Richmond Community Safety Partnership

DOMESTIC ABUSE RELATED DEATH REVIEW

Executive summary

Case of Adult 'Francis'

Died: July 2022

Report produced by Author Chris Ward.

Chair Simon Steel Foundry Risk Management Ltd.

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1. THE REVIEW PROCESS

1.1 This summary outlines the process undertaken by the Richmond Community Safety Partnership (CSP), Domestic Homicide Review panel in reviewing the circumstances of the death of Francis who was a local resident at the time of his death.

1.2 The following pseudonyms have been in used in this review to protect their identities.

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

1.3 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.

1.4 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.

2. CONTRIBUTORS TO THE REVIEW

2.1 Agencies were asked to check for their involvement with Francis and Sally and to secure their records. The approach adopted was to seek Individual Management Reviews (IMRs) for 6 agencies that had contact directly or indirectly with Francis and/or Sally with the exception of the Richmond Housing Trust, where a short report was requested.

2.2 The following agencies who had contact and their contributions are shown below.

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 options	Chronology
Richmond Housing Partnership (RHP)	Chronology & Report
Outreach (SPEAR)	Chronology

2.3 The IMR's were prepared by authors who were independent of any service delivery or case management regarding Francis and Sally.

2.4 The authors and panel members assisted the panel further, with one-to-one meetings and answering follow up questions as necessary.

3. THE REVIEW PANEL MEMBERS

3.1 The review panel members included the following agency representatives.

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

3.2 The review panel met on 4 occasions.

3.3 Agency representatives were of appropriate level of expertise and were independent of the case.

4. CHAIR & AUTHOR OF THE OVERVIEW REPORT

4.1 The Chair of the Review was Simon Steel. Simon has completed his Home Office approved training and has attended training by Advocacy After Fatal Domestic Abuse. He completed 20 years-service with Thames Valley Police retiring at the rank of Detective Superintendent. During his service he gained significant experience in response to Domestic Abuse, Public Protection and Safeguarding.

4.2 Simon has no connection with the Richmond Community Safety Partnership, or any agencies involved in this case.

4.3 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.

4.4 Chris has no connection with Richmond Community Safety Partnership, or any agencies involved in this case.

5. TERMS OF REFERENCE FOR THE REVIEW

5.1 The primary aim of the DHR was defined as examining how effectively Richmond's statutory agencies and Non-Government Organisations worked together in their dealings with Francis.

5.2 The purpose of the review is specific in relation to patterns of Domestic Abuse and/or Coercive Control, and will:

- Conduct effective analysis and draw sound conclusions from the information related to the case, according to best practice.
- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic violence including their dependent children.
- Identify clearly what lessons are both within and between those agencies. Identifying timescales within which they will be acted upon and what is expected to change as a result.

- Apply these lessons to service responses including changes to policies and procedures as appropriate; and
- Contribute to the Prevention of Homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.
- Highlight any fast-track lessons that can be learned ahead of the report publication to ensure better service provision or prevent loss of life.

5.3 Case specific key lines of enquiry included the following:

- Responding to crisis
- Was gender a factor as Francis was male and were interactions prejudiced by that factor.
- Was addiction a barrier to support
- MH and links to DA
- Disclosure of relationship status within the benefits arena.

6. SUMMARY CHRONOLOGY

Family Perspective June (Francis's Mother)

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 mum 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.

Perpetrator Perspective Sally

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
- Also is there 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, 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.

Metropolitan Police Service – MPS

6.11 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.

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

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

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

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

Probation Service – PS

6.16 Francis had an extensive history of being both homeless and significant Class A drug use. Both areas 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.

6.17 During his extensive probation review, it is clear that Francis rarely engaged with the PS. There are no records of interaction between Sally and the PS within the review period.

Richmond Community Drug and Alcohol Service - RCDAS

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

6.19 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.

6.20 Sally had been in treatment with RCDAS since April 2020

6.21 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.

6.22 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.

Kingston Hospital Foundation Trust - KHFT

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

6.24 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.

Doctors Surgery – GP

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

6.26 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.

Southwest London St George's Mental Health Trust – MHT

6.27 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.

6.28 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 friend, smoked heroin on foil, sniffed, then smoking on a pipe.

Richmond Housing Partnership- RHP

6.29 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.

6.30 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.

7. CONCLUSIONS AND KEY ISSUES ARISING FROM THE REVIEW

7.1 Tragically it has not been possible to build a picture from Francis's perspective. The review has had to rely on anecdotal reports collated by involved agencies. However, the review has been fortunate that that Francis's mother has shared valuable insights with the chair.

KLE1- RESPONDING TO CRISIS

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

KLE2 – WAS GENDER A FACTOR AS FRANCIS WAS MALE AND WERE INTERACTIONS PREJUDICED BY THAT FACTOR

7.3 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 has seen evidence that Francis was, when in one other relationship. The review has seen evidence of Sallys 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.

7.4 Sally was explicitly asked if she felt safe in the new relationship during a key worker contact with RDAS; Francis was not. The panel have considered this as an example of gender bias however believe it was unconscious bias. Unconscious bias as described[1] 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 thoughts when dealing with a male service user were apparent in this review.

7.5 The panel accept the research identified regrading 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 lens (SME) lens for male victims. The lack of visible male pathways has been highlighted by the panel and the service offer for males need 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 Francis was given less opportunities to be heard.

KLE3 – WAS ADDICTION A BARRIER TO SUPPORT

7.6 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 disclose challenges in the relationship, than perhaps people without those challenges in their lives. 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 with the challenges

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

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.

KLE4 – MH and LINKS TO DA

7.7 Francis had reported anxiety, depression and stress related to drug use. 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.

7.8 SafeLives in the report Safe and Well Mental Health & Domestic Abuse[2] report:

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.

Also, in the reviews key findings it reports:

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[3] 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.

KLE5. DISCLOSURE OF RELATIONSHIP STATUS WITHIN THE BENEFITS ARENA

7.9 There is no evidence that this was a barrier. The chair has also spoken with the panel member 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 form the information that the review has seen it appears very clear that both Francis and Sally were quite open about their living arrangements

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

[3] Working definition of trauma-informed practice - GOV.UK

including when they were both arrested by the police during this review period (for minor criminality) clearly to support addiction.

8. LESSONS LEARNED

8.1 Francis's untimely death was a tragedy and has affected his family deeply. He was in a relationship for a short time with Sally, 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.

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

8.3 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.

9. 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.