Version 3.1

Richmond Community Safety Partnership

DOMESTIC ABUSE RELATED DEATH REVIEW

Overview report

Case of Adult Francis

Died: July 2022

Report produced by Author Chris Ward.

Chair Simon Steel Foundry Risk Management Ltd.

Report Completed on

08/06/2025

Version 3.1

Contents

Version 3.1

Preface

The London Borough of Richmond Community Safety Partnership (CSP) would like to express their condolences to all those affected by the sad loss of Francis. This review sincerely hopes the learning and recommendations gained from our enquiries and deliberations will help agencies to prevent similar events happening again in the future.

The following tribute has been prepared by the family and friends of Francis

"Francis was a much-loved son, brother, uncle and grandson. His infectious laugh, constant guitar playing and beautiful smile will be forever missed by all his family."

- *Francis' Mother*

"There is so much I could say about Francis, that you would be here for hours upon hours of just me telling you about one of my favourite friends who is no longer here due to someone's cruel intentions upon him.

Over 26 years of my life Francis was with me and gave me some of the best years and memories that I could contain. This is a man that had a heart of gold and spread that gold over all the people that he loved and cared for. Frances was not just any normal day-to-day man he became the pillar to the community. He was one of Richmond's greatest assets and was welcomed and loved by everyone.

My children are forever going to miss Francis. Francis looked out for my children for eight months when I really could not look after them myself. He would find my eldest son and make sure all my children were grand and well looked out for. My child will forever be grateful to him for all his help and know never gave up on me or them. That's what real friends do. We don't give up on each other.

I miss hearing him shout out my name down the High Street and embarrassing me. They say you don't know what you've got until it's gone though. Francis was always there when I couldn't cope only talk or even just needed someone by my side, he would be there helping no hesitation.

The world without Frances is a totally different place. He should be here with me getting old together and making more memories with that infectious smile. Francis will always be remembered and loved and more for being such a beautiful and caring in kind-hearted man that he was. I will never get over losing Francis really, as how can you when that person made such an impact on one's life. He always helped and looks after so many that there is so much love for Frances! I will always be so grateful to have had our Francis in my life."

- *Francis' Friend*

Foreword

The independent chair of this Domestic Homicide Review panel would like to thank all agencies who contributed to the process in an open and transparent manner. The panel is confident that the learning points and recommendations will provide a platform to help national, regional, and local agencies to implement measures designed to embed a preventative approach to addressing domestic abuse.

Following this death, there is emerging evidence of positive change at a local level. We all must do our utmost to take immediate action to protect the victim and to deal effectively with the perpetrators of domestic abuse and the chair would urge everyone to take note and act on the findings of this review. Together we must take the threat and harm posed by domestic abuse seriously at a leadership, frontline, and community level to help bring these types of incidents to an end.

1. Introduction

1.1 This Domestic Homicide Review (hereafter "the review") was established under Sec 9(3) of the Domestic Violence Crime and Victims Acts 2004. It examines agency responses and support given to Francis who was a resident of Richmond prior to his death in July 2022. The report addressed the agreed Terms of Reference. The full terms of reference are set out at Appendix 1. This review aims to identify the learning from the death of Francis, and for actions to be taken in response to that learning with a view to preventing deaths due to domestic abuse and ensuring that individuals and families are better supported.

1.2 The death of Francis was investigated by The Metropolitan Police Service. Sally was convicted of Francis's murder at Kingston-upon-Thames Crown Court and sentenced in August 2023 to life imprisonment with a minimum of 24 years.

1.3 The review will consider the agency contact and involvement with Francis for 2 years prior to his death. At the initial panel meeting agency members shared a summary of their engagement with Francis. This period was chosen to allow for an in-depth review of current methods and processes to be carried out and to ensure that recommendations and learning would be based on existing policies, procedures, and training. This time frame also covered the entire time of the relationship between Francis and Sally. As a result, this was considered a proportionate timeframe, however, agencies were informed should they note anything relevant outside of that timeframe, they were to include that detail in their IMR. The chair would constantly monitor this information and would amend the TOR if required. In addition to agency involvement, the review will also examine the past to try and identify any relevant background or trail of abuse, prior to the death, whether support was accessed within the community. By taking this holistic approach, the review attempts to identify solutions that will make the future safer.

1.4 The key purpose for undertaking reviews of this nature is to enable lessons to be learned from deaths which occur in similar circumstances and with a related background. For these lessons to be learned as widely and thoroughly as possible, professionals need to be able to fully understand what happened following each death, and most importantly, what needs to change, to reduce the risk of such tragedies happening in the future.

1.5 This review process does not take the place of the criminal or coroner's courts, nor does it take the form of a disciplinary process.

1.6 The review panel wishes to express its deepest sympathy to the family and friends of Francis, for their loss and thank them for their contributions and support for this process.

2. Timescales

2.1 The Metropolitan police (MPS) referred this matter to the Community Safety Partnership (CSP) on the 28 July 2022. The email recommended that the case be considered for a Domestic Homicide Review (DHR). On the 31 August 2022 the Home Office were informed by the Partnership of their intention to carry out a Domestic Homicide Review into this matter.

2.2 Simon Steel was commissioned to provide an Independent Chair (hereafter 'the chair') for this review on the 6 July 2023. The completed report was passed to the CSP in June 2025. It was submitted by the CSP to the Home Office Quality Assurance Board on 25 September 2025.

2.3 Home Office guidance states that a review should be completed within six months of the initial decision to establish one. The timeframe for this review was extended for several reasons:

Active criminal proceedings.

To enable contact with the family and respond to questions in the draft review.

To enable contact with the perpetrator.

3. Confidentiality

3.1 The findings of this review are confidential and will remain so until the Overview Report and Executive Summary have been approved for publication by the Home Office Quality Assurance Board. Information is available only to participating professionals/officers and their line managers.

3.2 Details of confidentiality, disclosure and dissemination were discussed and agreed between member agencies during the first panel meeting. All information was treated as confidential, and nothing was disclosed to third parties without the agreement of the responsible agency's representative.

3.3 Each agency representative was personally responsible for the safe keeping of all documentation that they possessed in relation to this review, and for the secure retention and disposal of that information in a confidential manner.

3.4 It was recommended that all members of the Review Panel used a secure email system, and that information should not be sent in any other way and also password protected.

3.5 This review has been suitably anonymised in accordance with the statutory guidance. The pseudonyms were agreed with the family and are used in the report to protect the identity of the individuals involved. The author selected a pseudonym for the perpetrator.

Pseudonym	Relationship	Age at the time of the incident	Ethnicity
Francis	Deceased	34 Years	White -British
Sally	Perpetrator	27 Years	White- British
June	Francis' mother	Adult over 18	White -British

3.6 As per the statutory guidance, the chair, author, and the review panel members are named, including their respective roles and the agencies which they represent. Agencies that provided information are also identified.

4. Terms of Reference

4.1 Following discussions at initial panel meetings the chair circulated the Terms of Reference (T0R), to the agencies that had contact with Francis and Sally. Details of the Terms of Reference are contained in Appendix 1. The review aims to identify learning from Francis's death and for actions to be taken in response of that learning with a view to preventing similar deaths and ensuring that individuals and families are supported in the future.

4.2 The review panel comprised of agencies from the London Borough of Richmond CSP, where Francis lived at the time of his death. They were contacted as soon as possible after the review was established to inform them of the need to identify and secure records and for their participation within this process.

4.3 Key Lines of Enquiry: During the review the chair and panel have considered the 'generic issues' as set out in the generic guidance and those relevant to this case. Various discussions have led to the following case specific issues being agreed:

1. Responding to crisis.
2. Was gender a factor as Francis was male, and were interactions prejudiced by that factor?
3. Was addiction a barrier to support?
4. Mental health and links to domestic abuse (DA).
5. Disclosure of relationship status within the benefits arena.

5. Methodology

5.1 Throughout the report the term 'domestic abuse' is used interchangeably with 'domestic violence', and the report uses the cross-government definition of domestic violence and abuse. This review commenced after the Domestic Abuse Act receiving royal ascent in April 2021 and defines domestic abuse as:

- The Behaviour of a person (A) towards another person (B) if.
  I. A and B are each aged 16 or over and are personally connected to each other and.
  II. The behaviour is abusive

- Behaviour is abusive if it consists of any of the following -
  1. physical or sexual abuse.
  2. violent or threatening behaviour.
  3. controlling or coercive behaviour.
  4. economic abuse (see subsection (4)).
  5. psychological, emotional, or other abuse.

It does not matter whether the behaviour consists of a single incident or a course of conduct.

Two people are Personally Connected to each other if any of the following applies.

1. They are, or have been, married to each other.
2. They are, or have been, civil partners of each other.
3. They have agreed to marry one another (whether or not the agreement has been terminated).
4. They have entered into a civil partnership agreement (whether or not the agreement has been terminated).
5. They are, or have been, in an intimate personal relationship with each other.
6. They each have, or there has been a time when they each have had, a parental relationship in relation to the same child (see subsection (2).
7. They are relatives.

It is defined as any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence, or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse, psychological, physical, sexual, financial and emotional.

5.2 Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

5.3 Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."

5.4 This definition, which is not a legal definition, includes so called 'honour' based violence, female genital mutilation and forced marriage and is clear that victims are confined to one gender or ethnic group.[1]

[1] https://www.gov.uk/government/news/new-definition-of-domestic-violence

5.5 This review has followed the statutory guidance. On notification of the death agencies were asked to check for their involvement with any of the parties concerned and secure their records. It was during this scoping process that chronologies were collated and combined. This document was reviewed by the chair and Individual Management Reviews (IMRs) for all the organisations and agencies that had contact with Francis were requested.

5.6 Document Reviewed: In addition to the combined chronology and IMR's, various documents and open-source research has been carried out including:

- Website for commissioned service for domestic abuse support.
- Home Office Documents referring to key Findings from analysis of previous DHR's.
- Reducing the risk report on London DHR's
- Citizens Advice document regarding "What is Public Sector Equality Duty".
- Richmond CSP website – Domestic Homicide Reviews.
- The Royal College of Nursing – Roles and Responsibilities of Health care staff.

5.7 Panel Meetings. Review Panel meetings took place on the 3 August 2023, 3 October 2023, 7 February 2024 and the 9 October 2024. The chair held when required individual agency discussions with panel representatives, and authors to seek clarification on points within agency IMRs and review Key Lines of Enquiry.

6. Involvement of Family, Friends, and Community

6.1 Following the decision to conduct this DHR the chair and the CSP via the Police Family Liaison Officer (FLO) wrote to both Francis's mother and father. The review had been able to make contact with Francis's mother however were not successful in contacting his father.

6.2 The chair also included details of Advocacy After Fatal Domestic Abuse (AAFDA) in the contact letters. June, Francis's mother replied and subsequently spoke with the chair. She gave permission for the chair to make an AAFDA referral for her.

6.3 The chair travelled and met with June along with her AAFDA advocate. June shared that she was aware that Francis had challenges with addiction and wished to be reassured that in his dealings with services that this was not an inhibiting factor. Also, she wished to ensure that his gender was not a factor and that he was not discriminated against because he was a male.

6.4 To date Francis's Father has not responded to the chair.

6.5 The chair via the probation service wrote to Sally. The chair met with Sally's probation officer to answer some questions Sally had about the DHR process and the chair sent an update to assist Sally. In the update it detailed what the chair would like to speak to her about (with her permission). This included:

- I would like your help in understanding if agencies that were involved with you, whether individually, or collectively, could have done anything to assist you that would have altered your trajectory.

- In thinking about interactions with agencies, I would like to understand if you feel any of the below were factors or barriers to receiving support that could have assisted with altering your trajectory.
- Your gender.
- The fact you had some challenges with addiction.
- Any other factor, or anything else that you think is relevant to this review.

