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DOMESTIC ABUSE RELATED DEATH REVIEW: EXECUTIVE SUMMARY

Report into the homicide of Pearl June 2024

SAFER KENSINGTON & CHELSEA PARTNERSHIP

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November 2025

It is difficult to put into words the impact that Pearl's tragic death has had on her family, friends and local community.

Nobody has felt the loss of Pearl more than her elder sister who recently lost her mobility following a fall. Pearl provided her with unstinting support, often sleeping for several days on her couch to be there on call. Nothing was too much trouble for her – shopping, cooking, prescriptions, arranging medical appointments – the list goes on. She became her life coach, encouraging her to have physio, eat healthily and get her hair and nails done. Her sister is still coming to terms with losing Pearl and still finds it difficult to even look at a photo of her without getting upset.

Her younger brother has lost somebody he could always confide in to get advice and support. She opened up his first bank account, helped with his various house moves and regularly sent him information on healthy living. Small things maybe but it feels a big loss, nothing was too much trouble for Pearl.

She was proud of the achievements of her two nephews and niece and would love hearing about them and getting photos. Pearl left quite a collection of photo albums and certificates.

Pearl was the life and soul of any event and had a wide range of friends.

She was particularly close to a group of Australian ladies whom she had known for nearly 50 years… they spoke and messaged most nights via social media.

Pearl was a passionate member of her community and willingly volunteered at various events. We often told her to pace herself and not wear herself out. She was nursing an injured foot, but put off the operation, so she could continue to help others.

She also helped out at a local wheelchair dancing club and could be seen putting her heart and soul into it. Pearl loved music and needed no excuse to dance.

This will forever leave a lasting hole in our lives, and we will miss Pearl dearly.

Pearl's brother

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Contents

Contents	Page
Glossary	3
Preface	4
Introduction	4
Overview	5
Summary of the incident	5
Summary of agency contact	5
Parallel Reviews	6
Domestic Abuse Related Death Review Panel	8
Independence	8
Terms of Reference and Temporal Scope	10
Confidentiality	11
Dissemination	11
Methodology	12
Narrative chronology	12
Key findings	18
Recommendations	22
Conclusion	22

Glossary

ASB: Anti-Social Behaviour

ASC: Adult Social Care

CGL: Change Grow Live

CNWL: Central and North West London NHS Foundation Trust

DARDR: Domestic Abuse Related Death Reviews

ICB: Integrated Care Board

IMR: Individual Management Review

LAS: London Ambulance Service

NHG: Notting Hill Genesis

RB: Royal Borough

RBKC: Royal Borough of Kensington & Chelsea

SUT: Substance Use Team

VAWG: Violence Against Women and Girls

DARDR into the homicide of Pearl[1]

Preface

[1] This is a pseudonym

The Independent Chair and the DARDR Panel members offer their deepest sympathy to all who have been affected by the death of Pearl, and thank them, together with the others who have contributed to the deliberations of the Review, for their participation, generosity, and patience.

1. Introduction

1.1 Domestic Abuse Related Death Reviews (DARDRs)[2] were enacted in April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act states that a DARDR should be a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by (a) a person to whom he / she was related or with whom he / she was or had been in an intimate personal relationship or (b) a member of the same household as himself / herself with a view to identifying the lessons to be learnt from the death.

This report uses the statutory definition of domestic abuse set out in the Domestic Abuse Act 2021.

1.2 The purpose of a DARDR 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 inform national and local policies and procedures as appropriate; prevent domestic violence and homicide and improve service responses for 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 opportunity; contribute to a better understanding of the nature of domestic violence and abuse and highlight good practice[1].

1.3. The chair of the Safer Kensington and Chelsea Partnership Board was formally notified by the Police on 5th July 2024 of a death which they believed met the definition of a domestic homicide under the Domestic Violence, Crime and Victims Act, 2004. The Safer Kensington and Chelsea Partnership Board met on 23rd July 2024 and agreed that a DARDR should be commissioned. The Home Office were duly notified.

1.4. An independent Chair was appointed in August 2024 and the victim's family informed.

1.5. The Panel met for the first time in September 2024. Further meetings of the Panel were held in December, January and February 2025 after which time the process was suspended to wait for criminal proceedings to conclude. Contact with Pearl's friends in Australia also occurred post-trial and these took a few weeks to set up. A draft copy of the final report was circulated in September and the Panel met for a final time in October 2025 to agree the wording of the final report.

1.6. The DARDR process concluded in November 2025.

1.7. Safer Kensington and Chelsea Partnership has undertaken four previous DARDRs. Each of these were reviewed to ascertain if there was any overlap

[2] Previously known as Domestic Homicide Reviews

in terms of issues identified and lessons learned. Alcohol was a significant feature in one of them but in very different ways to this DARDR.

2. Overview

2.1. Persons involved in this DARDR

Pseudonym used	Who	Age at the time of the incident	Ethnicity
Pearl	Victim	70	White British
Raymond	Perpetrator / ex-boyfriend	57	White British
Australian friend 1	Longstanding friend of the victim	n/k	White Australian
Australian friend 2	Friend of the victim	n/k	White British

2.1.2 Address 1 is where Pearl lived and died.

2.1.3 Address 2 is where Raymond lived.

2.2. Summary of the incident

2.2.1. Pearl and Raymond met around 14 months before her death. They both lived in West London, approximately 25 minutes' walk apart. Early one Sunday morning towards the end of June 2024, Raymond made a 999 call, stating he had concerns about his partner, Pearl.

2.2.2 Police and ambulance services attended address 1 and found Pearl deceased in her overflowing bathtub. She was dressed in a nightgown, which was on backwards.

2.2.3 Concerns were quickly raised about the sequence of events as described by Raymond as to how he had come to find Pearl. For example, in the 999 call he had said that he had looked through her letterbox when there was no reply and had seen her motionless on her bed. This was obviously factually inaccurate since when the officers gained access to the property, they looked through the letterbox that he purported to have looked through, and there were no signs of any person in the bed. It could be seen quite easily, as the bedroom was directly in the line of sight from the front door. Doubt would later be expressed in court that Raymond was even agile enough to have been able to bend down enough to see through the letter box.

