and ethnically diverse and well-informed on issues related to age, including the transition to adulthood (University of Birmingham, Barrow Cadbury Trust and T2A 2018), ethnicity, and serious violence. This includes being aware of the racial prejudice that is often embedded in narratives of violence involving young men from black and mixed ethnic backgrounds.
3. A Home Office requirement that local teams implement, monitor and respond to OWHR recommendations (Jones *et al,* 2024), and provide adequate (and targeted) resources to do so.
4. The Home Office monitor the age, sex and ethnicity of the individual victims and perpetrators in the offensive weapon homicide cases that are reviewed, to ensure that the representation of cases can be monitored and the findings can be put into context. It is stated in our FoI request[2] that this is not currently being done.
5. The Home Office collate the findings and recommendations of all OWHRs in a publicly accessible national database.

Foreword

This report is part of the Young Adults Safety project at the Centre for Crime and Justice Studies. Young adults (18- 25-year olds) have been identified as overlooked by existing homicide review powers (SCIE, 2020). Indeed, when Offensive Weapons Homicide Reviews (OWHRs) were initiated in 2023, young adults were highlighted as a key group to be prioritised by the new review panels. The statutory guidance for OWHRs states that homicides amongst 18- 25-year olds 'may not currently be reviewed at all' and that:

> *'the initial policy intent of OWHRs is to ensure that partners consider cases of adults aged 18-25, typically involved in gangs, street crime and knife crime […] We also know that a large and growing proportion of homicides in England and Wales involve individuals from this age group.'*
> Home Office, 2023a

Homicide reviews ask what happened? Why? And vitally, how can this information be used to better prevent future deaths? The potential merits of a process such as this cannot be overstated.

However, as this report highlights, several decades of existing homicide reviews show shortcomings and risks. The information provided may be skewed. Change as a result of a review may not be forthcoming. The recommendations of reviews may not, and as this report shows, often seemingly have not, been acted upon. Review recommendations do not come with additional resources. Implementing them is not mandatory. Should it be?

This report is the product of thoughtful work to better understand the potential of OWHRs, particularly to the development of better practices and policies for young adults affected by violence.

The authors are not able to assess the pilot of OWHRs itself. The pilot of OWHRs recently ended, but, at the time of writing, no information was available about it.

However, what Susie Hulley and Tara Young are able to do is helpfully bring together the evidence about existing homicide reviews. Homicide reviews have formally existed in this jurisdiction for over thirty years. There is important learning here about homicide reviews in general, as well as about OWHRs in particular, informed by the considerable experience and insights the authors bring.

In addition to informing the development of a new and evolving policy – OWHRs are due to come back to Parliament later this year – I hope the case made here about prioritising practices we already know work is listened to. As the authors state 'existing research has identified the factors that contribute to serious and offence related violence involving 18 -25-year olds'. Such recognition has failed to translate into better services addressing young adults' bespoke needs, according to recent critical evaluations. While pockets of good practice exist, a recent Probation Inspectorate review of provision noted a lack of support and bespoke services for young adults leaving custody, and regarding knife and weapons interventions specifically (HMIP, 2024). Likewise, the Home Office evaluation of Violence Reduction Units noted 'VRUs were not sufficiently prioritising young adults and young people who are already entrenched in offending and violence.' (Home Office 2023d).

At best the promise of OWHRs could help to address these gaps. At worse, they could be a further distraction.

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1 Introduction

In England and Wales, homicide is the unlawful killing of one person by another and includes offences such as murder, manslaughter and infanticide (Office for National Statistics, 2024a). Homicide causes great personal tragedy for each victim and their family and friends, and produces broader social, psychological, and economic harms.

Current rates of homicide (9.9 per million population in the year ending to March 2023) are higher than in the early 1960s (6 per million) but significantly lower than they were at their peak in 2002 (15.1 per million) (Office for National Statistics, 2024a). Killings with a sharp implement or bladed weapon, such as a knife, have consistently remained the most common method of killing for both men and women for the past ten years (Office for National Statistics, 2024a). Although the Government report a 'growing proportion' of homicides involving offensive weapons (Home Office, 2023a), homicides using a knife or sharp instrument have remained at between 31 per cent and 42 per cent of the total homicides over the last ten years, and in the year ending March 2023 were 13 per cent lower than in the previous year (Office for National Statistics, 2024a).

Victims of homicides involving offensive weapons, including guns and knives, are most likely to be men, and those involving sharp instruments are most commonly aged between 25- 34-years old (20.0 per cent), followed by 18- 24-year olds (18.9 per cent) (Office for National Statistics, 2024b). In addition to the profound loss of life - and the devastating impact of homicide on victims' families and friends - the economic cost to the UK society was reported to be £2.6 billion in 2022/2023 (Home Office, 2023a). Thus, reducing homicide was identified as a national priority (House of Commons Library, 2022) and, in an effort to reduce homicides involving weapons, the Conservative Government introduced Offensive Weapons Homicide Reviews (OWHRs) in the Police, Crime, Sentencing and Courts Act 2022.