6.6 The chair met with Sally virtually (prisons request). The chair reminded Sally this was a voluntary process and the purpose of the DHR process. Sally stated that she had an interaction with a hospital in July 2022. Sally stated that when she presented in A&E, she did not tell the truth about how her injuries were caused. On that evening, she alleged she was assaulted by Francis, and he was concerned that if the police were told he "Would get 5 years". Sally alleged they concocted a story that she slipped and fell out of the shower. They knocked at a neighbour's door to call an ambulance, however the ambulance said it would be an hour, so they decided to get a bus to hospital.

6.7 On route to hospital they stopped to see a drug dealer. Sally stated she knew she needed heroin to calm her down however Francis got her crack. They went to one hospital which was closed then got the bus to another hospital.

6.8 At hospital Sally did say she was asked about her injuries however she alleged she did lie because Francis was there. She also stated she attended hospital again a day or so later due to this injury and Francis followed her there. She stated she was looking for a code word to say to staff she was in trouble. An example she cited was stating she was aware of code words used when women are in situations in a club.

6.9 She did state at a separate point, that a member of the drugs team noticed a bruise and they asked her about it, but she denied any violence. She also stated she was concerned that the police had bailed Francis to her house (this was after they were both arrested for theft from a motor vehicle) when they knew he had previous for ABH on a former partner.

6.10 She also stated to the chair that when she formed her relationship with Francis in the May, she alleged that Francis wished for her to stop taking her MH medication which was on a repeat prescription. She questioned why this is not reviewed when the patient does not collect the medication.

6.11 Francis's mother has received a copy of the draft overview report, and she has had time to read through it. She has also asked a number of questions for clarification via AAFDA which the chair has answered. Francis's mother is content with the contents of the overview report and has agreed pseudonyms in relation to herself and Francis.

7. Contributors to the Review

7.1 The following agencies and the contributions to this review are:

Agency	Contribution
Metropolitan Police	Chronology and IMR
GP Surgery	Chronology and IMR
Probation Service	Chronology and IMR
Kingston Hospital Foundation Trust	Chronology and IMR
Richmond Community Drug and Alcohol Service	Chronology and IMR
West London St Georges Mental Health Trust	Chronology and IMR
Adult Social Care	Chronology
Richmond Housing Partnership	Chronology & Report
Outreach (Hounslow Housing)	Chronology

7.2 Quality and Independence of the IMR authors. The IMRs were prepared by authors who were independent of any service delivery or case management regarding Francis. The IMRs were comprehensive and allowed the panel to analyse the contact with Francis & Sally. The detail ensured that the panel were able to identify learning and recommendations for this review and where necessary, follow-up meetings were held, and questions sent to agencies. Responses were received, prior to, or at, subsequent panel meetings.

8 Review Panel Members

8.1 The Review

Name	Role/Job Title	Agency
Simon Steel	Independent Chair	Foundry Risk Management Consultancy LTD

Miranda Hibbert	Vulnerabilities Manager	Richmond and Richmond Community Safety Service
Albina Hiorns	Violence Against Women and Girls (VAWG) Manager	Richmond and Richmond Community Safety Service
Chris Ward	Author	Foundry Risk Management Consultancy LTD
Glen Atkinson	Specialist Crime Review Group (SCRG)	Metropolitan Police Service
Ayodeji Ogunyemi	Head of Service – Hounslow, Kingston and Richmond	Probation Service
Dr Andrew Smith	Safeguarding Lead	GP surgery
Francesca Butcher	Adult Safeguarding and MCA Lead Nurse, Best Interest Assessor	Kingston Hospital Foundation Trust
Jane Eastaway	Richmond and Wandsworth Addictions Borough Lead	Richmond Community Drug and Alcohol Service
Arlene Marshall	Clinical Service Lead; Richmond (Adults) Mental Health Teams	West London St Georges Mental Health Trust
Caroline McDonald	Service Manager, Mental Health	Adult Social Care
Jane Driver	Housing Advisor	Richmond Housing Partnership
Shola O'Grady	Head of Housing Services	Richmond Housing Partnership

Jocelyn Van Bruggen	Director of Domestic Abuse Services	Hestia
Sandie Cox	Safeguarding lead	Hounslow and Richmond community Healthcare
Peter Warburton	Designate Professional Safeguarding Adults Kingston	NHS South West London South West London Integrated Care System
Peter Bancroft	Richmond Integrated Team Leader	SPEAR
Jessica Whittock	Trust Domestic Abuse Co-ordinator	Chelsea and Westminster hospital NHS foundation trust

9 Chair & Author of the Overview Report

9.1 Simon Steel was appointed by the Richmond CSP as Independent Chair of this DHR panel. Simon is a retired Thames Valley Police Detective. He has considerable experience in the field of Domestic Abuse, Public Protection and Safeguarding. His experience includes specialist, strategic and generic investigative roles across the Thames Valley. He has also led complex Domestic Homicide Investigations.

9.2 Since retirement, Simon has established his own consultancy business and has now chaired multiple Domestic Homicide Reviews. Simon has been subcontracted by Foundry Risk Management who have a long history of chairing reviews.

9.3 Simon also has worked as the Head of Adult Support for an Autism Charity within the voluntary sector who are commissioned by Local Authorities and Integrated Care Boards (ICB). Simon has also worked as a Learning Disability and Autism Champion for an ICB. Simon believes his work alongside statutory, non-statutory and voluntary sector organisations provides him an enhancement to his policing portfolio.

9.4 Simon has completed Home Office approved Training and has attended subsequent Training by Advocacy After Fatal Domestic Abuse.

9.5 Simon has no connection with Richmond Community Safety Partnership.

9.6 Chris Ward was appointed as the independent author of this DHR. Chris is an experienced detective, serving for 31 years in Thames Valley Police. His experience

includes homicide investigation, where he was head of The Major Crime Unit, as well as child exploitation, child abuse and counter corruption investigations. Chris was latterly Assistant Chief Constable for Local Policing in Thames Valley Police.

9.7 Chris has completed Home Office approved DHR training.

9.8 Chris has no connection with Richmond Community Safety Partnership.

10 Parallel Reviews

10.1 Crown Court: Sally was convicted of Francis's murder at Kingston-upon-Thames Crown Court and sentenced in August 2023 to life imprisonment with a minimum of 24 years.

11 Equality and Diversity

11.1 The review panel considered all 9 protected characteristics under the Equality Act 2018 i.e.

- Age
- Disability
- Gender Assignment
- Marriage and Civil Partnership
- Pregnancy and Maternity
- Race
- Religion and Belief
- Sex
- Sexual Orientation

11.2 The panel reflected upon each of these in evaluating the various services provided to Francis. It is incumbent on this review to consider the duty on public authorities to[2]; remove or reduce disadvantages suffered by people because of a protected characteristic, meet the needs of people with protected characteristics, encourage people with protected characteristics to participate in public life and other activities.

11.3 Each protected characteristic was analysed by both individual agencies and the panel, against policies and procedures that were in place at the time of the death of Francis.

11.4 The Centre for Social Justice report that men are often overlooked as victims of Domestic Abuse. The truth is that one third of DA victims are men. Despite representing such a significant proportion of victims, men are often silenced by the hostility and incredulity when they open up to police and safeguarding services.

[2] https://www.citizensadvice.org.uk/law-and-courts/discrimination/public-sector-equality-duty/what-s-the-public-sector-equality-duty/

Support agencies often overlook cases involving the abuse of men and cases involving female abusers.

11.5 Men who experience domestic violence and abuse face significant barriers to getting help and access to specialist support services, according to a study by researchers at the University of Bristol's Centre for Academic Primary Care and Centre for Gender and Violence[3]. The study, funded by the National Institute for Health Research, looked at what stops men in abusive relationships from seeking help, and how services could be improved to make help-seeking easier.

11.6 The researchers analysed interview-based studies of men in heterosexual and same-sex relationships and organised their findings into a series of themes. Fear of not being believed or being accused as the perpetrator, embarrassment at talking about the abuse, and feeling 'less of a man' were found to be key reasons why men did not seek help.

11.7 Men also worried about the welfare of their partner, damaging their relationship or losing contact with their children if they opened up to someone outside their personal network of family and friends. Others lacked the confidence to seek help as a result of the abuse. The study also found that men were often either not aware of specialist support services or felt they were not appropriate for male victims of abuse. When men did seek help, they did so usually when their situation had reached a crisis point.

11.8 Confidentiality was very important to those seeking help from services, as was trust, seeing the same person over time, and a non-judgmental attitude. There were mixed views about how easy it was to open up to health professionals, such as GPs, but men consistently expressed a preference for receiving help from a female professional.

11.9 The panel has recognised the relevance of mental health to both Francis and Sally and have included this element as a KLE.

11.10 The panel has recognised the lack of visible services available to male victims of domestic abuse within Richmond. It is against the background of concerns raised in such reports, that the review will consider the circumstances of Francis's death.

12 DISSEMINATION

12.1 Once finalised by the Review panel the Executive Summary and Overview Report will be presented to the CSP for approval. Upon approval they will be sent to the Home Office for Quality Assurance.

[3] 2019: Male victims of domestic abuse | Centre for Academic Primary Care | University of Bristol

12.2 The recommendations will be owned by Richmond Community Safety Partnership, who will be responsible for disseminating learning through local professional networks as well as managing progress of the Action Plan which is created at the conclusion of this review and in response to the recommendations that have been made.

12.3 The following individuals and agencies have been identified as recipients of these reports

Agency
Richmond CSP
Richmond Safeguarding Adults board
Richmond Health and Well-being board
Richmond VAWG Strategic Delivery Group
Richmond Children's Safeguarding Board
The Office of the Mayor of London
The Domestic Abuse Commissioner
The Family
All Panel Members

12.4 This report will be published on the Richmond council website.

13 Background Information (The Facts)

13.1 At the time of his death Francis was 34 years old.

13.2 On an evening in July 2022 the London Ambulance Service were called to an area in Richmond, following reports of an assault. They discovered Francis who had been stabbed and was sadly pronounced deceased at the scene.

13.3 The investigation was passed to the MPS. In the early hours of the following day, officers attended the address of Sally, the partner of Francis. She was arrested on suspicion of his murder. She was charged with his murder and was subsequently convicted and sentenced in August 2023 to life imprisonment with a minimum term of 24 years.

14 Combined Narrative Chronology

14.1 The following section summarises contact between Francis and various agencies. To assist the reader, the table below summarises the names of the organisations and their role in this case. The paragraphs within the narrative chronology are pre-faced with the lead agency to identify the primary source of information and assist the reader.

Organisation	Role	Pre-Face
Metropolitan Police Service	Police	MPS
Probation Service	Probation	PS
Kingston Hospital Foundation Trust	Hospital	KHFT
Richmond Community Drug and Alcohol Service	Drug and Alcohol Service	RCDAS
South West London St Georges Mental Health Trust	Mental Health Service	MHS
Doctors Surgery	NHS GP Practice	GP
Adult Social Care	Social Care	ASC
Richmond Housing Partnership	Housing	RHP
Outreach (Hounslow Housing)	Chronology	OR

14.2 MPS Overview

There are a significant number of contacts between the MPS and Francis, dating back to the year 2000 (over 500). In relation to Sally, there are a much smaller number. The

author has highlighted the relevant contacts between July 2020 and the time of the death of Francis in 2022. Francis had some 40 convictions, the majority of which related to theft and minor offences due to his drug dependency. There is one conviction relating to domestic violence, when he was convicted of assaulting a previous partner in 2016. Francis began a relationship with Sally some months prior to his death. It is well documented that Francis had drug dependency issues relating to opiates and was often seen begging and living on the streets of Richmond.

