Domestic Homicide Review
Executive Summary

Under s9 of the Domestic Violence, Crime and Victims Act 2004

Review into the death of Rachel
in August 2018

Report Author: Christine Graham
July 2020

Preface

The Safer Brent Partnership and the Review Panel wish at the outset to express their deepest sympathy to Rachel's family and friends. This review has been undertaken in order that lessons can learned; we appreciate the support and challenge from her family throughout the process.

This review has been undertaken in an open and constructive manner with all the agencies, both voluntary and statutory, engaging positively. This has ensured that we have been able to consider the circumstances of this incident in a meaningful way and address with candour the issues that it has raised.

The review was commissioned by the Safer Brent Partnership on receiving notification of the death of Rachel in circumstances which appeared to meet the criteria of Section 9 (3)(a) of the Domestic Violence, Crime and Victims Act 2004.

Contents

Section One – The Review Process

1.1 Introduction and agencies participating in the Review

1.1.1 This summary outlines the process undertaken by the Safer Brent Community Safety Partnership Domestic Homicide Review Panel in reviewing the death of one of its residents. The death occurred in August 2018.

1.1.2 The victim was Rachel, aged 43, a Black Jamaican woman who was killed at her home by a man with whom she was in a fledgling relationship. He was a Black African man who was 40 years old. He pleaded guilty to her murder in December 2018. He pleaded not guilty to murder but offered a plea of guilty to manslaughter. He was tried and found guilty of her murder. He was sentenced to life imprisonment with a term of at least 21 years to be served before he could be considered for parole.

1.1.3 At just after noon on a Wednesday in mid-August 2018, police received a call from the brother of the perpetrator in this case, in which he said that he had been telephoned by his brother who said that he had killed his girlfriend.

1.1.4 One minute later, the perpetrator himself called the police saying that he had killed his girlfriend, Rachel, by cutting her neck. During the call he initially told the police that he was armed with a knife and a gun; in the same call he later retracted that he had possession of a gun.

1.1.5 Armed police, supported by uniform emergency response officers attended the address. The perpetrator, on direction of the police, came out of the address without resistance and was arrested.

1.1.6 Rachel was found in the bedroom of the flat. She had stab wounds to her neck and multiple stab wounds to her face and legs. Despite attempts by the London Ambulance Service and Helicopter Emergency Medical Service, Rachel was pronounced dead at the scene.

1.1.7 The subsequent post-mortem determined that the cause of death was an incised and stab wound to her neck. She was also stabbed through the left side of her neck, through the jugular. There were superficial stab wounds to her head and defensive wounds to both of her hands.

1.1.8 Safer Brent Community Safety Partnership was notified by the death by the Metropolitan Police Service in a timely way. On 10th September 2018, a multi-agency Domestic Homicide Review (DHR) meeting and the decision was taken to undertake a DHR. The Home Office was notified on 4th October 2018 that the Community Safety Partnership intended to undertake a review.

1.1.9 The Safer Brent Partnership's standard process would be to notify the victim's family via the Family Liaison Officer of the intention to complete a DHR at the same time as notifying the Home Office. Unfortunately, due to a restructure of the Community Protection Team and significant staffing changes between November 2018 and March 2019 the partnership is unable to confirm when and whether contact was made with the family during this time. In order to avoid recording gaps occurring in the future, Brent Council has recently purchased

the ECINS Case Management System to record current and future Domestic Homicide Reviews. This not only allows a consistency in the management of the DHR process and all related communications but also provides a secure location for the safe storage and processing of information related to the reviews.

1.1.10 Rachel's mother met with the Chair and Report Author, supported by the Victim Support Homicide Service on two occasions. She also attended the Review Panel.

1.1.11 An independent Chair and Report Author were appointed, and the Review Panel met for the first time on 15th April 2019.

1.1.12 The final meeting of the Review Panel was in September 2020 to finalise the report and the findings therein, and consider the actions needed to address the recommendations.

1.1.13 The review was not completed within six months as it could not commence, in full, until after the criminal process and it took time to gather information from the different medical organisations. This process was further delayed due to the Covid 19 lockdown as the Chair and Report Author were waiting to meet with the perpetrator.

1.1.14 The following individuals and agencies contributed to the review:

- Rachel's mother
- London Borough of Brent
- Metropolitan Police Service Service -Individual Management Review
- Camden and Islington NHS Foundation Trust – Serious Incident Investigation Report
- South West London and St George's NHS Trust – Individual Management Report
- GP for perpetrator – Summary Report
- GP for Rachel
- Chelsea and Westminster Hospital – Summary Report
- Guy's and St Thomas' Hospital – Rachel's employer – Summary Report

1.1.15 The perpetrator was approached by the Chair and Report Author and after a delay caused by the Covid lockdown, met remotely with the Chair and Report Author, supported by his offender manager.