OWHRs require local partners to formally review homicides in their area that involve offensive weapons, including guns, knives, bottles, bricks and 'corrosive substances', which are not currently reviewed under the four existing homicide review frameworks (Home Office, 2023a).[3] The purpose of the OWHR is to ensure that local agencies learn from the death and act to prevent future homicides and 'save lives' (Home Office, 2023a).

Prior to a national roll out of OWHRs, Section 34 of the Police, Crime, Sentencing and Courts Act 2022 required that a pilot be conducted. Therefore, an 18-month pilot of OWHRs across three areas of England and Wales was initiated on 1st April 2023 and is currently being evaluated. Successful national rollout of OWHRs hinges on the outcome of the pilot, which may also lead to changes to the statutory guidance (Home Office, 2023a). The results of the OWHR evaluation are expected to be published 'in due course'.[4]

In the absence of the pilot evaluation and in anticipation of its findings, this report explores the potential benefits, risks and limitations of the OWHRs as a new homicide review framework. It is informed by the statutory guidance on OWHRs (Home Office, 2023a) and related documents (Home Office, 2023b), which offer insight into the implementation of the OWHR pilot, its objectives and intended process. The report also draws on policy and academic research related to other statutory homicide reviews, given their similar frameworks and objectives and FoI requests that we submitted to the Home Office.[5]

Successful national rollout of OWHRs hinges on the outcome of the pilot, which may also lead to changes to the statutory guidance

2 Background: Young adults, homicide and OWHRs

The homicide data for England and Wales does not all align perfectly with the 18-25 age category that is the focus of this report. National data on homicide generally provides information about victims aged 16-24-years old. While there is data on victims of homicide involving sharp instruments aged 18-24, there is no published data on perpetrators of homicides involving weapons for this demographic (data is limited to 16- 24-year old suspects who are convicted of all homicides).

The national data on all homicide types indicates that, in the year to March 2023, there were 99 homicide victims aged 16-24, equating to around a sixth (16.8 per cent) of the total number of recorded homicide offences in that year (590) (Office for National Statistics, 2024b). Of these homicide victims aged 16-24 years old, 44.4 per cent were from a white ethnic background, 35.4 per cent from a black ethnic background and 19.2 per cent from 'other' ethnic background (Office for National Statistics, 2024b). Data on suspects convicted of homicide in the year to March 2023 show that, of 319, 29.5 per cent were aged between 16 and 24 years old, almost all of whom (98.9 per cent) were male (Office for National Statistics, 2024b).

In terms of homicides involving offensive weapons, in the year to March 2023, there were 46 young adult victims (aged 18-25 years old) killed by a sharp instrument (Office for National Statistics, 2024b). Like the general homicide data, the majority were male (91.3 per cent, compared to 8.7 per cent were female) and victims were most likely to be from a white ethnic background (41.3 per cent, compared to 32.6 per cent who were identified as from a black ethnic background, and 23.9 per cent from 'other' ethnic background) (Office for National Statistics, 2024b). While the numbers of young adult victims killed by a sharp instrument identified as white (19) and black (15) are similar, compared to the general population of young people aged 18-24 in England and Wales, young adults from black ethnic backgrounds are significantly *overrepresented* as victims (5.3 per cent in the general young adult population are black, compared to 32.6 per cent of victims of knife-enabled homicide), whereas young white adults were *underrepresented* (75.9 per cent of the general young adult population, compared to 41.3 per cent of young white adult victims of knife enabled homicide) (Office for National Statistics, 2023).

> Offensive Weapons Homicide Reviews (OWHRs) were introduced by the Conservative government, to ensure that offences in which a victim was killed with an offensive weapon were reviewed

What are Offensive Weapons Homicide Reviews (OWHRs)?

Offensive Weapons Homicide Reviews (OWHRs) were introduced by the Conservative government, to ensure that offences in which a victim was killed with an offensive weapon were reviewed. The stated purpose of OWHRs was:

> *'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.'*
> Home Office, 2023a

For the purpose of OWHRs, an offensive weapon is defined as 'any article made or adapted for use for causing injury to the person, or intended by the person having it with him for such use by him, or by some

other person', as in section 1 of the Prevention of Crime Act 1953 (Home Office, 2023a). Examples include knives, firearms, corrosive substances, glass bottles, bricks and baseball bats (Home Office, 2023a). OWHRs are part of a catalogue of formal homicide reviews in England and Wales, which compel multi-agency partners to investigate the circumstances that lead to particular types of fatalities, to establish what lessons can be learnt from the homicide, and to inform best practice and prevent future deaths. Table 1 shows the formal homicide reviews that exist in England and Wales (excluding OWHRs) (Social Care Institute for Excellence, 2020, also see NHS England, 2013).

