DOMESTIC ABUSE RELATED DEATH REVIEW

SAFER KENSINGTON & CHELSEA PARTNERSHIP

Report into the homicide of Pearl June 2024

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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

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

NHS: National Health Service

RB: Royal Borough

RBKC: Royal Borough of Kensington & Chelsea

SUT: Substance Use Team

VAWG: Violence Against Women and Girls

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DARDR into the homicide of Pearl[1]

Preface

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 which can be found in full at Appendix B.

1.2 The purpose of a DARDR is to:

a) 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;

b) 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;

c) apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;

d) 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;

e) contribute to a better understanding of the nature of domestic violence and abuse; and

[1] This is a pseudonym
[2] Previously known as Domestic Homicide Reviews

f) highlight good practice[3].

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.[4]

1.4. An independent Chair was appointed in August 2024 and the victim's family informed (see section 10 for further details).

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. Domestic abuse is a key priority for Safer Kensington and Chelsea Partnership and is part of their Safer Kensington and Chelsea Partnership Plan. Violence Against Women and Girls (VAWG) is one of the key priorities within it. Their goals include preventing abuse through early intervention, improving support for survivors, holding perpetrators accountable, and strengthening multi-agency collaboration to safeguard vulnerable individuals.

1.8. Domestic abuse is also a priority for the Royal Borough of Kensington and Chelsea. They commission:

- Domestic abuse outreach and advocacy
- Refuge
- Mental health support
- IDVA service
- Support for survivors of modern slavery
- Young people's supported accommodation
- Drop-in service
- Domestic abuse housing support, which includes:
    - Safety planning
    - Emergency contact numbers (including out-of-hours housing support)
    - Help navigating housing options for those fleeing abuse
    - Recognition of coercive control and non-physical abuse

1.9 There are also several Greater London Authority funded domestic abuse services available locally:

- Culturally Integrated Family Approach (CIFA) (a perpetrator programme)
- Ascent services[5]

[3] Home Office, (2016) "Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews", https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

[4] An administrative error meant that the original notification on 24th July 2024 was not received. The home office were notified a second time in October 2025.

[5] This encompasses a wide range of services to both individuals and to professionals. More details here: https://www.wrc.org.uk/ascent

1.10. Safer Kensington and Chelsea Partnership has undertaken four previous DARDRs. Each of these were reviewed to ascertain if there was any overlap 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 which is approximately 25 minutes' walk from address 1.

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. 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 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)

2.3.2 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

2.3.2 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.

4.4. As set out in paragraph 1.5, the Panel met a total of five times. Although the Panel did not meet again after that, there was some email correspondence including the circulation of a revised final report to take account of Panel discussions.

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.

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. Further details are provided in appendix C.

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 at appendix A. 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[6] 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] These are a person's: age; disability; gender reassignment; marriage or civil partnership; pregnancy and maternity; race; religion or belief; sex and sexual orientation.

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 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 (see section 9 for more detail) 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.

7.3 The Executive Summary of this report has also been anonymised.

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 paragraph 2.3.1 for a list).

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 from these 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 circulated to the Panel and a copy of this is included at appendix D.

9.4 All meetings were held online with Panel members being allocated to breakout rooms for small group discussions on the materials provided by agencies about their interactions with either Pearl or Raymond. 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 (see paragraph 10.4 below).

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. Involvement of family and friends

10.1. The family of the victim – her two siblings - were informed about the commencement of the DARDR and invited to participate with a variety of options presented. As the criminal investigation was still on-going at this point, initial contact was made through the Family Liaison Officer and then the Victim Support Homicide Team Officer. The Home Office leaflet and contact details for AAFDA were provided.

10.2 Pearl's brother initially replied and chose the following ways in which they wished to be involved:

- To be kept updated on the progress of the review and to see a copy of the draft and final versions of the report which are produced.
- To comment on the Terms of Reference.
- To recommend that the following family names [names redacted for privacy] are not used in the report.
- To provide a pen portrait at a later stage in the process.

10.3 Subsequent to this, it was determined the wife of Pearl's brother would be the point of contact for the family. Some comments were made on the terms of reference and incorporated. Written updates sent after each Panel meeting (approximately monthly) documenting the progress being made until such time as the process was suspended to allow for criminal proceedings to conclude. This regular contact also allowed for some questions to be asked which received very helpful replies.
Once a draft report was ready, a copy was provided to the family for comment.

10.4 At the suggestion of Pearl's brother, contact was also made with two of Pearl's friends in Australia. This had to wait until the trial had concluded as both were involved in giving evidence.

10.5 Pearl was extremely sociable and community minded. This included being very active within her neighbourhood and she was often the person in her block who would report repairs that were needed or that a neighbour needed some assistance. As such, she had a positive working relationship with her housing officer, so the chair also spoke to him to gain some insights into Pearl. He suggested speaking to the Chair of the local resident's association but despite contact being made, no reply was received.