2.3.4 Other aspects of Raymond's account didn't appear to make much sense. As a result of the very confusing picture he gave, he was arrested on suspicion of murder. He was taken to a nearby police station and interviewed about what had happened.

2.3.5 The investigation was able to quickly establish that the cause of death was drowning involving a third party, that is, she had not accidentally slipped in the bath. Pearl had extensive bruising to her back and ribs as if she had been forcibly held down. She had also consumed an excessive amount of alcohol prior to her death.

2.3. Summary of agency contact.

2.3.1 Each agency's involvement with Pearl and Raymond is summarised in the table below.

Agency name	Summary of involvement
Adult Social Care (ASC)	Adult Social Care's involvement with Pearl was limited and took place in three distinct periods. There was some occupational therapy support in 2018; hospital discharge planning and reablement support in the winter of 2020/21 (the most involved episode of care); and some brief contact in April 2024 about the possibility of reablement support after foot surgery planned for May 2024. ASC were first made aware of Raymond in the early stages of COVID lockdown. In April 2020, he was struggling financially and emotionally with the effects of the lockdown. Practical support was given, particularly in relation to foodbanks, and support was offered in relation to his expressions of suicidal thoughts, and the stresses of caring for his very ill father. In 2020/21, Raymond was supported by the substance use team (SUT) because of excessive alcohol use, and from later 2021 until the summer of 2024, ASC had sporadic contact as concerns were received about his drinking, altercations to which the police were called, and his suicidal thoughts. These concerns were typically passed to mental health colleagues.
Age UK Kensington and Chelsea	Pearl received support from Age UK Kensington and Chelsea's foot care clinic as well as attending activities and events.
Foreland Medical Centre	Raymond was a registered patient at the practice until May 2022. He consulted on a number of occasions with physical and mental health problems
Imperial College Healthcare NHS Trust	Emergency care given to Pearl along with an admission and also outpatient appointments. The admission was alcohol related and a package of care required for discharge. Raymond accessed emergency care only and self-discharged on all occasions.
London Ambulance Service NHS Trust (LAS)	In the temporal scope of the review, LAS had contact with Raymond on 25 occasions and with Pearl once. Raymond presented under the influence of alcohol with a long-standing history of alcohol abuse, he often referred to drug use (heroin) and mental health issues. On most occasions he was conveyed to hospital. The only contact with Pearl was following the incident when she was found deceased. Towards the end of 2023, Pearl was mentioned by Raymond on some contacts with him although she was not on scene when LAS attended.
Notting Hill Genesis	NHG housed Raymond for four years from 2021 until 2024. During this time, he occupied various different properties as he needed to be decanted for repair works to his flat. He often

	presented himself to NHG as under the influence, mentally unstable, anxious and depressed. There are several records which state he was upset and could be abusive. One incident does refer to him waving a knife and having a breakdown. NHG engaged other agencies such as social services, the bi borough substance use team, and various safeguarding referrals were made. He was in high arrears of over £8,000. NHG's involvement with Pearl was limited but she is referenced as Raymond's friend who was supporting him and attended a viewing for a property with him.
Portland Road Practice	This is one of Raymond's GPs. He frequently called in distress, intoxicated, upset with often suicidal ideations. He had long standing anxiety which was complicated by drug and alcohol abuse. He was referred to the mental health team and Turning Point (Kensington and Chelsea). Raymond was known to all the doctors at the practice, and they all were involved with his care at some point.
The Golborne Medical Centre	This was Pearl's GP surgery, and they provided GP services and reviews. Only her contacts about her alcohol consumption were relevant to this DARDR. These were first noted in 1997 and in February 2021, she stated she had stopped drinking. The GP checked this at various points and in December 2023, Pearl was still reporting abstinence.
Turning Point	Raymond was known to Turning Point since May 20th, 2020. In that time, he has had three episodes of treatment which were 20th May- 31st July 2021, 1st August 2021 – 01 June 2022, 4th October 2022- 11th Jan 2023, 8th December 2023 - 9th July 2024. He disclosed using alcohol, crack cocaine, cocaine and heroin. Raymond was allocated a key worker and a care and recovery plan was co-created to support him in moving of support to move towards his goals of abstinence, support with Employment, Education and Training, therapeutic group work and a single episode of inpatient detox and inpatient rehab. However, at the time that Raymond was in custody, he had not achieved long-term abstinence and was continuing to use substances. Raymond's keyworker reached out to the Family and Friend's lead, as Pearl was struggling with Raymond's drinking. The Family and Friend's lead contacted Pearl and discussed with her the options for support. During the risk assessment, Pearl was asked about domestic abuse. She said she was not at any risk and had never been previously either. Pearl decided to speak to the Family and Friend's lead three months later, stating she wanted to access support. The lead

	had a conversation around how she was doing and gave her the information about the groups and support available. Following that, he contacted her two weeks later to check in and see if she wanted to join. She stated she would come after the visit from her friend from Australia had finished. That was the final contact Turning Point had with Pearl.

2.3.2 All of the agencies listed below were asked to complete both a chronology and an Individual Management Review (IMR).

- Adult Social Care (ASC)
- Age UK Kensington and Chelsea
- Foreland Medical Centre
- Golborne Medical Centre
- Imperial College Healthcare NHS Trust
- London Ambulance Service NHS Trust (LAS)
- Notting Hill Genesis
- Portland Road Practice
- Turning Point (drug and alcohol agency)

2.3.3 In addition to the above, the following agencies were asked to provide a chronology, but contact was so minimal or outside of the temporal scope that an IMR was not required.

- Change Grow Live (CGL)
- Central and North West London NHS Foundation Trust (CNWL)
- Metropolitan Police Service
- RBKC Housing Services

2.3.4 As the Review began its work, it came to light that Pearl had at one point been referred to Cruse for bereavement counselling. Cruse was contacted and subsequent to a thorough search of the records, was able to confirm that Pearl had never made contact with them.

3. Parallel reviews

3.1. At the start of the DARDR process, the coroner was notified that a DARDR was taking place. An inquest was opened and then suspended pending the outcome of criminal investigations. At the time of writing, it has not been resumed.

3.2 A trial took place over four weeks but was preceded by several postponements. These proceedings eventually concluded with sentencing taking place in September 2025.