The OWHR statutory guidance reported that an estimated 69.3 per cent (483) of the 696 recorded homicides in England and Wales in 2021/22 did not meet the criteria for inclusion in the existing homicide reviews outlined in Table 1 (Home Office, 2023a) and that, therefore, opportunities for learning from these fatalities was lost. Of the 483 cases, 45.5 per cent (220) were flagged as involving an offensive weapon.

In order to avoid duplication with existing homicide reviews,[6] cases of homicide that trigger an OWHR are those in which the victim was aged 18 or over and the death (or events surrounding it) involved the use of an offensive weapon (Home Office, 2023a). The alleged perpetrator may be any age, including under 18. In order to qualify for an OWHR, the victim or perpetrator must be known to review partners.[7]

In Wales, the procedure is slightly different. The devolved government have drafted statutory guidance on a Single Unified Safeguarding Review process, which incorporates all homicide and safeguarding reviews (including OWHRs) into one unified process. One aim is to ensure that families affected by such deaths do not need to take part in more than one review (Welsh Government, 2023). It is unclear how this guidance will impact the OWHR pilot in South Wales.

Where did OWHRs come from?

The origin of OWHRs is not explicitly stated in policy documents, such as the Statutory Guidance (Home Office, 2023a). The concept seems to have evolved from a report that analysed statutory reviews of homicides and non-fatal violent incidents in London, which was commissioned by the Mayor of London's Violence Reduction Unit (VRU) and conducted by the Social Care Institute for Excellence (SCIE) in 2020. The report analysed a sample of 64 statutory reviews that were published over a three-year period in London

Table 1: Existing homicide reviews in England and Wales

Type of review	Scope of reviews
Domestic Abuse Related Death Reviews (previously 'Domestic Homicide Reviews' (DHRs), renamed in the Victims and Prisoners Act 2024)	Deaths resulting from domestic abuse, including homicides and suicides
Child (Safeguarding) Practice Reviews (previously 'Serious Case Reviews')	Death or serious harm to child aged under 18
Safeguarding Adult Reviews (SARs)	Deaths of vulnerable adults that result from neglect or abuse
Independent Investigation Reviews (sometimes known as Mental Health Homicide Reviews)	Homicides perpetrated by a person who is receiving mental health care

(2016-2019) to support the VRU's long-term strategy to combat violence in London (SCIE, 2020).

The report noted that, despite the existing statutory review framework, there was a significant lack of learning in relation to forms of homicide that fell outside the criteria of existing reviews (SCIE, 2020). This included homicides involving adult victims 'who are not vulnerable, in a relationship or related', and young people aged 16-24. The report identified that only five existing reviews (four Serious Case Reviews and one Independent Investigation report) related to youth homicides had been published in London between 2016 and 2019, despite there being over 120 deaths of young people aged 16-24 during this timeframe (SCIE, 2020). The authors concluded that this 'small number of reviews raises important questions about how the system is learning from serious incidents involving adolescents' (SCIE, 2020).

One of the SCIE (2020) report recommendations, therefore, was for the VRU to collaborate with the government to identify the need for further 'learning processes' for cases that fell outside of the existing statutory reviews. Reflecting on these findings, the London Mayor, Sadiq Kahn stated that they revealed that there were 'lost opportunities to learn lessons and better understand risks and preventative opportunities' in homicides involving victims aged 18 or above (London Assembly, 2022). As a result of discussing his concerns with the government, he noted that statutory reviews for homicides involving offensive weapons against adults were to be introduced.

Although OWHRs do not focus on homicides involving 18- 25-years old specifically, it is clear that concerns about fatal violence among young people (including young adults of this age) were central to the evolution of OWHRs

Hence, although OWHRs do not focus on homicides involving 18- 25-years old specifically, it is clear that concerns about fatal violence among young people (including young adults of this age) were central to the evolution of OWHRs. This was also signalled in the OWHR Statutory Guidance, which stated: 'the initial policy intent of OWHRs is to ensure that partners consider cases of adults aged 18-25, typically involved in gangs, street crime and knife crime. Homicides amongst this group may not currently be reviewed at all.' (Home Office, 2023a). It is also likely that OWHRs will include many homicides involving victims and perpetrators within this age range, due to their representation in the homicide data and the criteria required to conduct an OWHR (particularly the requirement that the victim or perpetrator are known to agencies).

The piloting and evaluation of OWHRs

As noted above, according to the statutory guidance presented to Parliament, before the OWHRs can be rolled out nationally they have to undergo a pilot to ensure that the initiative meets the requirements of the commissioners and meets the principal aims and objectives (Home Office, 2023b). OWHRs were introduced on 1st April 2023 in three areas across England and Wales (Home Office, 2023a). These were:

1. London (in Barnet, Brent, Harrow, Lambeth and Southwark);
2. West Midlands (in Birmingham and Coventry); and
3. South Wales.