1.2 Purpose and Terms of Reference of the Review

1.2.1 According to the statutory guidance, the purpose of the Domestic Homicide Review is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims
- 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
- Apply these lessons to service responses including changes to policies and procedures as appropriate

- Prevent domestic violence and homicide and improve service responses to all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest possible opportunity
- Contribute to a better understanding of the nature of domestic violence and abuse
- Highlight good practice

1.2.2 The Review Panel agreed that the specific purpose of the Review is to:

- Establish the facts that led to the incident and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard the family.

- Identify what those lessons are, how they will be acted upon and what is expected to change as a result.

- Establish whether the agencies or inter agency responses were appropriate leading up to and at the time of the incident, suggesting changes and/or identifying good practice where appropriate.

- Establish whether agencies have appropriate policies and procedures to respond to domestic abuse and to recommend any changes as a result of the review process.

1.2.3 The scope of the Review, as agreed by the Review Panel, is to:

- Draw up a chronology of the involvement of all agencies involved in the Rachel to determine where further information is necessary. Where this is the case, Individual Management Reviews will be required by relevant agencies defined in Section 9 of the Domestic Violence, Crime and Victims Act 2004 (revised 2016).

- Produce Independent Management Reviews (IMRs) for a time period commencing 1st January 2012.

- Invite responses from any other relevant agencies, groups or individuals identified through the process of the review.

- Seek the involvement of family, employers, neighbours & friends to provide a robust analysis of the events.

- Produce a report which summarises the chronology of the events, including the actions of involved agencies, analyses and comments on the actions taken and makes any required recommendations regarding safeguarding of individuals where domestic abuse is a feature.

- Aim to produce the report within the timescales suggested by the Statutory Guidance subject to:
    - guidance from the police as to any sub-judice issues,

- sensitivity in relation to the concerns of the family, particularly in relation to parallel enquiries, the inquest process, and any other emerging issues.

Section Two – Agency contact and information learnt from the Review

2.1 A Domestic Homicide Review is charged with looking for a trail of domestic abuse within the relationship of the victim and perpetrator. The information that has come to this review leads us to ask a much more fundamental question which is 'were Rachel and the perpetrator in a relationship at the time of her death?'

2.2 In the weeks leading up to Rachel's death, the perpetrator was receiving Cognitive Behavioural Therapy from the Veterans' TIL service. He saw the psychologist three times in April, four times in May, twice in June, three times in July and twice in August before being discharged from the service. He never disclosed that he was in a relationship and described that he was having dates with people.

2.3 The perpetrator told the murder trial that he had met Rachel in 2017 or 2018 but he could not remember. He said that they met on Tinder and messaged for a couple of weeks before they met. He said that they had a physical relationship for a couple of months before they broke contact. He said that they had an argument and he stopped seeing her in March 2018. Whilst we cannot be certain what this argument was about, we do have the text messages between Rachel and the perpetrator from the beginning of July.

2.4 These tell us that he, out of the blue, made contact with Rachel at the beginning of July. She said that she was surprised to hear from him as he had told her that she acted like she was perfect and then blocked her. She then made reference to the fact that he has contacted her and apologises. She sent a message saying, 'I am not upset with you. Take care of yourself' which implies that she was ending the conversation. The perpetrator then engaged her in conversation and said that he wants to see her. She said she is wary, 'once bitten'. He tried to persuade her, and she made it very clear that she did not want to 'take another risk' on a relationship with the perpetrator.

2.5 Over the next few days, he messaged her a number of times, seeking to rekindle the relationship. He asked her for some pictures, and she refused. She then did not hear from him for another ten days, when she sent him a message asking how he was. He suggested that she went to his, but she said she was working, but she did ask him if he wanted to go to her flat. There were then a number of voice calls and Rachel sent a message to say, 'you did not let me know if you got in OK', which implied that they had met. A few days later Rachel made it very clear that at that point in time she did not trust him and that, if they were to have a relationship, she needed to trust him

again. He then appears to have got cross and she pointed out that he had come looking for her.

2.6 In his sentencing remarks, the judge said that the text messages that she sent showed her as a 'warm, concerned but cautiously and sensibly responsible young woman'.

2.7 On 1st August Rachel told the perpetrator that she had booked Sky Gardens if he wanted to go. They then met again on 4th August. In the texts there was a suggestion that he might be upset about not having stayed over at her flat. On 7th August he asked her when they were going to meet again. There were then a number of messages in which the perpetrator is sexually suggestive, and Rachel replied by saying, 'I'm actually not even smiling right now'. She then went on to say that she had wanted to start off differently to last time. She said, 'show me that you can be a sweetheart and a gentleman'.