14.3 March 2020

14.3.1 **GP.** 18 March 2020. Sally had an appointment with her GP following registration at the surgery. Sally described a history of having paranoid thoughts of people doing or saying bad things but that they had resolved, and she was seeking help from the drug and alcohol service. She had started Methadone 2 weeks earlier. The GP noted previous mental health and drug dependency issues from her historic medical records.

14.4 July 2020

14.4.1 **ASC.** 10 July 2020. Police informed ASC that they had issued Francis with a Community Protection notice warning letter whilst he was sat outside a supermarket begging for money, cigarettes and food. He stated he was living at a local hotel, needed money for drugs and was being supported by St Mungo's. This was the only recorded contact with Francis and ASC.

14.5 August 2020

14.5.1 **MPS.** 3 August 2020. London Ambulance Service (LAS) called police for assistance to deal with Sally outside an address in Richmond. She was highly agitated and making threatening gestures with her arms towards members of the public. She was arrested and charged with S.4 of the Public Order Act – threatening behaviour.

Whilst being detained by officers Sally managed to slip one of her wrists out of the handcuffs. A struggle ensued with the arresting officer, and she kicked them in the chest, causing injuries amounting to common assault. She was also charged with assaulting a police officer.

Whilst in police custody Sally seemed dazed and appeared to be hallucinating. Due to suspicion that she was exhibiting signs of drug withdrawal, she was taken to hospital. A Merlin[4] report was completed, dealing with Sally as a vulnerable person. This was recorded and shared with Adult Safeguarding via the MASH team. As no mental health professionals were available to assess Sally whilst in custody, she was taken to The Maudsley Crisis Suite. She was refused as a patient as they suspected she was in withdrawal from drugs and/or alcohol. She was then taken to Kings College Hospital to deal with the physical aspect of withdrawal.

[4] Information on creation of MERLIN reports | Metropolitan Police

Both the public order offence and assault on an emergency worker were discontinued without conviction at court.

14.5.2 **RCDAS.** 6 August 2020. Sally was sectioned under Section 2 Mental Health Act 1983. Noted as at risk of self-harm and risk of exploitation due to drug use.

14.5.3 **MPS.** 17 August 2020. Police were called to two men trying to break into cars in Hounslow at about 02:45. Francis was seen in the area by police and matched the description given by the witness. He was searched for stolen property with a negative result.

14.5.4 **MPS**. 19 August 2020. Francis was seen by police acting suspiciously in Hammersmith at about 18:30. He walked away from officers at a fast pace and then hid behind bins. The officers suspected he was smoking drugs, and he was searched. The search had a negative result, but Francis admitted he had just been smoking crack but had used all of it.

14.6 September 2020

14.6.1 **OR.** 4 September 2020. Francis was seen by Outreach workers at a local hotel where he had been supplied temporary accommodation. He stated he had not been staying there that often and had been sleeping out in Richmond town centre. He also stated he had lost his benefits and his mobile phone. Francis stated he would rather live on the streets than return to the Borough of Hounslow. Arrangements made to meet next week and speak about this further.

14.6.2 **OR.** 10 September 2020. Francis was asked to leave the hotel. On inspection of the room there were crack pipes and used 2ml syringes all over the room, also cluttered with clothes, toys, motor bike helmets and general waste. A letter was left in his room and at reception for Francis explaining that he needed to vacate the room immediately.

14.6.3 **MPS.** 12 September 2020. Police were called by a witness who had seen Francis attempting to break into a car. He was detained by members of the public and was violently struggling when police arrived at about 10.20. Francis told officers that he had been trying to find some coke to mix with the whiskey he had in his possession. It transpired that he had also damaged another vehicle. He was subsequently arrested and charged with criminal damage and motor vehicle interference. Whilst in custody he was observed to be under the influence of drugs. He admitted to being addicted to Xanax with a cost of about £60 per day to maintain. He was treated for drug withdrawal by the custody medical professional. Both charges were later discontinued at court.

14.6.4 **OR.** 15 September 2020. Francis was spoken to a by an Outreach worker. He stated he was angry and wanted no further support from this agency.

14.6.5 **MPS.** 22 September 2020. Sally was a patient at Queen Mary Hospital, Roehampton, where she was detained under S3 of the Mental Health Act. She attended a medical centre on escorted leave with a carer from the hospital in order to have a scan. There was a queue at the medical centre and Sally made excuses to go outside whilst her carer queued. She ran away and was last seen at about 11:00. Concerns were raised that Sally's mental health symptoms were controlled by medication and that without treatment she could become aggressive quite quickly. It was noted that Sally was not drug dependant at the time but was receiving treatment for this issue. Sally was found at her family address and was conveyed back to the Queen Mary Hospital in an ambulance at about 17:30.

14.7 October 2020

14.7.1 **MHS** 28 October 2020. Sally was accepted into Richmond Home Treatment following her discharge from hospital. She was assessed by Richmond Home Treatment on one occasion, 31 October 2020. The Richmond Home Treatment Team made several further attempts to see Sally which included telephone calls and an unannounced home visit; however, they were not able to make contact.

14.8 November 2020

14.8.1 **MHS** 6 November 2020, whilst under the Richmond IRH, Sally was initially under Care Programme Approach (CPA) with an allocated Care Coordinator (CC). On review of clinical documentation, there is clear evidence that between November 2020 and March 2021 the CC engaged with Sally and had contact with her family. She was also supported by the team recovery support worker for PIP applications and foodbank referrals. In addition, she was referred to the team employment specialist for intervention to support her back into employment.

14.8.2 **MPS.** 15 November 2020. Francis was arrested at about 00:15 hours as he was subject to an arrest warrant issued by Wimbledon Magistrates Court for failing to appear as directed on 13/10/2020, for the offence of motor vehicle interference. He was detained to attend court.

14.8.3 **RCDAS.** 17 November 2020. Sally attended an in-person consultation. She agreed to trial Naltrexone medication to treat her opioid use. Prior to dispensing medication, Sally left hospital. Follow up calls were made. Sally stated she was scared of men who were trying to "Pimp" her.

14.9 December 2020

14.9.1 **MPS.** December 2020. Sally was stopped by police at about 15:50 on suspicion of drugs possession. She was present in Hounslow in the stairwell of a parking garage. She was seen lighting something but made off before officers could challenge her. The officers found Sally hiding within the garage and she seemed nervous and

agitated. The car park was known for drug use, and they searched her for drugs with a negative result.

14.9.2 **PS.** December 2020, Francis was convicted of interference with a motor vehicle. He received a 12-month Community Order with a single requirement of 20 days Rehabilitation Activity Requirement (RAR). This required him to attend appointments with a Probation Officer and drug support services. He failed to attend any appointments and was breached.

14.9.3 **GP.** 16 December 2020. Sally had a telephone consultation where she described having a taken a pile of her medication a month earlier in a suicidal attempt. She was surprised to have woken the next day and didn't tell anyone. She asked to start antidepressants as she was feeling low. The GP made contact with the Richmond Recovery and Support team on the 17 December, and they advised against prescribing as they were in contact with her and would manage the mental health issues.

14.10 January 2021

14.10.1 **GP.** 4 January 2021. Sally was reviewed face to face by the GP described low mood, but much better than since being sectioned 3 months ago. She had occasional thoughts of self-harm. She asked about antidepressants and was advised that the GP would discuss with the Mental Health Team. She was advised to see Citizens Advice Bureau for benefits advice.

14.10.2 **GP.** 11 January 2021. Sally was reviewed in a telephone call where she reported that she was stable. It was noted that the Care Co-ordinator for the Mental Health Team had been trying to make contact but had been unable to do so and that Sally had not contacted any of the community support that she had been given contact details for.

14.10.3 **MPS.** 18 January 2021. Police were called to a male aggressively begging in Kew Road. Police arrived at about 14:00 and spoke with Francis, who was sitting in a doorway asking people for money as they passed him. The officers offered a referral to request housing, but Francis said that this had been done and that he was waiting for accommodation. He agreed to move on from the location and no action was taken.

14.10.4 **RCDAS** 28 January 2021. Sally attended a face-to-face consultation and it was noted that she was compliant with anti-psychotic medication. Discussions were held about the challenges of her drug use when maintaining friendships with other drug users.

14.10.5 **GP.** 28 January 2021. There was a telephone review with Sally, where she reported having been seen by the Mental Health Team psychiatrist and advised to start an

antidepressant in 2 weeks and had been referred on to the Drug and Alcohol Team. The GP arranged to await the clinic letters to confirm the follow up arrangements.

14.11 February 2021

14.11.1 **GP.** 5 February 2021. Sally had a telephone review where the letters from the Drug and Alcohol Team and the Richmond Recovery and Support Team (RRST) psychiatrist were discussed as were follow up arrangements. She acknowledged that she had started taking heroin again and she informed the GP that she had told the Drug and Alcohol Team.

14.12 March 2021

14.12.1 **MPS.** 18 March 2021. Francis was arrested at Richmond Train Station, having been circulated as wanted by Uxbridge Magistrates Court for breach of a court order issued on 17/12/2020. He was detained in police custody overnight due to being under the influence of heroin.

14.12.2 **PS.** 19 March 2021. Court Order returned to Court on 19/3/21 for Francis as he failed to comply with a previous order. He failed to attend, and a warrant was issued. He was arrested and produced at Court on 22/3/21 with an additional 10 days RAR added to his Community Order. He again did not attend any appointments with Probation and breach proceedings were undertaken.

14.13 April 2021

14.13.1**. MPS.** 18 March 2021. A vehicle was broken in to whilst parked in Richmond. The victim's bank cards were stolen and later used in several transactions. CCTV images of the suspect were circulated, and Francis was identified. He was interviewed and bailed, however CPS declined to charge, and the matter was discontinued due to evidential difficulties.

14.14 July 2021

14.14.1 **RCDAS.** 20 July 2021. A consultation was held with Sally. She stated that she was still using heroin and cannabis. Discussion about planning pregnancy and the risks involved whilst being drug dependant.

14.15 August 2021

14.15.1 **MPS.** 27 August 2021. Francis was sentenced to 16 weeks imprisonment following his conviction for a burglary of a private garage where property had been stolen. He was forensically linked to the crime.

14.16 September 2021

14.16.1 **PS.** 20 September 2021. Francis was released from HMP Richmond and failed to engage with Probation as required.

14.16.2 **RCDAS.** Between September 2021 and April 2022 Sally was offered numerous appointments with the team, however, missed most of them. There is evidence she contacted the team to reschedule appointments, and the team responded and arranged further appointments.

14.17 October 2021

14.17.1 **GP.** 8 October 2021. Sally had a face-to-face mental health review where it was noted that she was taking Buprenorphine prescribed by the Drug and Alcohol Team and had been changed from Risperidone to Aripiprazole in September. Her compliance had been irregular; however, she reported taking it regularly at that time.

14.17.2 **PS.** 10 October 2021. Francis was released from custody and failed to engage with Probation as required.

14.17.3 **PS.** 12 October 2021. A Fixed Term Recall was initiated against Francis and a warrant issued.

14.17.4 **RCDAS.** 21 October 2021. A consultation was held with Sally. She stated that she was smoking heroin daily and that it was adversely impacting her ability to study. Her medication was subsequently increased.

14.17.5 **MPS.** 28 October 2021. Francis was arrested as he was circulated for being wanted on a recall to prison. He was returned to prison as directed.

14.17.6 **PS.** 28 October 2021. Francis was recalled to prison as a result of failing to engage with Probation.

14.17.7 **MHS.** 29 October 2021. Sally was seen by the team consultant psychiatrist and medication changes were made.

14.18 November 2021

14.18.1 **PS.** 10 November 2021. Francis was released from custody and failed to engage with Probation as required.

14.19 December 2021

14.19.1 **RCDAS.** 1 December 2021. Sally had a consultation where she discussed her increasing use of heroin and the effect on her sleep. Her medication was increased.