The areas were selected as pilot sites due to the variation in their homicide levels (Home Office, 2021a).

Very little information has been published on the progress or findings of the OWHR beyond the identity of the pilot sites and the length of the evaluation period. However, we do know that only homicides which meet the inclusion criteria (see above) and occur within 9 months of 1st April 2023 were to be included in the pilot. Thirty-six OWHRs were estimated to take place during the pilot period (Home Office and Ministry of Justice, 2023b) and a report was expected to be put before Parliament following the completion of the pilot at the end of September 2024.

At the time of writing, no documents reporting on the findings of OWHR were in public circulation. What we could ascertain from an update from the Welsh Government was that 'the qualifying pilot period ended with one review in Cwm Taf and one awaiting decision in Cardiff' (Wales Safer Communities Network, 2024). An FoI request for data on the number of completed OWHRs in England and Wales during the pilot period led to a statement that noted that the findings from the evaluation were expected to be published 'in due course'.[8]

Very little information has been published on the progress or findings of the OWHR beyond the identity of the pilot sites and the length of evaluation period

3 What are the potential benefits of OWHR?

Asserting seriousness

In the aftermath of a homicide, a review can demonstrate that such incidents are serious and worthy of attention and satisfy a public appetite to determine the 'truth' of the matter (Peay, 1996). In this way they perform a symbolic reassurance role. Homicide reviews indicate that the Government are committed to exploring the factors that contribute to the homicide event and the relevance of local services to the event, in order to restore or improve public confidence in these services (Crichton and Sheppard, 1996). Although, it has been suggested in the context of homicide inquiries involving perpetrators with mental illness, they can have an adverse impact and fuel public fears to such an extent that 'public confidence is undermined, not restored' (Szmukler, 2000).

The potential symbolic role of homicide reviews is particularly relevant to OWHRs, as there has been significant public concern about knife crime, including among young adults (Nacro, 2023; Michelmore *et al*, 2019). While OWHRs may dissipate public anxiety (Peay, 1997), their success in this regard is an empirical question that will need to be explored as part of the evaluation. In terms of reassuring young adults, research suggests their concerns about knife crime are alleviated by specific interventions that support their feelings of safety in their immediate locality (Nacro, 2023). It is yet to be determined if OWHRs will help identify and inspire such interventions, but there is a risk that they may raise expectations about local action, which may not occur due to issues outlined in the sections below.

By tracing the events that led up to the death, homicide reviews can provide answers for families and friends of the bereaved, providing them with information that may have not been in the public domain

Secondary victims understanding the homicide incident

For those directly impacted by homicide, it can be difficult to comprehend. Many bereaved families lose faith in the idea of a 'just world' and the ability of social institutions, like the police, to protect and provide justice (Rock, 1996). The immediate aftermath of a death marks the beginning of a long journey for the bereaved, one which seeks to understand the context that led to it and why it happened (Casey, 2011). By tracing the events that led up to the death, homicide reviews can provide answers for families and friends of the bereaved, providing them with information that may have not been in the public domain (e.g., if the perpetrator pleads guilty and there is no trial). In this way, OWHRs could serve an important public/private function for the families and friends of young adults killed using an offensive weapon, by publicly responding to their private tragedy (Crichton, 2011).

Providing valuable new information

At present, there is little publicly available data on weapons-related homicide which provides sufficient detail to track, for example, the age and gender of the perpetrator and the victim, and their relationship. OWHRs have the potential to contribute to what we understand about this type of offence, nationally. Homicide reviews bring together information about the victim(s) and perpetrator(s), the nature of their relationships (strangers, family member, partners), the event preceding the homicide and the immediate context in which it occurred, as well as the wider social environment (e.g., health, economy, education) (Jones

et al, 2024). It provides rich, in-depth information on each. By cataloguing multiple OWHRs in one place, for example if a library of OWHRs was created, it would be possible for researchers and interested parties to explore important questions about offensive weapon homicides using secondary data, which has not been possible to date.

This data has the potential to facilitate the identification and monitoring of offensive weapon homicides on a local and national basis, and to identify the risk and protective factors associated with such homicides involving young adults (although, note issues related to identifying so-called 'causal' factors, identified below). This could inform the development of national evidence-based strategies to improve the monitoring and prevention of the loss of young adults' lives. As a resource, the OWHR could also provide an evidence-base upon which to empirically test, and potentially challenge, the assumptions about young adult victim(s) and perpetrator(s) of homicide where weapons have been used to inflict fatal harm. For example, it could improve practitioners' understanding of issues related to racial stereotyping, if identified (see below). However, as noted below, the limiting criteria for which offensive weapon homicides will be reviewed (including victims/perpetrators being known to agencies) risks the national information that is published being partial and limited in important ways.