10.6 The Chair would belatedly learn that Pearl had a strong relationship with her local Filipino community. Efforts to identify those that knew her did not bear any fruit.

11. Narrative Chronology

11.1 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'.*

11.2 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 (one of the friends mentioned in paragraph 10.4). Pearl's problems with alcohol first developed when she was in her thirties, but she also had long periods of abstinence.

11.3 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.

11.4 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'.*

11.5 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.

11.6 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.

11.7 Her local housing officer remarked *"She felt very strongly that residents should be, and rightly in my view, that residents needed to be listened to and that we needed to use the intelligence that residents were sharing with us to improve services".*

11.8 *"She was curious in a way that I found striking. And anything that she wanted to follow up, she was a bit like a dog with a bone".*

11.9 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. Given that much information Raymond provided proved to be untrue, attempts were made to verify his status as a black cab driver. These proved unsuccessful as Transport for London declined to share any information.

11.10 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. He had a very historic criminal record, with only a bail violation from 30 years previously appearing on his enhanced DBS. More recent involvement with the criminal justice system is listed below in paragraph 11.10.

11.11 Raymond claimed to be Pearl's fiancé, but due to '*pre-existing medical conditions'*, the relationship was not a sexual one. This raises questions about the Viagra found by family members when clearing away her flat although Pearl did tell her Australian friend that she and Raymond were never intimate. Family members were sure Pearl would have told them if she planned to get married (which she had not). Family members also raised concerns to police about Raymond's involvement with others (neighbours) before they died. 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.

11.12 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.

11.13 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.

11.14 Raymond 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, but over this period Raymond was variously arrested for disorderly conduct (twice), racially aggravated assault, warned about his behaviour (twice) and threatened with arrest for wasting police time if he again reported a non-existent burglary.

11.15 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. Police thought some/many of his allegations were '*fictional'* and that he had '*a history of binge drinking and possible mental health issues'*.

11.16 In the period 2003 to 2011 Pearl came to police attention three times: in an apparent theft of a phone by an ex-boyfriend (2003), reporting the burglary of 18 sheds in the basement area of her flat (2004) and as an informant to the robbery of an elderly male (2008).

11.17 There is no further reported agency contact for either Pearl or Raymond until 2016 when Pearl again was an informant to a robbery of an elderly man whilst Raymond was charged for a public order offence where he was very intoxicated and making threats. Later that year Pearl was found drunk and incapable in a public place and referred to Adult Social Care. She readily admitted to drinking too much, in her own words, 2-3 bottles of wine daily. She agreed to be referred to Change Grow Live (CGL) and half-heartedly engaged with them for about ten weeks before declining any further service.

11.18 In 2017 the police were called again to the on-going dispute between Raymond and his neighbour, which had now been flagged as racial due to (unspecified) comments made by Raymond, but no further action was taken.

11.19 In 2018 Pearl reported anti-social behaviour (ASB) in her neighbourhood but no further details are known. Information from housing suggests that Pearl took a keen interest in her neighbourhood and regularly reported incidents of ASB, cleanliness and maintenance issues.

11.20 At the beginning of spring 2020, just before and in the early stages of the first COVID lockdown, Raymond again came into contact with 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.

11.21 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.

11.22 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 had been in contact with him, but Raymond felt they '*don't seem to be interested*'.

11.23 At this time, his older brother stated that Raymond was in a bad mental state and had to be taken to a rehab centre which the family had arranged. He added that Raymond was '*imagining things and making comments that were just not true'*. For example, over these weeks he variously claimed that he had been pickpocketed in the street and held at knifepoint in his flat by three people, allegations which the police could not substantiate. He also said his wife and child had died, contradicting what he had said previously.

11.24 He entered residential rehab in early December and, although it was initially scheduled for 12 weeks, he was still there in April 2021. His cat was fostered during the rehab and arrangements were made for him to be rehoused on completing his treatment. 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.

11.25 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.

11.26 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 and told them that he had last worked as a cab driver in 2020. Occasionally he would try to stay sober or abstain from drugs, but this never seemed to last longer than a few days.

11.27 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.

11.28 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[7]. 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). She once even contacted the council about the build-up of rubbish outside the local library (March '23).

11.29 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.

11.30 In late November, while on the phone to housing, Pearl disclosed that a neighbour was '*taking advantage' of her*.' No further details are available, but she was advised to report this to the police.

11.31 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.

11.32 She was discharged and '*reablement work'*[8] 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.

11.33 It was reported that, after three weeks reablement: *"Pearl feels she has had a very positive experience with the reablement carer, who has supported her and helped her increase her mobility and confidence. She now feels she is independent and ready to continue managing on her own, and able to access the community, as she wishes."*

11.34 Pearl continued to engage with 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

[7] 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).

[8] This is short term occupational health.

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'*.