4. Domestic Abuse Related Death Review Panel

4.1 The DARDR Panel was comprised of the following:

Name	Role	Agency
Davina James-Hanman	DARDR Independent Chair	-
Alex Green	Neighbourhood Service Coordinator	Royal Borough of Kensington & Chelsea

Anna Daramola	Safeguarding Specialist – NE London (observer)	London Ambulance Service NHS Trust
Corinna Hyman	Director of Services	Age UK Kensington & Chelsea
Delyth Shaw	Strategic Safeguarding Manager	Adult Social Care Bi-Borough Councils
Gabriella B	Senior Service Manager	Advance
George Selwyn Sharpe	Social Worker - Substance Misuse	Turning Point
Glen Atkinson	Detective Sergeant	Specialist Crime Review Group, Metropolitan Police Service
Hugh Constant	Safeguarding Service Manager	Adult Social Care Bi-Borough Councils
Julie Ryan	Safeguarding Manager Family, Carers and Women's Services Manager	Turning Point
Kevin Rynne	Community Service Manager – Mental Health Services	Central and North West London NHS Foundation Trust
Levi Burke	Head of Neighbourhoods	Royal Borough of Kensington & Chelsea
Manju Lukhman	Violence Against Women and Girls - Strategic Lead	Royal Borough of Kensington & Chelsea and Westminster City Council
Musthafar Oladosu	Designated Professional for Safeguarding Adults	North-West London Integrated Care Board
Natalia Croney	Safeguarding Specialist – NW London	London Ambulance Service NHS Trust
Nicci Wotton	Head of Safeguarding	Imperial College Healthcare -NHS Trust
Rachel Dow	Head of Operations	Notting Hill Genesis
Sabrina Hymes	Operations Manager	Notting Hill Genesis
Susan Bray	Domestic Abuse Prevention Lead	Central and North West London NHS Foundation Trust
Viran Wiltshire	Detective Sergeant – Review Officer	Specialist Crime Review Group, Metropolitan Police Service
Zoe Ladbrook	VAWG and Family and Carers Service Lead	Change Grow Live

4.2 DCI Alison Foxwell from the Metropolitan Police attended the first Panel meeting as the Senior Investigating Officer in this case.

4.3. At the second Panel meeting, Monsura Mahmud from the Silver Project at Solace Women's Aid was invited to make a presentation on age and domestic abuse and Zoe Ladbrook from Change, Grow, Live was asked to present on women and alcohol as these were themes in this case.

5. Independence

5.1. The author of this report, Davina James-Hanman, is independent of all agencies involved and had no prior contact with any family members. She is not associated with any of the agencies in the Royal Borough of Kensington & Chelsea and has not previously undertaken any DARDRs there.

5.2. Davina is an experienced DARDR Chair and is nationally recognised as an expert in domestic abuse having been active in this area of work for almost four decades. She has completed more than 60 DARDRs and assesses other aspiring Chairs who have attended the mandatory training.

5.3 All Panel members and Individual Management Review (IMR) authors were independent of any direct contact with the subjects of this DARDR and nor were they the immediate line managers of anyone who had had direct contact.

6. Terms of Reference and Scope

6.1. The full terms of reference can be found in the overview report. The key lines of inquiry were as follows:

1 Each agency's involvement with Pearl of address 1 and Raymond of address 2 between January 2020 and June 2024.

2 Whether practices by all agencies were sensitive to the nine protected characteristics[3] of Pearl and Raymond and consideration given as to how these may impact on their decision making? Were any special needs or other vulnerabilities explored, shared appropriately and recorded? Provide evidence for your assertions.

3 What was known about their relationship? When did it begin and what was the nature of their relationship? [NB The perpetrator claims pre-existing medical conditions ruled out any possibility of it being a sexual relationship. Do we have any evidence to support this?]

4 Was anything known about the perpetrator? For example, were they being managed under Multi Agency Public Protection Arrangements, and if so, how effective were these arrangements? Were they subject to a perpetrator behaviour change program? Were there any injunctions or protection orders that were, or previously had been, in place? Did he have a history that could have given rise to any concerns?

5 A significant sum of cash was found in the victim's flat: do we know the source of this? Were there any other indications of financial abuse?

6 Alcohol was a feature in both their lives. How did agencies respond to Pearl and Raymond and are there any lessons to be learned, including over how potential dual diagnosis was responded to?

7 Did COVID impact on this case in any way?

8 When, and in what way, were the victim's wishes and feelings, safety and needs ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make

[3] These are a person's: age; disability; gender reassignment; marriage or civil partnership; pregnancy and maternity; race; religion or belief; sex and sexual orientation.

informed decisions? Were they provided with a response that met their needs at the point of contact? Were they signposted to other agencies?

9 How accessible were the services for the victim and perpetrator? How do we know this?

10 Did any family members or friends know about any abuse or exploitation and what did they do with this information? How would they know what to do with this information?

11 Were there any changes to your agency over the period under review that impacted on your ability to respond?

7. Confidentiality

7.1. Throughout the process of undertaking the DARDR, findings were restricted. Information was available only to participating officers/professionals and their line managers, until after the Review had been approved for publication by the Home Office Quality Assurance Board. Members of the victims' family were offered sight of a copy of the report and their feedback has been incorporated into this report.

7.2 As recommended within the '*Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews'* to protect the identities of those involved, pseudonyms – chosen or approved by family members - have been used and precise dates obscured.

8. Dissemination

8.1 Subsequent to permission being granted by the Home Office to publish, this report and the executive summary will be widely disseminated to key local statutory and partnership boards including, but not limited to:

- Safer Kensington and Chelsea Community Safety Partnership and its agencies
- All agencies involved in the review and beyond through publication on the Safer Kensington and Chelsea Partnership website

8.2. The reports will also be shared with the Commissioner of the MPS, the Mayor's Office for Policing and Crime (MOPAC) and the Domestic Abuse Commissioner.

8.3. Once permission is granted by the Home Office to publish, the recommendations will be owned by the commissioning body (Safer Kensington & Chelsea Partnership). They will be responsible for monitoring progress on implementing the action plan.

8.4. A one-page learning summary will be created for professionals and used to aid learning across the partnership. Learning will be further incorporated into local VAWG training programmes.