2.8 They continued to exchange messages and on 10th August Rachel suggests that they could meet up at the weekend and she suggests some BBQs and parties that they might go to. On 12th August, Rachel told the perpetrator that the time of the party had been changed but there is nothing to indicate that they met up at this time. Later that day, the perpetrator asked Rachel to go to his flat and she agreed. At 1.20 am on 13th August she let him know that she had arrived home safely.

2.9 On 14th August Rachel asked the perpetrator if she should go to his flat when she finished work or leave it for another day. He agreed and she replied to say that if she left work late, she would not go. However, the next morning she messaged just after 8 am to say that she was on her way.

2.10 Rachel's colleague told the review that she had told them nothing about this new relationship or even indicate that she was thinking of beginning a relationship. This was unusual as she did talk to her colleagues about her personal life. For example, she had told her colleagues about her son and the circumstances of his death.

2.11 Rachel's mother told the review that she knew nothing about Rachel seeing the perpetrator until she was told of her death. She is adamant that if they had been 'girlfriend and boyfriend' Rachel would have told her or her sisters.

2.12 Whilst the review accepts that there were voice calls between Rachel and the perpetrator, the content of which we cannot know, the review believes that, as does her mother, that Rachel was cautious about rekindling this relationship and that she was taking it slowly. They may have been in the early stages of a relationship but that was as far as it had gone.

2.13 The perpetrator agreed to meet with the Chair and Report Author and this issue was specifically explored with him. He was very clear that they were in the early stages

of a relationship. They were 'not at the stage where they were a couple' and that they had met up a couple of times and been out a couple of times.

2.14 Therefore, the review, having considered all aspects of domestic abuse, is not able to identify a trail of abuse in a relationship that was not yet established.

Section Three – Key issues arising from the Review

3.1 **The perpetrator's mental health**

3.1.1 We know, from the judge's sentencing remarks, that the perpetrator had a history of depressive illness that stretched back to his teenage years. In his early twenties, he tried to cut his own throat and concealed his mental ill-health when he enlisted in the army in 2002. In March 2010 he had spent 20 days in a psychiatric hospital and, shortly after being discharged, he had attempted to strangle his mother. He was medically discharged from the army in 2012 because of his ill-health. This was not known to agencies treating him in later years.

3.1.2 The perpetrator continued to suffer from depression, anxiety and PTSD to varying degrees over the time considered by this review. The review notes that the perpetrator was economical in the information that he shared with those carrying out assessments. He did not tell anyone about the mental health struggles that he had in early life. He also withheld this information when he applied to join the army.

3.1.3 This tendency to only share what he wished was evident when the perpetrator met with the Chair and Report Author. He maintained that he had bipolar disorder, post-traumatic stress disorder and depression 'as a result of being in Iraq'. When he was asked about his mental health difficulties prior to his time in the army, he denied that he had any such issues.

3.1.4 The review considered his access to treatment and found that he received assessment and treatment in line with the guidance for veteran's care.

3.1.5 The review considered the deterioration in the perpetrator's mental health in the days leading up to Rachel's murder and given that the perpetrator had been discharged by the specialist mental health service and was reporting to the GP only that he was experiencing difficulty sleeping and low mood, the review considers that any decline in his mental health was not evident to those who saw him.

3.2 **The perpetrator as a perpetrator of domestic abuse**

3.2.1 There is no doubt that the violence used to kill Rachel was not an 'isolated incident'. We know from his history that the perpetrator was known to use extreme violence on previous occasions. The review is aware that, in the past, he had tried to strangle his estranged wife.

3.2.2 Monkton-Smith has found that certain violence is more dangerous than others, not only in the serious injury that it causes but also in what it predicts. Research studies have shown

that strangulation is dangerous and highly predictive of future homicide (Schwartz, 2010)[1]. It is important that we remember that strangulation is a powerful symbolic act of control, and a very real threat to life[2].

3.2.3 Whilst we do not have evidence to suggest that the perpetrator attempted to strangle Rachel, what we do have the evidence to suggest is that he is a man who feels *entitled* to use violence when his wishes or desires are not met. His mother was not fitting in with his plans for the day, his estranged wife would not let him see his child when he wanted, she would not act affectionately towards him when he wished. This leads us to ask, 'what was it that Rachel would not do that he wanted?' The judge, in her sentencing remarks, was very clear that the perpetrator wanted to have sex with Rachel but that she was hesitant.

3.2.4 This review has sought to try to understand the speed with which this relationship progressed to murder. Given the early stages of the relationship between Rachel and the perpetrator, her murder may be considered to be a 'crime of passion' homicide characterised by spontaneous and unpredictable violence motivated by something the victim has done, and which is perceived by the perpetrator to be intolerable[3]. Monckton-Smith cited the research undertaken by Lees (1997) of Old Bailey trials in which he identified three key behaviours sanctioned as bad enough to potentially produce justifiable fatal violence. These were nagging, infidelity and rejecting the gendered order[4]. The review suggests that Rachel's reluctance or refusal to have sex with the perpetrator, in his eyes, was rejecting the gendered order – that he was entitled to have sex with her.