14.19.2 **MPS.** 27 December 2021. Francis was arrested as he was circulated as being wanted on a recall to prison, having failed to comply with his license conditions. He was returned to prison as directed.

14.20 January 2022

14.20.1 **PS.** 6 January 2022. Francis was released from custody.

14.20.2 **PS.** 7 January 2022. Francis attended Probation and indicated that he was of no fixed abode and was withdrawing from Class A drug use. He was directed to collect a Methadone script the same day. At this point he was managed by Probation under Post Sentence Supervision (PSS) and thus legally the Probation Service was unable to recall him to custody. He failed to engage with Probation after this date.

14.21 February 2022

14.21.1 **RCDAS.** 3 February 2022. Sally attended a consultation. She stated that she was struggling with low mood and suicidal ideation which had caused her to increase her heroin use. Methadone was prescribed.

14.21.2 **ASC.** 22 February 2022. Following a Police MERLIN report, ASC attended the address of Sally. ASC noted that she appeared under influence of cannabis and that there was paraphernalia within her house. Sally stated that she had psychosis. Her house was described as messy but clean.

14.22 March 2022

14.22.1 **RCDAS.** 15 March 2022. A consultation was held with Sally where her ongoing use of crack cocaine and other drugs was discussed. Sally stated that she feared that drug dealers were looking to take over her flat and exploit her.

14.23 April 2022

14.23.1 **RCDAS.** 5 April 2022. A consultation was held with Sally. She tested positive for opioids, cannabis, cocaine and Methadone. No concerns were raised about suicidal ideation, although she did state that she still feared her flat being taken over by drug dealers.

14.23.2 **GP.** 19 April 2022. Sally contacted the emergency telephone triage. She reported having paranoid thoughts but not feeling suicidal. She asked for a letter for university as she had been unable to complete coursework. She reported having regular contact with the psychiatry team and taking Aripiprazole and Sertraline regularly.

14.24 May 2022

14.24.1 **MPS.** 26 and 27 May 2022. Anti-social behaviour and suspected drug use were reported at an address linked to Sally.

14.24.2 May 2022 June shared that Francis rang her this month to tell her about his relationship with Sally and that it was new (a few weeks). June also recalls speaking with Sally at this time.

14.25 June 2022

14.25.1 **RHP.** 7 June 2022. RHP emailed Sally informing her that they had received reports that she was playing music, moving furniture and having screaming arguments every night. Sally was advised to reduce the noise where possible.

14.25.2 **MPS.** 13 June 2022. Police officers were made aware of high levels of suspicious activity around Sally's address. There were frequent visits from apparently homeless people, who appeared to be storing stolen property at the address. There was much evidence of drug usage and supply at the address, and residents were concerned that Sally could be vulnerable and being cuckooed. No action was taken from this report.

14.26 July 2022

14.26.1 **RCDAS.** 4 July 2022. Sally attended an appointment with Francis but was seen alone. She stated that she had increased her drug usage but was in a new relationship. She stated she did not fear drug dealers at present; however, she disclosed recent self-harm and having paranoid thoughts.

14.26.2 **RCDAS.** 4 July 2022. Francis attended an initial appointment for his own drug dependency issues. He stated that he had daily heroin, crack and cannabis usage. He stated that his partner was Sally and that he had no domestic abuse issues, including coercion or control threats.

14.26.3 **RCDAS.** 7 July 2022. Francis attended his consultation with Sally. He was seen alone. He stated that he had depression and anxiety. Safeguarding questions were posed to him, and he stated that he had no concerns. He also stated that he was in a relationship with Sally and wanted to make a success of this. No suicidal ideation or self-harm was disclosed. Medication was prescribed.

14.26.4 **RCDAS.** 11 July 2022. Sally was seen for a repeat prescription. She stated she felt safe in her new relationship.

14.26.5 **RCDAS.** 12 July 2022. Francis was seen for an in-person consultation. He described his increasing use of heroin and crack cocaine and stated that he was now engaged to Sally.

14.26.6 **MPS.** 15 July 2022. A resident in the road where Sally resided called police as she was concerned for the safety of her female neighbour. She explained that her neighbour appeared to have mental health issues and had recently been living with a male who looked like a heroin addict.

She could hear screaming, shouting and crying coming from the address and feared that the male had harmed the female. Police attended at about 00:42, at which time Sally's address appeared to be empty. The male and female appeared to have left before they arrived. The officers believed the female to be Sally and the male to be Francis, based on the descriptions provided by the informant and the connection to Sally's home. Police made several attempts to contact Sally in person and by telephone in the hours after this this incident was reported, however this was met with no response. The report was screened into the local Public Protection Unit, and the report was marked for officers to re-attend to establish face to face contact with Sally to ensure her safety and wellbeing. However, officers were unsuccessful in contacting Sally before the murder of Francis.

14.26.7 **KHFT.** 15 July 2022. Sally presented at the hospital with Francis. She had a laceration to her hand which she stated had been caused after Francis threw a mobile telephone at the wall. No concerns were raised, and she was discharged.

14.26.8 **KHFT** 16 July 2022 Sally attended hospital alone. Stated her wound was sore. It was noted she appeared unkempt and was agitated. Stated she had not done this to herself but refused to discuss who had. Stated she felt safe at home and did not want the matter reporting to the police. A short time later Francis arrived. He was told to wait outside, and Sally became agitated. Francis spoken to and denied any domestic abuse issues or concerns for his safety.

14.26.9 **MPS** In July 2022. Report of serious assault. Francis had been the victim of an assault and was pronounced deceased at the scene.

14.26.10 **MPS** Sally was later arrested at her address on suspicion of the murder of Francis.

15. Overview

This section summarises what information was known to each agency, and the professionals involved, within the review period. Any other relevant facts or information are also included in this section.

15.1 Metropolitan Police Service – MPS

15.1.1 The MPS have conducted a full review of their systems for contact between Francis and Sally for the agreed review period. This has included reports of domestic abuse

for both parties as either victim or perpetrator. Given the relatively short duration of the relationship between Francis and Sally, this has included previous reports relating to historic partners and relationships.

15.1.2 Francis had considerable contact with the MPS. From 1 January 2000 until his death, there are 527 MPS reports relating to contact with Francis.

15.1.3 Francis had some 40 convictions; these were for minor offences attributable to his drug dependency. There is one conviction relating to domestic abuse, when he was convicted of assaulting a previous female partner (Female 1) on the 16 November 2016.

15.1.4 Francis had several relationships prior to meeting Sally. The most significant appears to be with Female 2. There is reported domestic abuse between Francis and Female 2, with Francis highlighted as the perpetrator.

15.1.5 Sally had considerably less contact with the MPS, having only come to notice for theft, prior to her mental health decline.

15.2 Probation Service – PS

15.2.1 Francis had an extensive history of being both homeless and of significant Class A drug use. Both factors were linked to his offending behaviour, and he was assessed as posing a medium risk of serious harm to members of the public by way of physical and psychological harm in the commission of acquisitive and violent offending.

15.2.2 During his extensive probation review, it is clear that Francis rarely engaged with the PS and this is analysed further in this report

15.2.3 There are no records of interaction between Sally and the PS within the review period.

15.3 Richmond Community Drug and Alcohol Service - RCDAS

15.3.1 Francis came into treatment with RCDAS in July 2022, shortly before his death.

15.3.2 Francis had been referred to the Richmond Community Drug and Alcohol Service for support around dependent heroin and crack use. He reported past intravenous drug use and previous Methadone prescription treatment in prison. He had not had any community or residential treatment.

15.3.3 Francis had reported anxiety, depression and stress related to drug use. He had been of no fixed abode until he resided with Sally. He had a forensic history of drug-related thefts. His last prison sentence was in January 2022; at the time of his death, he was on licence and had a court date pending in July 2022.

15.3.4 Sally had been in treatment with RCDAS since April 2020.

15.3.5 Sally had diagnoses of both Paranoid Schizophrenia and Schizoaffective Disorder documented on clinical notes and a long history of polysubstance misuse which had historically played a role in a deterioration in her mental state. Heroin and cannabis

were her primary substances of use during her contact with RCDAS, and crack cocaine towards the end of her contact.

15.3.6 Sally was known to local mental health services in the community as an inpatient. Her alcohol use had always been minimal. Her first treatment intervention for drug use was pre-RCDAS' involvement, when she was aged 19.

15.4 Kingston Hospital Foundation Trust - KHFT

15.4.1 There was very limited contact between KHFT and Francis. He was present on one of two occasions that Sally attended the hospital. He was not present during her consultation shortly before his death.

15.4.2 Sally presented at KFHT on two occasions in July 2022, with lacerations to her hand and head. Sally was directly asked if she felt safe at home to which she stated she did. Sally refused the offer of reporting the incident to the police.

15.5 Doctors Surgery – GP

15.5.1 Sally registered as a patient with the surgery in late January 2020.

15.5.2. During the review period there were several consultations between Sally and her GP. In the main, these related to mental health concerns as well as supporting her interaction with RCDAS. During the consultations there is no evidence of disclosure in relation to domestic abuse.

15.5.3 There are no GP medical records relating to Francis within the review period. This is probably unsurprising given Francis was engaged with other support agencies.

15.6 Southwest London St George's Mental Health Trust – MHT

15.6.1 Sally had a long history of association with MHT. She had diagnoses of both Paranoid Schizophrenia and Schizoaffective Disorder documented on clinical notes and a long history of polysubstance misuse which has historically played a role in a deterioration in her mental state.

15.6.2 Polysubstance misuse is a theme throughout clinical notes since she was first known to services. Sally also had a long history of opiate dependence and polydrug misuse. She started using cannabis aged 15. By 16 years of age, she was using cocaine powder, ketamine, LSD, magic mushrooms, and ecstasy. Around age 18 she was still using recreational drugs but became heroin dependent after being introduced to the drug by a friend, smoked heroin on foil, sniffed, then smoking on a pipe.

15.7 Richmond Housing Partnership - RHP

15.7.1 Sally was housed by RHP, and the panel have seen encouraging information in relation to their policies and processes which address much DA and anti-social behaviour.

15.7.2 RHP takes the prevention and reporting of domestic abuse very seriously and they have a zero-tolerance approach to mistreatment, abuse and violation of victims and survivors. The safety of customers and their households is a priority. Their aim is to provide victims and survivors of domestic abuse with reassurance, support and clear guidance on what to expect whilst providing a service where victims and survivors feel safe and believed when disclosing their experiences. They aim to empower victims and survivors through their service and partnership working with multi-agencies and support their customers to make choices.

16. Analysis

16.1 Hindsight Bias

As the report author, the chair has attempted to view this case, and its circumstances as it would have been seen by the individuals at the time. It would be foolhardy not to recognise that a review of this type will undoubtedly lend itself to the application of hindsight. Hindsight always highlights what might have been done differently and this potential bias or 'counsel of perfection' must be guarded against. There is a further danger of 'outcome biases' and evaluating the quality of a decision when its outcome is already known. However, I have made every effort to avoid such an approach wherever possible.

The analysis of the combined chronology, IMRs and discussions with panel members and IMR authors revealed themes that are further explored within the individual agency analysis that follows.

16.2 Agency Involvement

In the period there were numerous agencies involved with Francis and Sally.

16.3 Metropolitan Police – MPS

16.3.1 There were a large number of interactions between the MPS and Francis during the period of the review. There were significantly less for Sally. This analysis has focused on those interactions involving both Francis and Sally that were proximate to the murder of Francis.

16.3.2 On the 22 of April 2022 Francis and Sally were arrested for motor vehicle interference. At about 00:50 hours a witness saw two people breaking into a vehicle parked in the street. Police attended and the suspects were identified as Francis and Sally. They were both arrested and interviewed about the offence. Francis was charged with motor vehicle interference, and no further action was taken against Sally. The case against Francis was later discontinued at court.