8.5. All local DARDRs are published on a permanent hyperlink: https://www.rbkc.gov.uk/housing/personal-and-community-safety/domestic-abuse-and-violence-against-women-and-girls#domestic-abuse-related-death-reviews-dardr

9. Methodology

9.1. An initial scoping exercise established that thirteen agencies had had contact with one or more of the subjects of the DARDR. These agencies were asked to secure their

records and to produce chronologies. The nine agencies with significant contact were asked to submit an Individual Management Review (IMR) (see section 2.3 for details).

9.2. After the trial had concluded, permission was sought – and granted – for statements and reports gathered in the course of the criminal investigation to be made available. Family members generously allowed the Panel access to their Victim Impact Statements. Extracts appear at the start of this report.

9.3. A rapid review was also undertaken to ensure that all participating agencies had relevant and up to date polices in place, that training was being provided to staff and that there was appropriate participation in local partnerships designed to address domestic abuse. The results of these 'spot checks' were compiled and can be found in the overview report.

9.4 All meetings were held online with Panel members being allocated to breakout rooms for small group discussions on the IMRs. The panel met on five occasions with the process being suspended after the fourth meeting to allow for criminal proceedings to conclude and for contact to be made with witnesses.

9.5. This report is an anthology of information and facts gathered from:

- The reports detailed above
- The Police Senior Investigating Officer
- The criminal trial
- The judge's sentencing remarks
- DARDR Panel discussions, enhanced by expert input (see Panel membership above)
- Friends and family of the victim

10. Narrative Chronology

10.1 Pearl was born in Essex and had three siblings of which one died as a child. He was disabled and as was common in those days, he was placed in a home. Her friend commented: *'I think that Pearl always carried that memory and had a deep concern for people living with disabilities due to her brother… she really enjoyed spending time with Jocelyn - who was disabled, non-verbal and required personal care'.*

10.2 Pearl was 70 at the time of her death. She described a '*lovely childhood'* but her father's death when she was 15 years-old '*greatly changed'* her life. She moved to London in the 1970s and worked as a legal secretary at a firm that has since closed. It was there that she met Katy, an Australian woman, who would become a lifelong friend along with Katy's sister. Pearl's problems with alcohol first developed when she was in her thirties, but she also had long periods of abstinence.

10.3 Pearl was very interested in other cultures, embracing their music, food and customs with enthusiasm. Towards the end of her life, she had become very involved in the local Filippino community. Pearl had an unusual stance on immigration and refugees; believing that borders should be open to anyone and everyone. Pearl was also an accomplished knitter and her friend remarked how *'we were all the recipients of the most gorgeous luxurious hand knitted items, including many exotic and beautiful textures of wool and sometimes very complicated patterns'.*

10.4 Pearl felt that she always ended up in relationships with '*the wrong men'*, although she had met someone – a Hungarian man called Henrik - who had settled in the UK many years ago. They met around 2000 and remained in a platonic relationship until he died in late 2020. Pearl relied a great deal on the support and company that Henrik

gave her, regularly going out to concerts and exhibitions together. He was somewhat older than Pearl, being in his late 80's when he died, and it is believed their relationship was akin to a father/daughter one. Pearl was devastated by his death, very depressed and started drinking heavily again. As a result of this depression, Pearl was very vulnerable and possibly an easy target for exploitation.

10.5 Pearl knew how to use WhatsApp and email, was very involved in her local community and knew how to access services. She was seen as kind, curious, sharp-witted and tenacious.

10.6 Raymond, 57 at the time of the murder, claimed to have worked as a black cab driver when he was not incapacitated by drink, drugs or mental health problems. This job was first noted in records in 2008 and intermittently thereafter with the last reference being in 2020 when he complained that the COVID restrictions prevented him from making a living.

10.7 Raymond had an older brother and a cousin (who he also referred to as his sister) who provided him with some support. He said he had a wife and child, whom he variously claimed to be dead or living in the Caribbean.

10.8 Raymond claimed to be Pearl's fiancé, but due to '*pre-existing medical conditions'*, the relationship was not a sexual one. Family members were sure Pearl would have told them if she planned to get married (which she had not). Pearl and Raymond were '*obviously close'*, but it is unclear in what capacity. Initially, Raymond had claimed to Turning Point that she was his carer.

10.9 According to the police, Raymond revealed himself to be an '*utter fantasist'* in interviews, claiming that he was a police informant, that multiple family members had died horribly such as at Grenfell or by suicide and that he was receiving regular injections for depression. Police were unable to find any evidence to support these claims.

10.10 This review concentrates on the period starting from early 2020 (just before the first COVID lockdown in the UK), but Raymond was known to the police for nearly 20 years. He appears in police reports 23 times between 2002 and 2011: it is a litany of allegations of threats, assaults, burglaries, ongoing disputes with neighbours and various local youths, racial abuse; Raymond was cast as both victim and perpetrator. Mostly these appeared to take place against a backdrop of heavy drinking and often no further action was taken.

10.11 There were three incidents involving two different partners/ex-partners – in each case Raymond alleged he was the victim, but no further action was taken in any of these cases and alcohol seemed to be a factor in all of them.

10.12 At the beginning of spring 2020, just before and in the early stages of the first COVID lockdown, Raymond came into contact with Adult Social Care (ASC) and the police. He said he was suffering from back pain, and his depression was exacerbated by the fact that his father was dying of cancer. He variously complained about having no food in the house, feeling isolated and not being able to work as a cab driver due to COVID restrictions, and threatened suicide more than once. When police attended, they found Raymond drinking and there was food in the fridge. This suicidal ideation continued throughout April and May – the police, ASC and health service were all involved with trying to help him. He was referred to drug and alcohol agencies and reported that he was drinking heavily and had resumed using crack cocaine in February following his father's cancer diagnosis after '*several years'* of abstinence. By June, he revealed that he was experiencing paranoia, including hallucinations. He also said that his wife and children lived in Barbados and that he was in regular contact with

them by phone whilst at the same time reporting to his housing provider that his wife had *'jumped off a tower block last week'*. Over the next few weeks, he became more difficult to contact and largely disengaged from the agencies trying to help him.

10.13 Meanwhile, Pearl was struggling with her own health problems. She had two falls in quick succession (which she attributed to her new *'shiny boots'*), the first of which happened while dancing and resulted in a wrist fracture. She explained that she had poor eyesight and wore contacts but denied any drinking. She was also experiencing issues with her gallbladder.