Section Four – Recommendations

4.1 **Ministry of Defence**

4.1.1 That the Ministry of Defence identifies a role within the organisation that would act as single point of contact for future DHRs and that this role is sufficiently briefed about the importance of DHRs.

4.2 **Metropolitan Police Service Service (MPS) - BCU Level South West Basic Command Unit (SWWBCU)**

4.2.1 That SWBCU Senior Leadership Team remind officers that they are to complete the required five-year intelligence checks for Domestic Abuse incidents. This should include mandatory searches of databases including PNC, CRIS, MERLIN and CRIMINT ensuring that the intelligence check results are recorded on the CRIS report.

4.2.2 That SWBCU Senior Leadership Team monitor compliance of completed intelligence checks by dip sampling DA flagged CRIS reports**.**

[1] Cited in Domestic Abuse, Homicide and Gender, Monckton-Smith et al, Palgrave Macmillan, 2014
[2] Monckton-Smith et al, Domestic Abuse, Homicide and Gender, Palgrave Macmillan, 2014
[3] Monckton Smith, Jane ORCID: 0000000179255089, (2019) Intimate Partner Femicide: using Foucauldian analysis to track an eight stage relationship progression to homicide, Violence Against Women. ISSN 10778012 (In Press)
[4] Monckton Smith, Jane ORCID: 0000000179255089, (2019) Intimate Partner Femicide: using Foucauldian analysis to track an eight stage relationship progression to homicide, Violence Against Women. ISSN 10778012 (In Press)

4.3 **Department of Health**

4.3.1 That the Department of Health continues to remind primary care providers of the requirement to co-operate with Domestic Homicide Reviews.

4.4 **Clinical Commissioning Group**

4.4.1 That the CCG raises awareness of the process of engaging primary care in the learning from this review to ensure that each practice can consider the implications and actions to promote ongoing professional development in this area[5].

4.5 **Camden and Islington NHS Foundation Trust**

4.5.1 That formal consideration of risk should take place, not only at the initial assessment but at any review of treatment and at the end of treatment. This would ensure clear documentation of the risk assessment process.

4.5.2 That if people are referred from a source other than a GP, then there should be an automatic request to the GP for background information. Information from other sources will be requested depending on individual circumstances.

4.5.3 That the Trust should explore whether trainee psychologist entries in electronic clinical records should be validated by their supervisor and the technological feasibility of doing this.

4.6 **South West London and St George's NHS Trust**

4.6.1 That all Talk Wandsworth clinicians are reminded of the NHS England guideline and the commitment of the service to prioritise war veterans for treatment at Steps 2 and 3 thereby ensuring minimal waiting times for clients in this group.

4.6.2 That when veterans or other clients report at the telephone triage or any point during treatment that they have recently stopped or changed their medication, the resulting changes in symptomatology (eg re-emergence of sleep patterns) should be explored and reviewed with the client and their GP should be made aware via a telephone call or letter. In instances when a client reports a significant re-emergence of depression and anxiety symptoms following the discontinuation of or changes to their medication regime, a referral to a secondary care psychiatrist for a medication review should be considered and discussed with the GP.

4.7 **Brent Community Safety Partnership**

4.7.1 That Brent Community Safety Partnership reviews its engagement with faith groups in the area and identifies where relationships could be strengthened.

[5] It is noted that some of this work will be included as part of the IRIS programme and training platforms with participating practices

6.7.2 That Brent Community Safety Partnership works with the Clinical Commissioning Group to ensure that there is clarity about the engagement of primary care with Domestic Homicide Reviews.

Section Five – Conclusions

5.1 The victim in this case was only 31 years old when her life was tragically ended by a vicious, unprovoked attack by this perpetrator.

5.2 She had given years of selfless service to others through her nursing and had suffered the tragedy of losing her only child to illness only few years previously.

5.3 She met this perpetrator via an internet dating app at a time when she wanted a stable relationship with a potential new partner. Much of their relationship building was carried out over text and they met only a few times in person.

5.4 The development of this relationship, such as it was, highlights how life has changed in the way that relationships develop, given the reliance upon social media as a primary means of communication. The inherent dangers in developing a relationship in this way are clearly exemplified by this awful case.

5.5 The perpetrator in this case had suffered from what he had seen and experienced as a member of Her Majesty's Armed Forces. However, he lied about his past when joining those forces. When he left, undoubtedly suffering from some form of Post-Traumatic Stress Disorder, he did seek help through his GP and specialist services. They did their best for him, but he was again economical with his disclosures and became reliant upon someone to listen to him.

5.6 There is only one person to blame for the death of Rachel, and that is this offender.