16.3.3 On the 13 of June 2022, there were community concerns at Sally's address. Officers were made aware of high levels of suspicious activity around Sally's address. There

were frequent visits from apparently homeless people, who appeared to be storing stolen property at the address. There was much evidence of drug usage and supply at the address, and residents were concerned that Sally could be vulnerable and being cuckooed. No action was taken from this report, although it would have been appropriate to complete a welfare check on Sally. This could be considered a missed opportunity. The police were planning to conduct a search warrant for drugs at the address, but this was not actioned prior to Francis's murder.

Recommendation: MPS are to ensure officers understand the importance of swift positive action on reported behaviours around vulnerable persons' addresses

16.3.4 On the 15 July 2022 a member of the public reported a domestic incident at Sally's address. The caller stated she feared for the vulnerability of Sally. She explained Sally appeared to have mental health issues and had recently been living with a male. The caller stated she could hear screaming, shouting and crying coming from the address and feared that the male had harmed the female (this appears to be the incident which Sally referenced to the chair when he met with her). Police attended at about 00:42, but the address appeared to be empty. The male and female appeared to have left before they arrived. The officers believed the female to be Sally and the male to be Francis, based on the descriptions provided by the caller.

16.3.5 Police made several attempts to contact Sally in person and by telephone, in the hours after this incident was reported however this was met with no response. The report was screened into the local Public Protection Unit, and the report was marked for officers to re-attend to establish face to face contact with Sally to ensure her safety and wellbeing. However, officers were unsuccessful in contacting Sally before the murder of Francis.

16.3.6 It is clear from information held on MPS systems that Francis was addicted to opiates at the time of his death and appeared reliant on crime and begging to fund his habit, estimated by him as £65 per day. He appeared to favour vehicle crime and was often found begging outside of High Street supermarkets.

16.3.7 Francis was a known Domestic Abuse perpetrator, having had volatile relationships with different women. There are a considerable number of reports dealing with controlling and coercive behaviour from Francis against his female partners, however this is not reflected in his criminal conviction history with only one conviction for violence against a previous partner, resulting in a Protection from Harassment Order being issued by Kingston Crown Court to prevent Francis from contacting her.

16.3.8 Sally's contact with the MPS suggests that she has a propensity for violence when suffering with poor mental health. There is also the repeated suggestion that she suffers with drug addiction which compounds the issue. Sally's defence case statement (at the subsequent murder trial) said that Sally and Francis had been in a relationship for four months prior to Francis' death. Due to the frequency of contact between Francis and the Police, this would suggest their relationship to be fairly recent.

16.4 Kingston Hospital Foundation Trust – KHFT

16.4.1 There was limited interaction with both Francis and Sally. Sally attended the ED on two occasions two days apart, shortly before the murder of Francis. Good documentation on the second attendance states that Sally was seen alone, not with her partner, Francis, and was directly asked if she felt safe at home. She stated that she did and when she asked if she wanted the Police informed which she didn't.

16.4.2 This is clearly the incident that Sally refers to when she spoke to the chair. Also, the incident, which was when the police were called and they attended, and no one was at home would have been when sally attended hospital the first-time 15th of July 2022.

16.4.3 This was an opportunity given the presentation of Sally. The hospital did utilise good practice and ask her in a private room however the panel believe that a referral should have been made to the police.

16.5 Doctors Surgery – GP

16.5.1 All of the analysis of contact with the GP relates to Sally. There are no records of GP contact with Francis during this review time. This is perhaps not unusual, as Francis was under the care of other services which were managing his medical issues and prescribing of medication.

16.5.2 The panel noted a number of good practices relating to the treatment of Sally during the review period. These included:

1 Being available at short notice by the use of telephone triage in both the morning and afternoon.
2 There was the ability to allocate both same day and future appointments and those appointments could be either face to face or telephone appointments.
3 The choice was determined by factors such as patient preference, clinical need and level of COVID risk at the time.
4 Sally was often able to consult with the same GP so that the understanding of the clinical situation was clearer.

16.5.3 The surgery often struggled to be able to confirm what the psychiatry teams had advised Sally during clinic appointments and reviews; however, these were always followed up by the GP. Sally quite often missed appointments and was difficult to contact on occasions.

16.6 Probation Service – PS

16.6.1 In reviewing the organisation's engagement with Francis over this period, the panel concluded that there are elements of practice where lessons can be learnt within this case. These include whilst on PSS, Francis's failure to engage was not addressed by way of breach enforcement. Due to his non-engagement, whilst PS were unable to recall him back to custody, they could have initiated breach proceedings which would have returned him to Court. The Court would then have had the power to impose a 14-day custodial sentence for his failure to comply. On reviewing the case, there is insufficient recording of any enforcement discussions taking place between 7 January 2022 and the death of Francis.

16.6.2 The panel note that steps have been taken since to improve PS monitoring of cases where breach/enforcement action is overdue. Weekly data is sent to relevant practitioners to action to reduce the risk of non-enforcement when people on probation fail to comply with licences/orders.

16.6.3 There is evidence of attempts to engage with Francis from both Housing and substance misuse services to support him in these areas. The panel felt that greater communication with these agencies and closer collaboration, may have improved Francis's opportunity to engage with PS.

16.6.4 Due to the extent of Francis's offending, he was eligible for the Integrated Offender Management (IOM) scheme. PS contacted the IOM scheme as he was previously managed under the scheme. However, the recording of subsequent engagement or communication isn't present. There has been a move away from acquisitive offending towards more prolific violent offending which would have made Francis ineligible for this scheme but it is evident he was well-known to Police and Council services for an extensive period of time.

16.6.5 In the main, whilst on licence there were appropriate decisions taken to return Francis to custody. The timeliness of these decisions varied and a new process to complete recalls to custody has been implemented nationwide since 4th December 2023.

16.7 Richmond Drug and Alcohol Services – RCDAS

16.7.1 Sally had been in treatment with RCDAS since April 2020, and Francis came into treatment with RCDAS in July 2022, shortly before his death. Francis had been referred to RCDAS for support around dependent heroin and crack use. He reported past intravenous drug use and previous Methadone prescription treatment in prison. He had not had any community or residential treatment. He reported anxiety, depression and stress related to drug use. He had a forensic history of drug-related thefts. His last prison spell was in January 2022; he was on licence and had a court date pending in July 2022.

16.7.2 Sally had diagnoses of both Paranoid Schizophrenia and Schizoaffective Disorder documented on clinical notes and a long history of polysubstance misuse which had historically played a role in a deterioration in her mental state. Heroin and cannabis were her primary substances of use during her contact with RCDAS, and crack cocaine towards the end of her contact.

16.7.3 Cannabis and crack cocaine in particular are known to have a direct negative impact on mood and mental state; heroin use, and crack use are likely to destabilise a person's social situation as they are both likely to lead to dependent use and thus require regular funding which can quickly negatively impact someone's social functioning.

16.7.4 Richmond Community Drug and Alcohol service (RCDAS) is commissioned by the Local Authority. It is a consortium service which South London & Maudsley NHS (SLAM) leads with We Are With You, St Mungo's (large national voluntary sector agencies) and (CDARS), a small drug and alcohol recovery charity, as partners. The team provides a range of services for drug and alcohol users in the borough. It takes

referrals from all over the borough but most of its clients have referred themselves. It provides harm reduction services for opiate users as well as opiate substitution treatment (OST-Methadone, Buprenorphine and Buvidal).

16.7.5 The team consists of a consultant psychiatrist, nurses (most of whom are non-medical prescribers) and recovery workers. They provide comprehensive assessment, case management and a range of psychosocial interventions including motivational interviewing and relapse prevention.

16.7.6 RCDAS contact with Sally from April 2020 to July 2022 was regular and consistent for the majority of the period. Medical contacts were regular due to opiate substitution treatment prescribing, and medical assessments were consistently thorough, with comprehensive treatment plans detailed in the notes, including liaison and updates to SWLSTG and GP given mental health involvement. Mental state and risk to self/others was always considered.

16.7.7 The formal care plan was not updated in line with these reviews, which is an omission in terms of local record keeping standards, but the plan was clear from the medical entries. Appropriate offers were made around dose optimisation even though Sally largely declined these. She was also seen promptly when she missed her medication and required a re-titration.

16.7.8 The RCDAS key worker was diligent in terms of follow up if Sally did not attend or fell out of contact. Retaining Sally in drug treatment and offering access to psycho-social interventions (e.g. groups) as well as medication would offer the best chance of overall stability (physical, mental and social) and reduce likelihood of illicit drug use. Illicit drug use would have been likely to contribute to a less stable mental state and in turn increased risk to self or others. Due to Sally being on a course she did not access the full psycho-social treatment offer available to her, which would have best supported her stability and recovery potential.

16.7.9 Documentation in terms of contact events was consistently prompt and to expected standards. Consideration was given to relationships with others, including family and a previous boyfriend, during key work sessions. Attempts to contact the mental health team throughout contact, and the ward during a psychiatric inpatient admission mid-2020, were appropriate in terms of best practise partnership working to minimise risk and maximise safe treatment. The doctor who regularly reviewed Sally did also appropriately flag with mental health colleagues her non-compliance with her mental health medication.

16.7.10 The key worker for Sally left her role in April 2022. This was approximately two weeks after the last contact with Sally. At the time, her clinical presentation was not stable. In February and again in March she had to be ‘restarted’ on OST due to missing days at the chemist, and from mid-February to mid-March she had not been seen face to face. The case was held by duty workers from April to June 2022; a duty worker did follow up on agreed actions from an ad hoc contact in April, but the service was less pro-active than usual in terms of attempts to re-engage until her case was reallocated to a new worker in June 2022. The service was unfortunately reliant on new agency staff to plug workforce vacancies at this time, which is not ideal in terms

of team stability. The panel understand the challenges with vacancies in key support services roles.

16.7.11 Once Sally was re-engaged in early July, interventions were appropriate including pregnancy testing and discussion around contraception. She was seen alone despite attending with her new boyfriend Francis, which offered the chance for her to disclose any concerns with this new relationship.

16.7.12 The service rightly insists on seeing couples separately and allocating separate workers with coercion, control and domestic abuse risk in mind. RDAS have an IDVA from the local DV service weekly onsite for consultation and can contact them in between should concerns for any service users arise; RDAS also have a MARAC rep who attends MARAC meetings to ensure joined up liaison.

16.7.13 With the above in mind, Francis was also seen alone for his initial triage despite being accompanied by Sally. The triage was by an agency worker. There was very limited time for the newly allocated worker and wider service to get to know Francis before he sadly died. During the short period from his initial presentation leading to his sad death, the focus was primarily on stabilising his OST medication. There is no suggestion that there were specific concerns raised regarding his new relationship beyond the couple clearly using substances together which was likely to contribute to both being less stable overall, and likely exacerbating each other's use

16.7.14 Francis disclosed his engagement to Sally at his last contact with the service. RDAS would ideally have been concerned how rapidly and intensely the relationship was developing, but there was little opportunity to fully explore this in terms of risks in the time period. Francis's and Sally's presentation at the time did not overtly suggest risk to each other. Additionally, Sally had stated that she felt safe in the new relationship.

16.7.15 Sally was explicitly asked if she felt safe in the new relationship during a key worker contact; Francis was not. Given the apparent intensity of the new relationship the team would be concerned around escalating drug use but did not appear to explicitly consider any other risk towards Francis.

16.7.17 There is evidence of gender bias by not asking Francis if he felt safe.

Recommendation: All agencies to ensure when working with service users regardless of gender that they are asked the same questions regarding being safe.