Generating local lessons for relevant agencies

Homicide reviews are identified as having a procedural function. By pulling together the details about the offence, including details of the context and the work of relevant agencies, they can be a valuable resource for professionals involved in the care and protection of young adults at risk of becoming a victim or perpetrator of serious violence, as well as a potential conduit for changes in practice (although note reviews may be limited in this regard, as outlined below). An evaluation of Domestic Homicide Reviews (DHRs) found that they assisted in the identification of cases of best practice, provoked good interagency working, encouraged effective conversations with the secondary victims and fostered the timely assessment of cases (Home Office, 2021). In this way, OWHRs offer an opportunity to glean a nuanced understanding of weapon-enabled homicide at a local level and could help practitioners shape bespoke responses, as recommended in the College for Policing (2024) problem solving guide for homicide prevention. In principle, OWHRs would present an opportunity for policy makers to consider offensive weapon homicides nationally, to identify common themes relevant to the offence(s), to determine practitioner knowledge of victim(s) and perpetrator(s), to assess the efficacy of the response to the homicidal event, and to identify possibilities to support evidence-based approaches to tackle weapons-related homicide. However, the potential learning from OWHRs may be limited due to the risks and limitations of these homicide reviews, as outlined below.

OWHRs offer an opportunity to glean a nuanced understanding of weapon-enabled homicide at a local level and could help practitioners shape bespoke responses

4 What are the potential risks and limitations of OWHRs?

Unlikely to prevent weapon-enabled homicides or save lives

While the effectiveness of OWHRs to assist learning and improve professional responses to homicide is yet to be determined, the evidence published in existing reviews calls into question the central claim that OWHRs will prevent future victims and save lives. For example, the number of fatalities committed in the context of domestic violence and abuse has not fallen since the implementation of DHRs in 2011 (Jones *et al,* 2024; Bugeja *et al,* 2015, in Kim and Merlo, 2023). Longitudinal data show that there were, on average, 126 domestic homicide victims per year between 2013 and 2023, with a small amount of variation between years (Office for National Statistics, 2024b).[9]

In the context of Serious Case Reviews (SCRs), there is some indication that violent deaths of children have decreased, but again '[to] attribute any fall in rates of maltreatment to the impact of SCRs, however, is a huge extrapolation' (Sidebotham, 2012). Bugeja *et al* (2013) suggest that aiming to prevent the homicides via the review process 'may be an inappropriate measure of the impact [of the review], because it essentially sets them up to fail to meet their stated aims.' In the case of DHRs, it has been noted that while recommendations are often made at the national level, local authorities tend to have limited power to implement them (Haines-Delmont *et al,* 2022) and unless this changes, the impact of such reviews on homicide rates will be minimal. This suggests that the key purpose of OWHRs should be reconsidered.

> These issues highlight the risk that OWHRs' findings and recommendations may receive little local or national attention

Lack of engagement with findings and recommendations

Previous evaluations of homicide reviews have revealed that recommendations are rarely collated and that there is often little national or local engagement with their findings and recommendations for three main reasons, outlined below.

First, homicide inquiry reports into incidents involving individuals engaged with mental health services have been described as very long, meaning that they are rarely read by practitioners. Warner's (2006) research with 39 social work practitioners found that few had read more than four Homicide Inquiry reports, although all had read one particularly high-profile report (that of Christopher Clunis). This 'story-like' style report attracted more attention than others revealing the risk that some homicide reports may be read more than others, because of the dramatic content for example (Warner, 2006), potentially skewing readers understanding of 'the problem' (linked to a further risk of OWHRs outlined below).

The second issue is the considerable lag between the homicide event and the publication of its review. This time lapse can affect engagement with the outcome, as people move positions and interest wanes over time (McGrath and Oyebode, 2014). Although the OWHR statutory guidance requires that reviews are conducted within one year of the event (Home Office, 2023a) and indicates that early learning will be shared, it is yet to be established if such an ambitious timeframe for OWHRs will be met, and when OWHRs will be available in the public domain.

Thirdly, the absence of a central, national repository for homicide reviews has made it challenging to gather, collate, and analyse various inquiry recommendations to establish relevant trends and

patterns across reviews (Dangar, Munro and Andrade, 2022). The lack of coherent methodology and consistency between reviews can also limit the comparability recommendations, in order for systemic learning to be achieved (McGrath and Oyebode, 2014). These issues highlight the risk that OWHR's findings and recommendations may receive little local or national attention.