10.14 In late July 2020, Raymond's father died, leading to a further spiralling of his mental health. He sought help for his substance abuse, admitting that he was drinking heavily and taking crack. In September he reported to Turning Point that he smoked crack whenever he could afford to and had access to it, spending £30-£200 daily and smoking cannabis regularly. He was '*unsure'* of his usual drinking patterns, other than it was daily and started first thing in the morning. He was able to specify that he had drunk eight litres of cider the previous day. He had '*terrible shakes'*. He wanted to access support to begin the process for detox and rehab as he felt unable to reduce his drinking by himself. He reiterated that he was '*struggling'* following his father's death, sometimes thought of ending his own life and did not feel his GP was helping him. He stated he heard voices. Mental health services had been in contact with him, but Raymond felt they '*don't seem to be interested*'.

10.15 He entered residential rehab in early December, arranged by his family, and, although it was initially scheduled for 12 weeks, he was still there in April 2021. Arrangements were made for him to be rehoused on completing his treatment and his new tenancy was signed remotely in February 2021. By April he was clamouring to leave rehab and was transferred to another residential rehab. He repeatedly violated rules there and in mid-May he either self-discharged or was evicted from that facility (the notes are unclear). He quickly started using drugs and drinking again. The ASC Substance Use Team (SUT) Social Worker and other agencies started receiving dozens of drunk, sometimes abusive voice messages and emails from him.

10.16 In May 2021, in a telephone conversation with a Turning Point keyworker, Raymond spoke about having written extensively about childhood sexual abuse whilst he was in rehab; this abuse he believed to be the root of his addiction and issues in life, but he had never been anywhere long enough to properly deal with it. Raymond said there was no aftercare plan and that he felt psychologically unsafe because of revisiting his childhood. He also spoke about his poverty and lack of basic equipment like a cooker.

10.17 The same pattern as before continued for the rest of the year and throughout 2022: reports of visual and auditory hallucinations, paranoia, suicidal ideation, false or unverifiable claims to police that people were trying to kill/harm him, and disclosures of heavy alcohol and crack cocaine use. Throughout this period, Turning Point were in contact with him, but his engagement was intermittent, and he did not always take his prescribed medication. In November, Raymond's neighbours made a complaint about him to the Housing Association. They contacted ASC (SUT) to request support for Raymond as he was drinking heavily and causing nuisance on the road. He was referred to CGL by ASC just before Christmas 2021. Occasionally he would try to stay sober or abstain from drugs, but this never seemed to last longer than a few days.

10.18 In January 2022, Raymond contacted Notting Hill Genesis (Housing Association) in a very distressed state, saying he couldn't go on, was lonely, had no friends and mentioned hanging himself several times. A safeguarding report was made, and a housing officer visited the next day. Raymond was under the influence of alcohol but

very chatty, explaining about the death of his father and his addictions. They discussed what support he had, and Raymond said he was speaking to a support worker who was helping him to get back into rehab.

10.19 Pearl was very involved with her local council housing department: from October 2020 until her death in mid-2024 there were more than 90 contacts (or attempted contacts) between herself and housing, mostly by email or phone[4]. These mainly dealt with issues in her block of flats and the immediate neighbourhood, ranging from Anti-Social Behaviour (suspected drug dealing, noise, littering) to issues with building maintenance, CCTV, communal lights (not working or being on unnecessarily during the day), heating, blocked rubbish chutes, and general cleaning of walkways and other communal areas. Pearl was also concerned about her neighbours, including contacting Housing about the appearance of mice in a neighbour's flat. It was not all complaints, however: she expressed herself '*delighted'* when her flat was done under the Old Age Pensioner redecoration scheme (July '23) and let the council know that the new CCTV installed in communal areas had helped with ASB (January '23).

10.20 In late 2020, Henrik died. Pearl described him as '*her best friend'*. She said she had been caring for him and was traumatised by his death. It made her feel depressed and led her to what she called '*dependent drinking'*, admitting to a bottle of gin a day. She also complained that she had some belongings in his flat and was having difficulty in retrieving them. She felt unable to cope with clearing out his flat but at the same time, housing was requesting urgent return of the keys.

10.21 Following Henrik's death, there were ongoing concerns among health and other professionals that Pearl was not taking care of herself properly (including not eating), drinking too much, was prone to falls (Pearl attributed this to alcohol) and feeling lonely and depressed. She spent about two weeks in hospital undergoing alcohol detox and was referred to psych and alcohol liaisons. During this time, however, she was very anxious to be discharged. A care package was planned for her, including rehab support, support with shopping and food preparation, bereavement counselling, and referral to alcohol services.

10.22 She was discharged and '*reablement work'*[5] started a few days later, in mid-December, ending in the first week of January 2021. By the end of 2020 Pearl said she was five weeks sober and looking forward to counselling.

10.23 Pearl continued to engage with the CGL counsellor but became increasingly dissatisfied with the direction of the sessions, which concentrated overly, in her view, on alcohol, and not on bereavement as she wanted. Finally, she discharged herself in February 2021, preferring to search for Cruse (bereavement counselling), reasoning that she had no problem with alcohol and that it was '*all in the past'*.

10.24 Pearl continued to have regular check-in calls with CGL throughout the spring and into summer. She was doing very well and by June, her case was closed.

10.25 Raymond, meanwhile, continued the same pattern as before. Police reported that throughout 2022 there were 16 MERLINS[6] recorded, all related to Raymond's mental health concerns or alcohol. There were five crime reports (none of which were

[4] There were only two significant periods where there was no or little contact recorded: May-October 2022 (zero contact) and July 2023 – May 2024 (one contact).

[5] This is short term occupational health.

[6] A MERLIN is a report by the police to the appropriate safeguarding authorities for a vulnerable person or child.

related to domestic abuse) where Raymond was both victim and suspect in ASB / neighbour-related incidents. Mental health indicated a possible diagnosis of schizophrenia and reported that neighbours were *'fearful of his threats and disturbed behaviour'* (April 2022). A referral was made to ASC.