16.8 Southwest London St George's Mental Health Trust – MHT

16.8.1 Sally was known to Southwest London St Georges MH services since 2012, inclusive of Mental Health Crisis Services. She had inpatient settings between 2017 and 2020. Whilst under the Richmond Integrated Recovery Hub (IRH) Sally was initially under Care Programme Approach (CPA) with an allocated Care Coordinator (CC). On review of clinical documentation there is clear evidence that between November 2020 and March 2021 the CC engaged with Sally and had contact with her family. She was also supported by the team recovery support worker for PIP applications and foodbank

referrals. In addition, she was referred to the team employment specialist for intervention to support her back into employment.

16.8.2 From April 2021 onwards Sally was reviewed by medical and duty staff within the team. The team faced significant staffing pressures in 2021 which was a contributing factor to Sally not being allocated another CC. On review of the clinical documents, it was noted in the clinical review letter that Sally was no longer under CC. This highlights that the downgrading from CPA process/procedure was not followed in line with national and local policy.

16.8.3 Between September 2021 and April 2022 Sally was offered numerous appointments with the team, however she missed most of them. There is evidence she contacted the team to reschedule appointments, and the team responded and arranged further appointments. During this time frame there is little evidence to indicate the team attempted to assertively engage Sally when she did not attend appointments. Sally was reviewed by the team consultant psychiatrist on 29 October 2021 and medication changes were made. The documentation around these changes has been identified as lacking with no clear rationale or context for changes and no recorded plan in place for the team to follow up and monitor response to treatment. Sally had a scheduled appointment with the team consultant psychiatrist in April 2022. She did not attend this appointment, and there was no evidence she was contacted following this.

16.8.4 It is not clear from clinical records whether there was an MDT plan to downgrade Sally from CPA. The CPA policy was re-circulated to the team and the process of downgrading to non-CPA was reviewed within the team. All patients who are downgraded from CPA to non-CPA are discussed in the weekly MDT. This discussion and rationale are documented on clinical record. Discharge CPA is discussed with patients and carers (where appropriate) and documentation outlining the change to care plan is forwarded to the patient and their GP.

16.8.5 There was a high turnover of staff during this period which may have contributed to Sally not being reallocated a CC. Since this incident the team have developed processes to ensure patients on a medical caseload only have required contact which includes monthly caseload review and telephone/face to face welfare checks. In addition, the team have improved their process of re-allocation of patients under CC when staff leave. The team manager has better oversight of patients under CC and caseloads are reviewed monthly. The panel see this as a positive step.

16.8.6 Sally had a history of not attending appointments. The Trust's 'did not attend' (DNA) policy was not used to manage nonattendance. Since this incident, this policy has been recirculated. The team have implemented a process whereby patients who DNA are discussed in the weekly MDT, and a plan is developed to support patient engagement or discharge from the service if clinically appropriate. Risk assessments were not completed in line with Trust policy. Fields of the SWLSTG risk assessment were left incomplete and the formulation and risk management plans were left incomplete. Since this incident the team have received additional risk assessment training, with a focus on when to complete risk assessments and what to include in risk assessments. The team manager reviews the team's mandatory training

compliance monthly, to ensure all staff are compliant with Mandatory Risk Assessment Training.

16.8.7 Documentation and care planning following medication changes was lacking. Following the incident, a review of the case was carried out by the Trust Deputy Chief Pharmacist who made recommendations around practice. This learning was shared with the team and clinician involved in treatment changes. Since this incident, The Richmond Borough has employed a dedicated pharmacist who can support the team with medication recommendations and monitoring plans.

16.8.8 Crisis planning was lacking. Sally did not have a relevant or recent crisis plan. All patients under CPA should have a collaborative crisis plan recorded on the crisis planning section on their clinical record. Crisis plans should be developed collaboratively with the patient and, where possible, family. Patients on non-CPA have their crisis plan included in their most recent clinical correspondence. Following this incident an audit was carried out to review compliance and quality of care plans, and recommendations were forwarded to the team. The team continue to carry out 6-monthly audits of crisis plans so compliance is monitored regularly. In addition, in line with the Trust's Fundamental Standards of Care, each team carries out a twice weekly audit of randomly selected clients to review their care plans, risk assessments and crisis plans.

16.8.9 There was evidence of good interagency communication between Richmond IRH and RCDAS, however, there is no evidence that a joint review was considered when Sally did not attend appointments scheduled with Richmond IRH. Since this incident, the Trust has employed a Co-Occurring Mental Health Alcohol and Drug (COMHAD) practitioner in each borough. The Richmond COHMAD practitioner attends the RCDAS MDT meeting fortnightly to discuss cases known to Richmond Mental Health Services. In addition, they support referrals into Richmond Community Mental Health Services. The Clinical Manager for Richmond Community Mental Health Services has agreed to be a sponsor for the RCDAS team manager and for the consultant to have read only access to their clinical records; this will be reciprocal with clinicians in Richmond Mental Health services having read only access to RCDAS clinical records.

16.9 Key Lines of Enquiry KLE1 – RESPONDING TO CRISIS

16.9.1 There is evidence throughout the review from agencies responding to both Francis and Sally at various points throughout the review period. By the very nature of the challenges in both their lives, crisis was a common theme throughout this review.

16.10 Key Lines of Enquiry KLE2 – WAS GENDER A FACTOR AS FRANCIS WAS MALE, AND WERE INTERACTIONS PREJUDICED BY THAT FACTOR?

16.10.1 The facts of this case are that Sally was convicted of murdering Francis. That act alone results in Sally being a perpetrator of Domestic Abuse. The review has not seen any other evidence that suggests Sally was a perpetrator of DA; however, it has seen evidence that Francis was, when in one other relationship. The review has seen evidence of Sally's aggressive behaviour and nature (especially linked to her mental health). In the incident shortly before the death of Francis, Sally alleges that Francis assaulted her and also says that he controlled her medication.

16.10.2 In paragraph 16.7.16 from RDAS Sally was explicitly asked if she felt safe in the new relationship during a key worker contact; Francis was not. The panel have considered this as an example of gender bias however believe it was unconscious bias. Unconscious bias as described[5] by Imperial College London is a term that describes the associations we hold, outside our conscious awareness and control. Unconscious bias affects everyone. Unconscious bias is triggered by our brain automatically making quick judgments and assessments. They are influenced by our background, personal experiences, societal stereotypes and cultural context. It is not just about gender, ethnicity or other visible diversity characteristics - height, body weight, names, and many other things can also trigger unconscious bias. As females present the majority of DA victims and males the majority of offenders, the panel feel that as a result the unconscious bias when dealing with a male service user were apparent in this review.

Recommendation: All agencies to ensure that unconscious bias training is mandatory.

16.10.3 The panel accept the research in chapter 11 on male victims. The panel is made up of predominantly females however both the chair and the author are male. A decision was made to invite Respect to join the panel to give a Subject Matter Expert (SME) lens for male victims. The lack of visible male pathways has been highlighted by the panel and the service offer for males needs to refreshed and relaunched. We will never know if the incident on the day of his death is the only occasion that Francis was subjected to abuse, but it is clear that Francis was given fewer opportunities to be heard.

Recommendation: CSP to refresh and relaunch a visible male pathway.

16.11 Key Lines of Enquiry KLE3 – WAS ADDICTION A BARRIER TO SUPPORT?

16.11.1 There is no direct evidence that addiction was a barrier to support. By nature of the addiction challenges faced by both Fracis & Sally it perhaps led to more interactions with agencies. There is a consideration that because of these additional interactions there could well have been more opportunities to be observed in the relationship, or to disclose challenges in the relationship, than perhaps people without those challenges in their lives would have had. However, notwithstanding that, there is the offending profile in the main of Francis, and what was his relationship with agencies and whether he felt he was able or would be believed had he felt able to disclose. Also given the challenges they both faced with addiction it has also been considered that the overwhelming need of the addiction perhaps outweighed the need to report any DA if it was taking place.

16.12 Key Lines of Enquiry KLE4 – MH and LINKS TO DA

16.12.1 Francis had reported anxiety, depression and stress related to drug use. Sally had diagnoses of both Paranoid Schizophrenia and Schizoaffective Disorder documented

[5] Unconscious bias | Administration and support services | Imperial College London

on clinical notes and a long history of polysubstance misuse which had historically played a role in a deterioration in her mental state.

16.12.2 SafeLives, in their report 'Safe and Well Mental Health & Domestic Abuse'[6] state:

We must respond to the mental health needs of those perpetrating abuse. Although most people with mental health needs will never be violent, evidence suggests having mental health problems is a risk factor for perpetrating domestic abuse. Mental ill health is never an excuse for perpetration of abuse, but building an understanding of the mental health needs of perpetrators can help services develop more effective interventions. Interventions aimed at targeting violent behaviour are less likely to be effective if mental health needs are ignored.

The report's key findings further note:

1. There is a strong association between having mental health problems and being a victim of domestic abuse. Mental ill health is also a risk factor for abuse perpetration.

2. Despite the strong association, domestic abuse often goes undetected within mental health services and domestic abuse services are not always equipped to support mental health problems.

3. Survivors with mental health problems are more likely to be experiencing multiple disadvantages. And perpetrators with mental health needs are more likely to have higher additional needs.

4. A range of trauma-informed services[7] must be available for survivors - and for those perpetrating abuse where these are required as part of appropriate challenge and support.

5. Inadequate progress by the UK Government and NHS leaders to drive integration of domestic abuse into the health sector is prolonging the period in which victims have no support, and perpetrators are left free to continue unchallenged.

6. Greater awareness of the relationship between domestic abuse and mental health within all organisations and the public will help people get the support they need faster.

Recommendation: All agencies to provide awareness to staff that there is a strong association between having mental health problems and being a victim of domestic abuse. Also, that evidence suggests having mental health problems is a risk factor for perpetrating domestic abuse.

---

6 https://safelives.org.uk/wp-content/uploads/Safe-and-well-Mental-health-and-domestic-abuse-spotlight-report.pdf

7 Working definition of trauma-informed practice - GOV.UK

16.13 Key Lines of Enquiry – KLE5. DISCLOSURE OF RELATIONSHIP STATUS WITHIN THE BENEFITS ARENA

16.13.1 There is no evidence that this was a barrier. The chair has also spoken with the panel members directly regarding this KLE. There is no evidence that this question was ever asked by Housing or would have been asked given the circumstances that presented. The panel acknowledge that in some relationships this could be a barrier when interacting with services but from the information that the review has seen it appears very clear that both Francis and Sally were quite open about their living arrangements including when they were both arrested by the police during this review period (for minor criminality), clearly to support addiction.

17. Conclusions

17.1 Francis's untimely death was a tragedy and has affected his family deeply. He was in a relationship for a short time with Sally of around 4 months. Both were well known to services and there were opportunities for intervention highlighted in this review: namely the report to the MPS in June 2022 regarding the home address of Sally, and then the incident on the 15 of July 2022 when the police were called, and Sally attended hospital with injuries. In approaching learning and recommendations, the Review Panel has sought to do two things. First, to try and understand what happened and consider the issues in Francis's life that might help explain the circumstances of his death. Second, to use this case to consider a wider range of issues locally, including provision for male victims of domestic violence and abuse.

17.2 The Review Panel would like to extend their sympathies to all those affected by Francis's death.

18. Learning Points

18.1 Information provided by the agencies involved in this review would appear to demonstrate that there are several themes that need to be considered because of Francis's death. There are various themes within the review; each of these have been explored during this process and the various learning points and recommendations are intended to support victims and survivors facing similar difficulties and challenges. In approaching these learning points and recommendations the Review Panel has sought to try and understand what happened and recognise the issues in the life of Francis. The themes identified are:

- Lack of professional curiosity.
- Unconscious bias.
- Visibility of male pathways.

18.2 However, if an agency has already introduced the learning into their practices as a result of the review process, then the need to include a formal recommendation in this review isn't deemed to be necessary.

19. Recommendations

Single Agency

Recommendation 1: MPS are to ensure officers understand the importance of swift positive action on reported behaviours around vulnerable persons' addresses.

Recommendation 2: CSP to refresh and relaunch a visible male pathway.