This suggests that a commitment from the Government is needed to ensure that OWHRs recommendations are centrally collated, tracked and evaluated to ascertain whether they have been implemented

No statutory duty to implement findings

The lack of practitioner engagement with the outcomes of homicide reviews calls into question the extent to which recommendations are integrated into policy and practice. Petch and Bradley's (1997) analysis of homicide inquiries involving individuals engaged with mental health services found little evidence of review recommendations being followed up or their implementation being evaluated, either locally or nationally. In the context of domestic homicides, there has been no statutory duty to follow up the recommendations of DHRs (now Domestic Abuse Related Death Reviews) or to report the factors that facilitate and complicate implementation (Jones *et al*, 2024). In light of this, McGrath and Oyebode (2014) question whether 'lessons' are really learned from homicide events. Other jurisdictions, such as Iowa in the US, require that recommendations of homicide reviews are monitored and demand a response, including through legislation (Bugeja *et al,* 2013). This suggests that a commitment from the Government is needed to ensure that OWHRs recommendations are centrally collated, tracked and evaluated to ascertain whether they have been implemented and the extent to which they are able to achieve their stated aims.

The risk of implementation failure is particularly relevant to offensive weapon homicides involving young adults, as the SCIE (2020) report noted that homicide reviews that reported on youth peer violence (across all the review types) identified the multiple risks that young people were exposed to, but could not identify a single agency as responsible for young people's risks. They also failed to see young people's risks in the context of safeguarding, in which they recognise their criminal behaviour in the context of grooming gangs, for example (see Firmin, 2020).

The repetition of homicide review recommendations across many years illustrates the lack of systemic learning. A Home Office review of DHRs in 2023 (Home Office ,2023c), which mirrored a 2016 report (Home Office, 2016), found that five of the nine themes were consistent across both reports. These were themes related to: policy, record keeping, referral, risk, and training. While four new themes appeared in the latest DHR review – under the headings 'assessment', 'contact', 'information' and 'support' - the substantive content of these themes were all covered in the 2016 review, but under different headings. This suggests that services that support victims and survivors of domestic abuse and violence have not acted upon previous recommendations, or progressed enough, despite numerous DHRs conducted between 2016 and 2019. For instance, Jones *et al*, (2024) observed that the recurrent call for professional training in multiple DHRs over many years suggests that effective training has not been successfully implemented. This potential limitation of homicide reviews should be borne in mind when reviewing the extent to which OWHRs offer

value for money in reducing weapon enabled homicide, including against young adults.

Risk of hindsight bias

The learning and recommendations that emerge from homicide reviews are based on explanatory theories developed by the review panel in the aftermath of a killing. Carson (1996) expressed that inquiries into homicides involving individuals receiving mental health care involved a great deal of supposition, but were presented as the 'truth of the matter'. Homicide reviews rely on hindsight bias, which suggests that an outcome is 'inevitable: a plausible chain of causes [that] can easily be traced backwards through time' (Szmukler, 2000). Such bias ignores the many possibilities that could affect a homicide, but may not have come to the attention of the homicide review panel. This leads to an oversimplification of the complexity of most homicide incidents and risks reinforcing stereotypes about certain types of homicide, the antecedent factors, and the victims and suspects involved. This is a particular risk for OWHRs involving young adults, due to the storied narratives about such offences and the specific racialised narrative of the gang (see below). Reiss (2001) observes that for homicide review panels to be effective there must be an awareness of the potential hindsight pitfalls, although Szmukler (2000) warns that even reminding panel members about hindsight bias does little to prevent it.

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Selection bias

The number of homicides meeting homicide review criteria often exceeds the capacity for reviews to take place (Reiss, 2001; McGrath and Oyebode, 2014) so that selection bias is introduced into the review process (McGrath and Oyebode, 2014). This risks extreme cases or the 'extraordinary murder' (Rock, 1996) being more likely to be the subject of a review. In the context of homicide inquiries into killings involving individuals who are engaged with mental health services, such bias has been linked to heightened public fears about homicide committed by individuals with mental health problems (Warner, 2006) - although reviews have also been noted to have undermined stereotypes of perpetrators as mentally 'deranged' (Crichton, 2011). Nonetheless, the introduction of selection bias may lead to an inaccurate representation of the broader issue of homicide and the misinterpretation of the potential solutions identified in recommendations. In the context of DHRs, Jones *et al* (2024) note the problem associated with jurisdictions where only a proportion of cases are reviewed, and emphasise the importance of capturing a representative and diverse set of cases.