10.26 Over the coming months there were incidents of possible self-harm and reports that Raymond was smoking heroin (early October 2022). He stated he took an intentional overdose in 2020 and was then placed in rehab. He admitted he was self-harming by biting and punching himself, had a high level of distress and felt isolated (late October 2022).

10.27 Raymond's mental health continued to decline during 2023. The police recorded a further seven MERLINS, noting his deteriorating mental health or alcohol concerns. Raymond's appearance at scheduled CGL sessions/appointments were patchy at best, he sometimes claimed brief periods of sobriety and attempted to detox, but he invariably relapsed. He was convinced drug dealers were after him[7]. In August he claimed his brother *'with whom he lived'* (he didn't) had died. He was arrested for being drunk and disorderly in October. Throughout this period, he also reported thinking often of suicide.

10.28 Between the end of March and early December, ambulances were requested for Raymond 10 times, including three times on the same day, for alcohol-related incidents/accidents, drug overdoses, self-harm and threats of suicide. Once (In May) the caller to LAS was Pearl; two days later he declined to go to hospital in the ambulance because '*his friend Pearl was visiting later'*. These were the first occasions when Pearl was identified as knowing Raymond in agency records, but her family members report Pearl recording in her diary that she met Raymond on 28th April 2023.

10.29 Raymond variously reported that his brother had died in August, that Pearl was his ex-wife and was planning to spend time with him, that his sister had died in October, and that both his siblings had died from overdoses. There is no independent evidence to verify any of these claims. When he was later arrested on suspicion of murdering Pearl, Raymond claimed that an appointment had been made at a Registry office for a wedding in August 2024, but when the Police checked this, no appointment had ever been made. This suggests that their relationship was elevated by him to something it never was.

10.30 In November, Raymond claimed his girlfriend Pearl '*fixes many of his problems'* and in December, during a telephone triage, he said that '*he has a girlfriend Pearl who is supporting him'*.

10.31 Raymond's erratic behaviour continued into 2024 and by the end of January Turning Point noted that because of his threats, '*certain care managers are not prepared to work with him'*. In February he was attacked by a neighbour, his account being supported by several witnesses; the neighbour was subsequently charged with Grievous Bodily Harm. At this time (mid-February) Raymond said he was staying at Pearl's place, although returning home to feed his cat. In early March he called a social worker to say that he had '*barricaded himself'* in his friend's flat, that he was scared and ignoring his GP's calls as he was worried about being sectioned. He expressed some paranoia, said he was '*hearing voices'*, and that his friend Pearl was unwell**.** Case notes record that he was slurring his words.

10.32 At the start of February 2024, Pearl disclosed to Age UK that she had a sister in Essex who she went to see and care for '*every now and again'*. Two weeks later, Pearl was referred by a keyworker for Turning Point access support groups for family and

[7] It is possible this was true and for unpaid debts rather than paranoia. It is difficult to understand how he managed to finance his addictions when he was not working.

friends impacted by relative's/partner's substance use. A risk assessment was completed. Pearl answered '*never'* for '*being a victim of domestic violence*' and '*being at risk of any violence'*. She disclosed no current risks but discussed past bereavement and previous alcohol use. She was invited to engage in the Family and Friends service but did not want to do so at that time. It is unclear when Pearl began drinking again but it seems likely that Raymond's presence may have tempted her to start drinking again. This is, of course, just speculation.

10.33 Pearl had a foot operation in early April, and she appeared to recover well. She discussed going to Eastbourne later in the year on an Age UK Kensington & Chelsea trip and was '*excited to be catching up with friends and getting away from noise of carnival'*.

10.34 In late May/early June, Turning Point was again trying to arrange a detox programme for Raymond, who had relapsed. During initial police enquiries at this time, Pearl spoke to police officers and referred to Raymond as her *'ex-boyfriend'*.

10.35 At the end of May 2024, Pearl called the Friends and Families lead at Turning Point stating that she felt ready to accept help as she no longer believed there was anything she could do to stop her partner drinking. She was invited to join the group in the first week of June; Pearl shared that her friend was shortly due to arrive from Australia for twelve days and she would be eager to join once her friend left.

10.36 The day before the murder Raymond unusually called Pearl's sister. They did know one another, but it was not usual for him to phone her. He alleged that he was being abused by Pearl, who forced him to wear pyjamas when in her flat, go to bed at 8:30pm and hit him with slippers. Pearl's sister pointed out that he had a flat of his own, so why didn't he just go there? She also thought that such behaviour '*didn't sound like Pearl'*.

10.37 Raymond had reported to police that he had been at Pearl's the previous night but had gone home to feed his cat. When he returned the following morning, there was no answer at the door. Raymond claimed he saw Pearl's legs on the bed through the letterbox, but this was not possible. Although the bedroom door faced the front door and the bed could be seen through the letterbox, there were clearly no legs visible. Indeed, the police noted that the bed had not been used. The police forced entry into the property and found Pearl in the overflowing bath. The bath's hot tap was running, and the plughole was covered with a towel, suggesting intentional obstruction to cause drowning. She was wearing a nightdress, which was on back to front. She was unresponsive and pronounced dead at the scene.

10.38 Raymond was the only person who had access to Pearl's flat and due to the '*very confusing picture'* he gave at the time, he was arrested on suspicion of murder. When the police searched his phone, they found several video clips he had sent to a friend whilst he was inside Pearl's flat at the time he claimed not to have been there. Pearl was nowhere to be seen. He also repeatedly asked officers to check CCTV to prove he wasn't at the address, suggesting he had deliberately chosen a route where he would not be captured by cameras. He was charged later the same day. When police officers searched his flat, they found a dead cat in his freezer.

10.39 Raymond tried to claim that he was in a loving relationship with Pearl and that they were engaged to be married in August 2024. However, no-one who knew Pearl was aware of the engagement and the local Registry Office where Raymond claimed the marriage would take place, had no record of any booking. Later, officers found

multiple messages and voice notes indicating that he would regularly get drunk and verbally abuse Pearl.

10.40 The postmortem revealed that her death was due to drowning. However, Pearl had sustained serious traumatic injuries before drowning, reinforcing the theory of foul play and undermining Raymond's claim that it was a tragic accident caused by her taking a bath whilst drunk. Her ribs were cracked at the back in a kind of reverse of injuries usually seen from CPR, indicating third party involvement. A postmortem toxicology screen showed that Pearl had a very significant amount of alcohol in her system at the point of death: equivalent to 3.5 times over the drink-driving limit which is a level that would be expected to result in extreme intoxication.