All Agencies

Recommendation 3: All agencies to ensure staff ask the same questions regarding safety in relationships of all individuals, no matter the gender of that individual.

Recommendation 4: All agencies to ensure that unconscious bias training is mandatory.

Recommendation 5: All agencies to provide awareness to staff that there is a strong association between having mental health problems and being a victim of domestic abuse. Also, that evidence suggests having mental health problems is a risk factor for perpetrating domestic abuse.

Version 3.1

APPENDIX 1

Action Plan - action plan is a live document and subject to change as outcomes are delivered

TO BE COMPLETED BY THE CHAIR OF THE REVIEW					TO BE COMPLETED BY THE RELEVANT AGENCY'S DHR PANEL MEMBER			
Rec. No.	Category of recommendation* according to Home Office choices	Recommendation (verbatim from the Overview Report)	What is the desired OUTCOME of this recommendation ? (What do we want the RESULT to be?)	How will we assess whether the desired OUTCOME has been achieved?	What are the ACTIONS or OUTPUTS necessary to achieve this result?	Who is responsible for completing this action and which agency do they work in?	Who will hold responsibility for reporting progress and ensuring the actions are completed. Which agency do they work in?	Proposed date of completion
1.	Local	**MPS are to ensure officers understand the importance of swift positive action on reported behaviours around vulnerable persons addresses**	To improve the quality-of-service delivery to vulnerable persons	Audit, Inspection and Review	• To ensure that risk is being identified and de-escalated where possible • To upskill staff in order that quality outcomes are secured for victims of crime • To support vulnerable people to live without fear and build trust with police	Governance and policy team	LRO for Domestic Abuse	Ongoing

2.	Local	**CSP to refresh and relaunch a visible male pathway**	To ensure that there are clear referral pathways for male victims of domestic abuse	Audit, Inspection and Review	• To ensure clear information on domestic abuse support available to male victims of domestic abuse is available on council's webpages • To ensure that training and awareness raising around domestic abuse highlights that domestic abuse can be experienced by males as well, and relevant referral pathways	Vulnerabilities manager, Community Safety Team at Richmond council	VAWG Strategic Delivery Group	Completed
3.	Local	**All agencies to ensure staff ask the same questions regarding safety in relationships of all individuals, no matter the gender of that individual.**	To ensure routine enquiry and safeguarding actions apply to all people, regardless of gender, sexuality or any other characteristics	Audit, Inspection and Review				
		Met Police			• To build trust and empower men to report domestic violence with confidence	Governance and policy team	LRO for Domestic Abuse	Ongoing

					• To understand the key factors men perceive as barriers when engaging with MPS officers when disclosing DA • To ensure staff have the knowledge and confidence to support all complainants of domestic abuse and seek lasting outcomes			
		Probation			This remains a key part of probation practice and all officers managing people on probation are trained to be inquisitive, ask questions and complete checks relating to relationships safety. Mandatory Domestic Abuse is required to maintain professional registration on a 3yr rolling basis.	Probation Service Learning and Development team.	Probation Head of Service	Complete - ongoing
		GP (Parkshot)			We have had whole practice IRIS training & became a registered IRIS practice on 5.12.24 – this highlighted the importance of asking the same questions to all individuals no matter the	Dr Claire Sillitoe	Dr Claire Sillitoe senior partner	Oct 2025

					gender. We will review this case in our next practice wide meeting to ensure all staff remain aware			
		GP (Sheen Lane)			Escalated by ICB			Ongoing
		Kingston & Richmond NHS Foundation Trust		Flag in 3B training (using a male example) share RE animation Future audit	Targeted RE as appropriate to service RE question should be in practitioner's own words Posters in ED, UTC and Community clinics re male DA 3B training example is male V/S	Adult SG	FB KRFT	30/09/2025

		Richmond Community Drug and Alcohol Service			All Staff and supervisors/ clinical leads have been reminded about this as an incident learning; specialist training was also provided to all staff; to be reviewed and reinforced during all relevant MDT meetings and supervision discussions; formal risk assessments do ask about harm from others regardless of gender	Borough Lead (Jane Eastaway) and all managers/ staff, RCDAS	Borough Lead	complete
		West London St Georges Mental Health Trust			Have undertaken audit to review whether routine enquiry questions are embedded in trust teams assessment frameworks. Have had them added where identified they weren't. Trust domestic violence adviser has designed specific training around routine enquiry and is in progress for delivering to all teams	Safeguarding team SWLSTG	Safeguarding team SWLSTG	Complete On-going

		Adult Social Care			To be implemented once 7 min learning is out	Dave Nwokedi ASC	Virindar Basi	Ongoing
		Richmond Housing Partnership			• To ensure information is collected via an initial report form. • To ask questions to capture detailed information.	All members of the Housing Services Team.	Housing Managers and Head of Service.	Completed
		Hestia			Information to be shared with all staff	Area Manager-Hestia	Director of Ops – Hestia	Completed
		SPEAR			SPEAR has Domestic Abuse training as a mandatory requirement for all staff across the services. This is annual and more frequent if there are any changes in legislation or practice.	SPEAR Learning and Development Coordinator	N/A	Completed
		Chelsea and Westminster hospital NHS foundation trust			The Trust DA training offers staff a framework for asking about safety in relationships. This framework is then adapted across different specialties. Routine enquiry on DA is implemented into sexual health services and maternity services across the Trust. In a health setting, it is	N/A	N/A	Completed/ Ongoing

					not feasible to ask all individuals the same questions around safety in relationships.			
		Richmond housing options			Officers have point of contact with specialist DA co-ordinator and mandatory training on Domestic Abuse including using Safe life checklist and IT system requires input and specific questions regarding risk. Training includes intersectionality which upskills officers to have awareness and pathways regardless of gender. Ensure that information and training is mandatory and updated. Offers have access to managers, DA coordinators, VAWG, Domestic Abuse Champions. Ensure that all officers are aware of DA resources available via dedicated SharePoint site and ensure officers are updated on forthcoming update of Councils DA policy	Homelessness and Sustainment Services Manager	Richmond Council Housing and Regeneration Housing Needs and assessments	Completed

4.	Local	**All agencies to ensure that unconscious bias training is mandatory**	To improve the quality-of-service delivery to vulnerable persons	Audit, Inspection and Review				
		Met Police			This training is included within the basic training offering for detectives. Elements are also included within other key areas. Expanding this to include all staff is under review	Governance and policy team	LRO – Domestic Abuse	Ongoing
		Probation			At Court, all reports have the mandated expectation of completion of the Effective Practice Framework 1 (EPF1) which removes bias in recommended proposals for sentencers. In the Community, all staff have mandatory completion of EPF2 which removes bias in licence conditions for those being released from prison. There are elements of unconscious bias that is intertwined with other mandatory training but no specific bespoke mandatory training.	Head of Service – Ayodeji Ogunyemi - Probation	Head of Service – Ayodeji Ogunyemi - Probation	Completed

		GP (Parkshot)			Unconscious bias training was included in our IRIS training, we will ensure this is reinforced at our next practice meeting & check to see whether there are any additional online training courses our staff can complete	Magda Nagadowska	Magda Nagadowska Practice Manager	October 2025
		GP (Sheen Lane)			Escalated by ICB			Ongoing
		Kingston & Richmond NHS Foundation Trust			Ensure included in DA training, poster campaign in Safeguarding Week. Explore with Education Centre what Unconscious Bias training we can offer	Adult SG	Frankie Butcher	31/09/2025
		Richmond Community Drug and Alcohol Service			This has been rolled out before for staff and again in July 2025. It was mandatory to attend. It is not yet confirmed as mandatory annually and we have to buy in an external trainer each year, so this is in progress	Borough Lead (Jane Eastaway)	Borough Lead	In progress

		South West London Integrated Care System			Will escalate to the regional lead in NHS England regarding implementing for West London St Georges Mental Health Trust.	Sian Carter – Jones ICB designate	Sian Carter – Jones ICB designate	January 2026
		Adult Social Care			Once 7 min learning is completed, will roll out to social workers and emphasis on safe relationships. Unconscious bias is part of Adult Social care training pack but is not mandatory, however other mandatory training incorporate this as such Trauma informed practice which is mandatory	Dave Nwokedi ASC	Virindar Basi	Ongoing
		Richmond Housing Partnership			Training offered by the MARAC will be mandatory for all Housing Services Staff.	All members of Housing Services Team.	Housing Services Managers and Head of Service.	Completed
		Hestia			Discuss with HR and ensure this is highlighted as mandatory training for all staff. Currently included in EDI training.	Area Manager Hestia	Director of Ops-Hestia	Completed

		SPEAR			Unconscious bias is a component of SPEAR's EDI training. This is mandatory and takes place annually or sooner if there are changes in legislation or practice.	SPEAR's Learning and Development Coordinator	N/A	Completed
		Chelsea and Westminster hospital NHS foundation trust			Unconscious bias training is already in place within EDI training which is mandatory.	N/A	N/A	Completed/ Ongoing
		Richmond housing options			Staff complete mandatory induction training which includes intersectionality with section on unconscious bias. Staff to undertake refresher training yearly as well as updates via DA newsletter and access to SharePoint DA site	DA Coordinator	Richmond Council Housing & Regeneration Housing Needs and Assessments	Completed

5.	Local	**All agencies to provide awareness to staff that there is a strong association between having mental health problems and being a victim of domestic abuse. Also, that evidence suggests having mental health problems is a risk factor for perpetrating domestic abuse**	To improve the quality-of-service delivery to vulnerable persons	Audit, Inspection and Review				
		Met Police			This factor forms part of the risk assessment process. The FLPDU are currently delivering training to all DA investigators throughout the MPS. Part of this training deals with mental health and associated risk/vulnerability	Governance and policy team	LRO Domestic Abuse	Ongoing
		Probation			Recent presentation by Community Mental Health Team which involved all staff in the Probation Delivery Unit (PDU) directly related to mental health, substance misuse and best practice re. partnership engagement for	Head of Service – Ayodeji Ogunyemi - Probation	Head of Service – Ayodeji Ogunyemi - Probation	Completed

					the person on probation. Ongoing engagement from this briefing/presentation to remain. Weekly presence and case discussions with mental health practitioners (from Together) held with officers to discuss management of those with Personality Disorder / Mental health issues.			
		GP (Parkshot)			This was included in our practice wide IRIS training which was completed in the last year, but will reflect on it as a practice at our next practice wide meeting	Dr Claire Sillitoe	Dr Claire Sillitoe Senior Partner	October 2025
		GP (Sheen Lane)			Escalated by ICB			Ongoing
		Kingston & Richmond NHS Foundation Trust			DA training to raise awareness. Not a causation or an excuse.Psych Liaison and Drug and Alcohol Liaison Nurse link with SGA to be increased (risk to self and others) Aim is to get Routine Enquiry into Psych Axs in ED	Adult SG	Frankie Butcher	31/03/2026

		Richmond Community Drug and Alcohol Service			Specialist training complete for staff and information on MARAC referrals forms part of staff induction	Jane Eastaway Borough Lead RCDAS	Jane Eastaway Borough Lead RCDAS	Complete
		West London St Georges Mental Health Trust			The link between mental health and DA to be added to trust DA Standard operating procedure on Domestic abuse. Also trust DA training incorporates this information into the training content.	Safeguarding team SWLSTG	Safeguarding team SWLSTG	On-going
		Adult Social Care			Once 7 min learning is completed, will roll out to social workers and emphasis on mental health being risk factor in Domestic abuse.	Dave Nwokedi	Virindar Basi	End of financial year
		Richmond Housing Partnership			• Source training which explores links between mental health and domestic abuse. • Roll out this training to all Housing Services staff.	All members of the Housing Services Team.	Housing Services Managers and Head of Service	Completed
6.		Hestia			Share learning from DHR in 6 weekly team meetings	Area Manager Hestia	Director of Ops - Hestia	Completed

7.		South West London Integrated Care System	GP forum Informing ICB via 7-minute briefing disseminated via comms Included in training completed by ICB to various agencies as necessary.	Evidence via minutes and comms information. Training packages can be shared.	7-minute briefing to be send via comms. In GP forum held September 2025 – designates to present link between MH and domestic homicide.	Sian Carter – Jones ICB designate	Sian Carter – Jones ICB designate	October 2025
		SPEAR			SPEAR has a robust Domestic Abuse identification process within our Assessment and Support Planning tool. This incorporates Mental Health also.	SPEAR	SPEAR	N/A
		Chelsea and Westminster hospital NHS foundation trust			The links between MH and DA are covered in DA training across the Trust, with tailored training provided annually for Liaison Psychiatry teams.	Trust DA Co-ordinator	Trust DA Co-ordinator	Completed/ Ongoing

		Richmond housing options			Safeguarding mandatory both training, refresher and practice. DA coordinator in role to ensure that officers have access to advice regarding complex and other DA cases and can assist in preparation of safeguarding referrals and safety planning Awareness via training that DA can have other safeguarding and complex facets which affect presentation of victim and perpetrators.	Homelessness and Sustainment Services Manager	Richmond Council Housing and Regeneration Housing Needs and assessments	Completed

APPENDIX 2

Terms of Reference

Domestic Homicide Review

1 Commissioner of the Domestic Homicide Review

1.1 The chair of the Richmond Community Safety Partnership has commissioned this review, following notification of the death of Francis.