The potential for selection bias in relation to OWHRs arises from criteria implemented for the purposes of the pilot. These reviews will only include homicides where 'one or more of the review partners possess or are expected to possess' information about the victim or at least one perpetrator, including details of their 'education, antisocial or criminal behaviour, housing, medical history, mental health, and safeguarding' (Home Office, 2023b).The statutory guidance on OWHRs does not specify why this criteria has been mandated, although the SCIE (2000) report, which appears to be the precursor to implementation of OWHRs, notes that victims and perpetrators of serious violence have often had contact with agencies. While Chris Philp, the then Minister for Crime, Policing and

Fire, stated in the House of Commons (on 16th November 2022) that it was to 'ensure that resources are directed at cases where lessons can genuinely be learned to help prevent future homicides' (Hansard HC, 2022). However, it is significant that no such requirement exists in relation to DHRs, which is the only other form of homicide review that is based on the type of offence (rather than the individuals involved). A Home Office review (2021) of 144 DHRs found that only 20 per cent of victims had been referred to a Multi-Agency Risk Assessment Conference (MARAC) (Home Office, 2023a), and half of the perpetrators were known to be an abuser by local agencies. Although this does not represent all possible agency contact, it indicates the potential for criteria that requires agency contact to lead to the exclusion of a high proportion of cases of weapon enabled homicide, in which the victim or perpetrator were not known to agencies.

Focusing on cases where the victim (or suspect) is known to agencies may lead to the over representation of certain types of weapons-related homicides, including those involving young adults from Black, mixed-race, and minoritised background. Selection bias is particularly troubling in this context, as research shows that children from mixed ethnic backgrounds are over-represented among those identified as 'in need', listed on the child protection register as in the care of the state (Owen and Statham, 2009). Education data also shows that the highest rates of permanent exclusions are among young people from Traveller, Gypsy/Roma, and Black Caribbean backgrounds (Alexander and Shankley, 2020). Consequently, by concentrating on homicides where the victims or perpetrators are known to services, OWHRs may distort our understanding of who is involved in weapon enabled homicides, particularly in relation to young adults. This issue is particularly pertinent considering the disproportionate representation of young adults from black ethnic backgrounds in knife related homicides (as outlined above). Indeed, the SCIE (2020) report noted that in their 'very small sample of cases' of youth peer violence, young black men were over-represented as victims, and that there was a lack of exploration of the complex links between ethnicity and vulnerability in these reviews.

Consequently, by concentrating on homicides where the victims or perpetrators are known to services, OWHRs may distort our understanding of who is involved in weapon enabled homicides, particularly in relation to young adults

The risk that OWHRs will generate racialised narratives of weapon enabled homicide is supported by the research on existing homicide reviews, which have been criticised for exhibiting racial stereotyping and a lack of cultural sensitivity (Bernard and Harris, 2019; Jones *et al*, 2024). Homicide inquiries involving individuals engaged with mental health services have been found to link extreme violence and ethnicity in ways that construct a 'master narrative' about particular people, and magnifies events in the public imagination, but are not necessarily representative of real-world events (Warner, 2006). For example, inquiry reports reinforced populist notions of young black men with schizophrenia posing a particular threat of violence, and perpetuated a narrative that homicides by people with mental health problems were the outcome of professionals and agencies failing to 'contain' 'dangerous Other[s]'.

OWHRs have the potential to replicate and further entrench embedded racialised narratives that link young black and brown men to homicides involving offensive weapon through the notion of the 'gang'

(Williams and Clarke, 2016; Young, Hulley, and Pritchard, 2020; Hulley and Young, 2024; Young and Hulley, 2024). This is indicated in the OWHR statutory guidance which identifies the 'initial policy intent' as related to 'gangs' (although no definition is provided as to what is meant by 'gangs'). Research on Serious Case Reviews (SCRs) identified a pattern in the 'racialized and gendered discourse' that emerged in reviews involving children from black and mixed ethnic backgrounds (Bernard and Harris, 2019). This included the misinterpretation of black boys' vulnerabilities and the neglect of their protection needs. They also noted that assumptions were made about young black boys being involved in gangs and drug dealing. Such homicide reviews, Bernard and Harris (2019) noted, failed to interrogate the processes by which professionals were able to apply racialised assumptions to their work or make recommendations as to how such beliefs and behaviours could be tackled. Selection bias, therefore, represents a serious risk to the integrity of OWHRs. Evaluations of DHRs (and Domestic Violence Fatality Reports in the US) have found that the composition of the review team is critical, including the need for greater diversity in terms of age and ethnicity (Jones *et al,* 2024).

5 Conclusion and recommendations

As we wait for the evaluation of the OWHR pilot project, it is not possible to know exactly what its findings will tell us about the value of these new statutory homicide reviews. However, our exploration of the statutory guidance, alongside analysis of the literature about existing homicide reviews, indicates that while there are some potential benefits to OWHRs, they are unlikely to meet their primary aims of preventing weapon-enabled homicides, including those involving young adults, and save the loss of future lives. OWHRs may offer symbolic assurance to secondary victims and the general public, could provide information to victims' families about their death, and may generate detailed, publicly available data on weapon-enabled homicides. However, the information provided is likely to be skewed, due to the hindsight bias and the selection bias which are baked into the process. In the context of offensive weapon homicides involving young adults, the overrepresentation of young black men as victims, combined with this bias, is likely to lead to the replication of racialised narratives in the stories of weapon-enabled homicides that emerge, as seen across the broader criminal justice system. Any potential lessons for local and national practice are also unlikely to be implemented due to limited resources, as well as issues related to the lack of collation of findings and accountability for recommendations.