10.41 Raymond's defence at court was one of complete denial. He did not convince the jury who pronounced him guilty of murder after a four-week trial. He was sentenced in September 2025 to life imprisonment with a remaining minimum term of 14 years and 307 days.

10.42 In his sentencing remarks, His Honour Judge Lodder KC said *'It is clear that she made efforts to control her alcoholism and to meet new friends and find new activities. It is a sad fact that irrespective of your influence she was not wholly successful. But it is also clear that both she and her few other friends were concerned that your influence was undermining of her efforts in both respects.*

The timeline establishes that it was when you were in contact with her that she lapsed in her attempts to remain alcohol free.

The evidence of her last few days alone demonstrates that whilst she remained in her flat you deliberately went out to purchase significant quantities of alcohol which you then supplied to her, resulting in her high level of intoxication.'

I have no doubt that you took advantage of her weaknesses, and whether your behaviour met the legal definition of coercion and control is irrelevant, since it is clear to me that you could, and did, manipulate and exploit her vulnerabilities.

'There is no direct evidence that during your relationship you were physically violent to [Pearl] but you certainly spoke in violent terms in her presence.'

11. Key findings by the DARDR Panel

11.1. This section addresses the overarching lessons that have been learned from this DARDR.

11.2 Loneliness and isolation

11.2.1 In today's digital world where friendships can be readily maintained across time and space, it can be easy to forget the value of physical proximity. Pearl's closest friends were based in Australia and although she had a wide social circle in London, there do not seem to have been any with whom she was especially close and in whom she confided. She was in touch with her siblings, but not on a day-to-day basis.

11.2.2 All of this meant that there were few people to notice or be aware of Raymond's increasing control and Pearl's descent into drinking again. Those that did know could do little from the other side of the planet.

11.2.3 It is well established that loneliness can kill[8]. What is less acknowledged is that the desperation to escape loneliness can result in people accepting unhealthy, even fatal, relationships. With the benefit of hindsight, it is easy to see how devastated Pearl was by the passing of Henrik and how lonely she became. She threw herself into community activities again, which brought her into contact with Raymond. We do not know what tales he spun her, but we do know that he is a complete fantasist, fabricating many stories about his life and circumstances. It is possible that – at least initially - Pearl saw Raymond as someone who she could help. Her Australian friend said: *Pearl always spoke very compassionately and almost protectively about Raymond's abuse[9] and background'.*

11.2.4 He was purportedly keen to address his addictions, and Pearl was very supportive towards him in this endeavour. He was someone who could keep her company during those hours that had dragged since Henrik died and who she could care for, feed and encourage.

11.2.5 Isolation is, of course, a well-known tactic of abusers and there is evidence that Raymond tried to sabotage and undermine Pearl's relationships with others. As one of her Australian friends said: '*Raymond was a damaged and self-obsessed character; he constantly bragged and it was difficult most of the time to know whether he was telling fantasy or lies or imagining events. He always spoke to me as if Pearl was not part of the conversation or it was almost as if Pearl was invisible…'*

11.2.6 Raymond also undermined Pearl's involvement with the Filipino Catholic community which was a big part of Pearl's life. Raymond convinced her that the community were taking money from her and that it was unaccounted for in an attempt to drive a wedge between them.

11.2.7 Further evidence of Raymond's attempts to control and isolate Pearl can be found in His Honour Judge Lodder KC's sentencing remarks when he said *'Additionally your violent and aggressive disposition was recorded in the evidence of [friend] who described your tone over the phone as coercive when you complained of the time [Pearl] spent with sister, and by [Australian friend 1] when she echoed [Pearl's]s own concerns as to how to extricate herself from this relationship, in observing that it could 'turn nasty' and forwarding your aggressive messages on to [Australian friend 1] 'in case something happened'.*

11.2.8 *I note [your sister's] attempts to speak to [Pearl] during the time leading up to [Pearl's] death, which were blocked by you indeed you even made counter allegations that Pearl had been violent to you.*

11.2.9 *It is significant that Pearl's excitement about [Australian friend 2]'s visit, and her enthusiasm to meet appeared to diminish and the plans came to nought at the same time as you insisted that [Australian friend 2] should come to [Pearl's] flat. Again, it is significant that [Pearl] spoke to [Australian friend 2] of 'dramas'. In my judgement it was your influence that led to [Pearl] not seeing [Australian friend 2] during this visit.'*

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[8] A. Nakou et al '*Loneliness, social isolation, and living alone: A comprehensive systematic review, meta-analysis, and meta-regression of mortality risks in older adults'*. Aging Clinical and Experimental Research (2025) https://doi.org/10.1007/s40520-024-02925-1

[9] Raymond said he was sexually abused as a child. The veracity of this has not proven possible to ascertain.

11.3 A lack of clarity about the relationship

11.3.1 We do not know that exact nature of their relationship: Raymond variously referred to himself as Pearl's partner, friend, his carer and even son. This lack of clarity may have affected how professionals understood them and hence whether they were fully alert to potential signs of abuse. Raymond was abusive to previous partners, but over a decade previously. As such, this was not only outside the temporal scope of this Review but also information that outside of the police, was unknown to any professional currently in contact with Raymond.

11.3.2 This highlights the need for professionals to think beyond intimate partner relationships as ones in which domestic abuse occurs.

Recommendation: If someone is talking about involving someone in their care, that ought to trigger a care assessment for that person, even if the parties do not live in the same property.

Recommendation: Agencies to be reminded of the value of ascertaining a client / patient's social history and documenting their potential support networks.

11.4 Domestic abuse is not just physical

11.4.1 There is no (recorded) evidence that Raymond was physically violent towards Pearl. In some ways, physical abuse may have made her situation clearer: it is hard to rationalise physical violence whereas sharp words, name calling, sulking and general unpleasantness can be more easily 'explained away' as having any number of causes other than someone being a controlling abuser.