1.2 All other responsibility relating to the review, namely any changes to these Terms of Reference and the preparation, agreement, and implementation of an Action Plan to take forward the local recommendations in the overview report will be the collective responsibility of the Review Panel.

1.3 The resources required for completing this review will be secured by the independent chair commissioned by Richmond Community Safety Partnership.

2 Aims of Domestic Homicide Review Process

2.1 Establish what lessons are to be learned from the death of SM regarding the way in which local professionals and organisations work individually and together to safeguard people in similar circumstances to those of SM.

2.2 Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

2.3 To produce a report which:

- summarises concisely the relevant chronology of events including:
  - the actions of all the involved agencies.
  - the observations (and any actions) of relatives, friends, and workplace colleagues relevant to the review.
- analyses and comments on the appropriateness of actions taken.
- makes recommendations which, if implemented, will better safeguard people experiencing domestic abuse, irrespective of the nature of the domestic abuse they've experienced.

2.4 Apply these lessons to service responses including changes to policies, procedures, and awareness-raising as appropriate.

3 Timescale

3.1 Aim to complete a final overview report by Feb 2024 acknowledging that drafting the report will be dependent, to some extent, on the completion of individual management reviews to the standard and timescale required by the independent chair.

4 Scope of the review

4.1 To review events up to the death of Francis. This is to include any information known about their previous relationships where domestic abuse is understood to have occurred.

4.2 Events should be reviewed by all agencies for 2 years preceding the death. However, if any agencies have any information prior to that they feel is relevant, then this should also be included in any chronology/IMR.

4.3 To seek to fully involve the family, friends, and wider community within the review process.

4.4 Consider how (and if knowledge of) all forms of domestic abuse (including the non-physical types) are understood by the local community at large – including family, friends, and statutory and voluntary organisations. This is to also ensure that the dynamics of coercive control are also fully explored.

4.5 Consider how (and if knowledge of) the risk factors surrounding domestic abuse are fully understood by professionals, and the local community – including family and friends, and how to maximise opportunities to intervene and signpost to support.

4.6 Determine if there were any barriers faced in both reporting domestic abuse and accessing services. This should also be explored against the Equality Act 2010's protected characteristics.

4.7 Whether organisations were subject to organisational change and if so, did it have any impact over the period covered by the DHR. In particular what were the effects of the Covid-19 pandemic on relevant organisations? Had it been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively.

4.8 Review relevant research and previous domestic homicide reviews (including those in Richmond) to help ensure that the Review and Overview Report is able to maximise opportunities for learning to help avoid similar deaths occurring in future.

5 Key Lines of Enquiry

5.1 The following themes have been prepared by the chair and discussed with the panel. Their purpose is to focus the review upon areas of learning and opportunities to improve service. They have been reviewed and discussed at various stages of this review.

1. Responding to crisis
2. Was gender a factor as SM was male and were interactions prejudiced by that factor.
3. Was addiction a barrier to support
4. MH and links to DA
5. Disclosure of relationship status within the benefits arena

6 Role of the Independent Chair

- Convene and chair a review panel meeting at the outset.
- Liaise with the family/friends of the deceased or appoint an appropriate representative to do so. *(Consider Home Office leaflet for family members, plus statutory guidance (section 6))*
- Determine brief of, co-ordinate and request IMR's.
- Review IMR's – ensuring that reviews incorporate suggested the outline from the statutory Home Office guidance (where possible).
- Convene and chair a review panel meeting to review IMR responses
- Write report (including action plan) or appoint an independent overview report author and agree contents with the Review Panel
- Present report to the CSP

7 Domestic Homicide Review Panel

7.1 Membership of the panel will comprise:

Name	Role/Job Title	Agency
Simon Steel	Independent Chair	Foundry Risk Management Consultancy LTD
Miranda Hibbert	Vulnerabilities Manager	Richmond and Richmond Community Safety Service
Albina Hiorns	Violence Against Women and Girls (VAWG) Manager	Richmond and Richmond Community Safety Service
Chris Ward	Author	Foundry Risk Management Consultancy LTD

Glen Atkinson	Specialist Crime Review Group (SCRG)	Metropolitan Police Service
Ayodeji Ogunyemi	Head of Service – Hounslow, Kingston and Richmond	Probation Service
Dr Andrew Smith	Safeguarding Lead	GP surgery
Francesca Butcher	Adult Safeguarding and MCA Lead Nurse, Best Interest Assessor	Kingston Hospital Foundation Trust
Jane Eastaway	Richmond and Wandsworth Addictions Borough Lead	Richmond Community Drug and Alcohol Service
Arlene Marshall	Clinical Service Lead; Richmond (Adults) Mental Health Teams	West London St Georges Mental Health Trust
Caroline McDonald	Service Manager, Mental Health	Adult Social Care
Jane Driver	Housing Advisor	Richmond Housing Partnership
Shola O'Grady	Head of Housing Services	Richmond Housing Partnership
Jocelyn Van Bruggen	Director of Domestic Abuse Services	Hestia
Sandie Cox	Safeguarding lead	Hounslow and Richmond community Healthcare
Peter Warburton	Designate Professional Safeguarding Adults Kingston	NHS South West London South West London Integrated Care System
Peter Bancroft	Richmond Integrated Team Leader	SPEAR
Jessica Whittock	Trust Domestic Abuse Co-ordinator	Chelsea and Westminster hospital NHS foundation trust

The above was confirmed at the second DHR Review Panel Meeting held on the 3rd of October 2023.

7.2 Each Review Panel member to have completed the DHR e-learning training as available on the Home Office website *before* joining the panel. (online at: https://www.gov.uk/conducting-a-domestic-homicide-review-online-learning)

8 Liaison with Media

8.1 Richmond Community Safety Partnership will handle any media interest in this case.

8.2 All agencies involved can confirm a review is in progress, but no information to be divulged beyond that.

8.3 Confidentiality

All panel members are bound by the agreed confidentiality agreement.

APPENDIX 3

Glossary of Terms

Adult Social Care	ASC
Clinical Commissioning Group	CCG
Community Mental Health Team	CMHT
Community Safety Partnership	CSP
Domestic Homicide Review	DHR
Domestic Abuse Stalking & Harassment and 'Honour'-Based Abuse	DASH
General Practitioner	GP
Individual Management Reviews	IMR
Mental Health Social Care Team	MHSCT
Multi-Agency Safeguarding Hub	MASH
Multi-Agency Risk Assessment Conference	MARAC
Opiate Substitution Treatment	OST
Threat Harm Risk Investigation Vulnerability Engagement	THRIVE*

APPENDIX 4

Home Office Quality Assurance Board letter

Home Office

Interpersonal Abuse Unit
2 Marsham Street
London
SW1P 4DF

Tel: 020 7035 4848

www.homeoffice.gov.uk

Albina Hiorns
Civic Centre
44 York Street
Twickenham
TW1 3BZ

14th May 2026

Dear Albina,

Thank you for submitting the Domestic Homicide Review (DHR) report (Francis) for Richmond Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Board. The report was considered at the QA Board meeting on 25th March 2026 I apologise for the delay in responding to you.

Please find the QA Board's feedback in the form below. On completion of the changes suggested the DHR may be published.

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter and the feedback form is published alongside the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Board letter and feedback form should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at DHR@domesticabusecommissioner.independent.gov.uk

On behalf of the QA Board, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,

Home Office DHR Quality Assurance Board

Version 3.1

DHR QA Board Feedback for the Community Safety Partnership

TITLE OF DHR	Francis
COMMUNITY SAFETY PARTNERSHIP	Richmond
DATE REVIEWED BY QA BOARD	25 March 2026
DECISION	Publish with amendments
GOOD PRACTICE COMMENDED	• There is a moving and heartfelt tribute from Francis' mother and friend. • Sincere condolences provided to family and friends of Francis in foreword and within the body of the report. • It is good practice that Respect was invited to join the panel to give subject matter expertise on male victims. • The Chair invested time and resources to travel to see Francis' mother which was commended. • This review has a well-developed focus on male victims of domestic abuse.
FEEDBACK FOR FUTURE DHRs	• Where suitable to the case, inviting a subject matter expert, as in this DHR, should be replicated in future reviews. • The Chair's personal visit to Francis' mother represents a positive and compassionate approach which should be replicated in future reviews.

	DHR SECTION	**DHR QA BOARD FEEDBACK (improvements required before publication)**
	Title Page	No amendments required.
1	Contents Page	Overview Report – please correct typo on Appendix 2.
2	Pen Portrait	No amendments required.
3	Condolences	Please consider moving these to earlier in the review.
4	Confidentiality and Anonymity	No amendments required.
5	Terms of Reference	No amendments required.
6	Equality and Diversity	No amendments required.
7	Background Information	No amendments required.
8	Combined Chronology	No amendments required.
9	Overview	No amendments required.
10	Analysis	No amendments required.
11	Conclusions	No amendments required.
12	Lessons learnt and recommendations	Please consider adding a review of all recommendations as seen in previous DHRs if possible.
13	Timescales	No amendments required.
14	Involvement of family / friends / community	No amendments required.
16	DHR contributors	No amendments required.
17	DHR Panel	No amendments required.
18	DHR Author	No amendments required.
19	Parallel Reviews	No amendments required.
20	Dissemination	No amendments required.
21	Action Plan	Please ensure the action plan is updated prior to publication.

22	Has there been a request to withhold publication? If Yes, include the reason for the request. Is it proportionate and appropriate?	No requests to withhold publication.
23	Any other comments	• Please correct typo in Section 7.6. • Please amend Home Office Quality Assurance Panel to Board throughout. • Please add 'honour'-based abuse to the DASH definition.

APPENDIX 5

Response to Home Office Quality Assurance Board letter

DARDR QA Board comment	Action
1.Contents Page Overview Report – please correct typo on Appendix	Report updated
3.Condolences - Please consider moving these to earlier in the review.	Report updated
12. Lessons learnt and recommendations - Please consider adding a review of all recommendations as seen in previous DHRs if possible	Action Plan has been added
21. Action Plan - Please ensure the action plan is updated prior to publication.	Action plan updated
23. Any other comments • Please correct typo in Section 7.6. • Please amend Home Office Quality Assurance Panel to Board throughout. • Please add 'honour'- based abuse to the DASH definition	Report updated