The Home Office's (2021b) own impact assessment of OWHRs stated that 'no studies could be located showing that the production of good quality homicide reviews reduces future homicides' and concluded that OWHRs offered no cost benefit. This supports our suggestion that the real potential of such reviews is in their performative function, as a symbol to demonstrate that something is being done rather than leading to any meaningful reduction in homicide rates.

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As the cost of OWHRs was estimated as £2.8million (which only covered the cost of the pilot), we propose that the Government consider the cost of a national roll out of OWHRs against other, evidence-based strategies that have the potential to prevent offensive weapon homicides and to save young adults' lives. For example, existing research has identified the factors that contribute to serious and offence related violence involving 18- 25-year olds, including: failing schools, school exclusions, insecure employment prospects, poverty, coercion and exploitation of children, lack of available youth services, overuse of policing strategies (e.g. stop and search), crime victimisation, substance misuse, and mental health issues (Irwin-Rogers *et al,* 2020; Browne *et al*, 2022). In this context, focusing policy and practice on support and opportunities for young adults' housing, education and employment would improve outcomes for individuals at risk of being implicated in weapon enabled violence (for example see Browne *et al,* 2022).

However, if, following the pilot, the Government go ahead with a national roll out of OWHRs, there is an opportunity for the Home Office to mitigate some of the risks identified in this report, as they relate to young adults aged 18- 25-years old. Five practical proposals we offer in this regard are:

1. Remove the OWHR criteria that requires that the victim or perpetrator is known to agencies. This would ensure that any insights derived from

OWHRs are as inclusive as possible, allowing for local and national learning from all homicides involving offensive weapons (outside existing homicide review frameworks).

2. Ensure that the chair and members of the review panel are culturally and ethnically diverse and understand the impact of their own biases, with practitioners being supported to have 'difficult conversations about race and cultural beliefs' (Bernard and Harris, 2019). They must also be well-informed on issues related to age, including the transition to adulthood (University of Birmingham, Barrow Cadbury Trust and T2A, 2018), ethnicity, and serious violence. Without close scrutiny and focused reflection on the role of race in the selection and processing of cases for the purpose of OWHRs, they risk compounding issues already found in the Criminal Justice System, in which weapon-enabled violence is seen as a 'young black culture' problem (Hulley and Young, 2024).
3. Implement a legal requirement that local teams implement, monitor and respond to OWHR recommendations (Jones *et al,* 2024). Embed this duty in the early stages of OWHR, while providing local teams with sufficient resources to do so (there is no indication in the guidance that this will be the case). It is important to include 'feedback loops' into the review process (Jones *et al*, 2024), in order to improve the implementation of recommendations contained with OWHR and the chances that they will work towards achieving their aims.
4. The Home Office to monitor the age, sex and ethnicity of the individual victims and perpetrators in the offensive weapon homicide cases that are reviewed, to ensure that the representation of cases can be monitored and the findings can be put into context. It is stated in our FoI request[10] that this is not currently being done.
5. The Home Office collate the findings and recommendations of all OWHRs in a publicly accessible national database.

Notes

1 (FOI12024/06185).
2 (FOI2024/06185)
3 The four existing homicide review frameworks are shown on page 9 of this report.
4 (FOI12024/06185)
5 Through FoIs we sought data related to: the number of OWHR pilot reviews that have commenced since April 2023, the number that are in progress, the number that have been completed in each of the pilot areas; the age and ethnic breakdown of the perpetrators and victims involved in the homicides under review, to date; and the number of OWHRs that have reviewed homicides involving two or more perpetrators (FOI2024/06185). The FoI request for data was rejected, on the basis that 'the information was exempt from disclosure' under section 22 of the FoIA, as findings from the evaluation were due to be published in a report to be laid before parliament. The FoI response further added that the withholding of information until the planned publication was 'in the public interest'.
6 The Home Office (2023) state that OWHRs will not duplicate other reviews, therefore there will be no duty to undertake a review where an existing review covers the circumstances of the death. However, OWHRs can be carried out alongside an Independent Investigation/Mental Health Homicide Review (and they are expected to be closely aligned) in which the victim is a vulnerable adult or receiving mental health care.
7 In such cases information can relate to education, anti-social behaviour, criminal behaviour, safeguarding or mental health history related to either the victim(s) and/or the perpetrator(s).
8 (FOI12024/06185).
9 Although Jones *et al* (2024) suggest that it is possible that the focus on local service provision and interagency working in DHR recommendations, means that any improvements are not easily captured by traditional evaluation methods.
10 (FOI2024/06185)

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