11.4.2 Evidence presented at trial proved that Raymond was abusive and controlling towards Pearl to the point that she recorded him being verbally abusive to her, explaining this to her friend as something she needed to do in case '*something happened'*. This suggests that Pearl was fully aware that all was not well in her relationship and towards the end, may have been pulling away from Raymond.

11.4.3 It is now firmly established that coercive control is a far more common antecedent to domestic homicide than a history of physical violence[10]. Awareness raising must continue to take place to ensure that everyone is aware that a non-negotiable '*line in the sand'* of physical violence is an insufficient safety measure.

11.5 Drugs and alcohol

11.5.1 Drugs and alcohol were a key feature of Raymond's life and alcohol a feature of Pearl's. Raymond disclosed to professionals using heroin, crack cocaine, cannabis and drinking heavily. Raymond's consumption was extensive enough for him to require detox and rehab even though he was unable to adhere to the rules. It is not clear if Pearl was ever aware of the extent of his drug taking beyond alcohol.

11.5.2 The likely impacts of this combination are dependency, anxiety, depression, paranoia and cognitive impairment, all of which Raymond displayed at various points. Although he had various mental health assessments – sometimes even when intoxicated – it was always with the same result. His mental ill-health was drug and alcohol related, and it was this that needed to be addressed. Whilst some minor improvements were identified to responses in this area, overall local professionals responded well to Raymond's presentations.

[10] '*Coercive Control and Intimate Partner Homicide'* Danielle Tyson in '*Criminalising Coercive Control*' (2020)

11.5.3 Pearl's alcohol consumption was sporadic but long standing, dating back several decades. Like many women, it seemed that she drank as a form of self-medication when life circumstances threated to overwhelm her. Women's alcohol consumption is distinctly different from men's. Men are more likely to abuse substance due to peer pressure, women for self-medication, women are more likely to develop a dependence at lower drinking levels than men. It is also the case that women are more likely to transition from substance abuse to substance dependence and addiction (telescoping) and do so at a faster pace. Women are also less likely to seek treatment.[11]

11.5.4 Alcohol alone is not a cause of domestic abuse. Many people who drink do not abuse and many who abuse do not drink. There are, however, many ways in which alcohol and domestic abuse are related. Many abuse incidents occur when one or both people involved has been drinking, and alcohol is more commonly involved in more aggressive incidents[12]. It is not just being intoxicated that can increase risk; lack of access to alcohol can make someone irritable or angry which can, in turn, create a trigger point.

11.5.5 Controlling access to alcohol can become part of the abuse. In his sentencing remarks, His Honour Judge Lodder KC *said 'The evidence of her last few days alone demonstrates that whilst she remained in her flat you deliberately went out to purchase significant quantities of alcohol which you then supplied to her, resulting in her high level of intoxication. It is clear that [Pearl] was the type of alcoholic who would drink excessively and quickly become incapable. You by contrast are a functioning alcoholic, much better able to control your drinking than she was able to do.'*

Recommendation: Detox and rehab facilities to ensure information on outcomes is communicated to the GP.

11.6 Raymond's anti-social behaviour

11.6.1 Raymond's anti-social behaviour towards neighbours, strangers in the street and aggression towards police and other first responders was highlighted along with his history of domestic abuse towards partners albeit that the most recent one known about was over a decade earlier than the temporal scope of this Review. Whilst there is no evidence to suggest that general anti-social behaviour is common among domestic abusers, it is possible that it is more common amongst domestic abusers who kill and certainly warrants further research.

Recommendation: In the current review of risk assessments, Home Office to ensure that checks are made as to whether general anti-social behaviour may be a risk factor.

11.7 Raymond's fantasy life

11.7.1 Raymond was an obvious fantasist. Stories about tragedies in his life were often given when he was being held to account for bad / criminal behaviour or when he had missed an official appointment – both of which may be reasons for the fabrications. It is also possible that they resulted from his years of drug taking and excessive alcohol consumption so that the line between fact and fiction became blurred. One of Raymond's stories about himself was that he used to be a boxer which, if true, opens up the possibility of him having had some traumatic brain injuries.

[11] Information from Zoe Ladbroke's (Change Grow Live) presentation to the Panel
[12] K Sontate et al *'Alcohol, aggression, and violence: From public health to neuroscience'.* Frontiers in Psychology, (2001) https://doi.org/10.3389/fpsyg.2021.699726

12. Recommendations

12.1 In addition to the overarching recommendations set out above, each agency who provided an IMR to this process identified their own lessons and these single agency recommendations can be found below.

12.2 Notting Hill Genesis

12.2.1 For Housing Managers to compile a list of all safeguarding cases and where no or limited progress is being made, ensure that these are listed at the monthly multi-agency safeguarding meetings for more intensive responses.

12.3 Portland MC

12.3.1 As part of a review of patients suffering with anxiety and/or substance misuse directly questioning on violent thoughts or behaviour could be contemplated.

12.4 ICHT

12.4.1 Implement the withdrawing from alcohol policy and strengthen the response to alcohol misuse across the Trust in partnership with the alcohol services. The policy should refer to safeguarding considerations as well as any posters for the clinical staff.

12.4.2 Review the self-discharge process when service users are or have been intoxicated in the context of next steps for staff regarding capacity and decision making. Audit these decisions through a safeguarding lens.

12.4.3 Audit referrals made to the alcohol liaison service to see whether safeguarding was considered.

12.4.4 Conduct an audit on injuries being presented to the Emergency Department and ascertain whether domestic abuse (victim/survivor and perpetrator) was considered.

12.5 Turning Point

12.5.1 Implement more domestic abuse training.

12.5.2 Staff to exercise more professional curiosity around the nature of the relationship for those supporting someone in treatment.

13. Conclusion

13.1 This case involved a somewhat ambiguous relationship between a proven fantasist and a generous, outgoing, compassionate woman keen to offer help where it was needed. From their initial meeting to her death took only 14 months but even in this relatively short period, there was already some evidence that Pearl was pulling away from continuing the relationship.

13.2 Only with the benefit of hindsight did it become known to authorities that the relationship was controlling and abusive albeit not involving (any reported) physical violence.

13.3 Nevertheless, the Review has been worthwhile in terms of considering practice and protocols to identify improvements in systems. The Panel sincerely hopes that the lessons learned will be a significant contribution to the changes needed to try and protect other vulnerable patients in the future.