11.35 Pearl continued to have regular check-in calls with CGL throughout the spring and into summer: she typically responding during this period as '*doing very well'*. By the start of June Pearl reported being motivated and engaging well with community support. She had joined a meet-up group to build healthy connections. She was more active and doing sleep hygiene, which had been helpful. Her quality of life had improved. Pearl thanked her practitioner for recognising how well she had done, including her continued good recovery from her addiction problem. Pearl agreed for her case with CGL to be closed in June 2021 as her treatment was considered complete.

11.36 Raymond, meanwhile, continued the same pattern as before. Police reported that throughout 2022 there were 16 MERLINS[9] recorded, all related to Raymond's mental health concerns or alcohol. There were five crime reports (none of which were 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). They added that the police reported that he has been known to them for many years, and when he lived elsewhere there was a '*similar pattern of behaviour'*. His Housing Officer noted that his mental health was deteriorating, resulting in '*a huge volume of complaints regarding his behaviour'*. A referral was made to ASC.

11.37 In mid-August Raymond talked about his early life to his doctor. He said he was deserted by his mother and brought up by his father. The latter's death during the pandemic had turned him from a '*functioning alcoholic to a non-functioning one'*; he stopped working as a taxi driver and became a '*recluse'*.

11.38 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).

11.39 At the start of 2023, it was reported that three friends had come round for Christmas dinner, and they thought Raymond's psychosis was getting worse. He continued to decline during 2023. Throughout 2023, the police recorded a further seven MERLINS, noting his deteriorating mental health or alcohol concerns. There were three reports on CRIS (Crime Recording Information System) which related to Pearl once and Raymond twice as being victims of crimes. 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. His mental health also continued to deteriorate. He was convinced drug dealers were after him[10]. In August he claimed his brother *'with whom he lived'* had died. He was arrested for being drunk and disorderly in October. Throughout this period, he also reported thinking often of suicide.

11.40 Between the end of March and early December, ambulances were requested for Raymond 11 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.

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

[10] 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 reported that this took place at a community centre/cafe near Grenfell Tower. They struck up an initial conversation as Raymond was wearing a West Ham shirt, a team which her brother supported. At this time, Raymond referred to her as a '*friend'*; in early December 2023, he was referring to her as '*his girlfriend'*. In spring 2024, Adult Social Care, dealing with Raymond's threats of suicide, first reported mention of '*my friend Pearl'*. 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.

11.41 Apart from the many contacts with Housing previously mentioned, there appears to have been no noted agency contact with Pearl until late January 2023, when she was referred for an out-patient appointment (OPA) by her GP regarding her feet. It was noted that Pearl had consumed no alcohol since January 2022[11], lived alone and that a '*good social history'* was taken. She had some appointments regarding her feet in mid-year and in November, was put on the waiting list for surgery.

11.42 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'*.

11.43 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.

11.44 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 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 her diary entries had numbers against each page possibly indicating the length of time she abstained from alcohol. The numbering and indeed the diary entries ceased towards the end of May 2024 when it seems likely that Raymond's presence may have tempted her to start drinking again. This is, of course, just speculation.

11.45 Pearl had her 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

[11] Previous notes from CGL indicate Pearl had been abstinent since at least mid-2021. It has not proven possible to rectify this disparity in records.

trip and was '*excited to be catching up with friends and getting away from noise of carnival'*.

11.46 In late April, Raymond called Turning Point to say that he had gone into his neighbour's flat and found him dead. He was very distressed about this as he had had a long friendship with the deceased. 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'*. Due to concerns regarding the odd behaviour of Raymond around the time of this death, the police investigation was re-opened in September 2024. This investigation is ongoing.

11.47 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 coming over from Australia for twelve days and she would be eager to join when her friend left.

11.48 18 days later, Pearl was dead.

11.49 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'*.

11.50 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.

11.51 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.

11.52 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.

11.53 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.

11.54 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.

11.55 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.'

12. Analysis: Equality and Diversity

12.1 The nine protected characteristics[12] under the Equality Act 2010 were reviewed and due consideration given to each, as to whether or not they were applicable.

12.2. Age, disability, religion and sex were found to be relevant.

12.3. There was no evidence to suggest that gender reassignment, marriage and civil partnership, pregnancy and maternity, race, or sexual orientation were relevant to the circumstances of this case.

12.4 Age was felt to be potentially relevant in two ways. Firstly, Pearl was 70 when she was murdered. One in six older people in the community will experience abuse each year, equivalent to around two million people in England and Wales. One in four domestic homicides involve a victim aged 60 or over. In a European study[13], more than

[12] These are: age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex and sexual orientation.
[13] *'Domestic abuse in later life: A secondary analysis of the crime survey for England and Wales* Hannah Bows et al (2025)

one in four women aged 60 to 97 had experienced domestic abuse from a partner in the last year. It is only since 2017 that the Crime Survey England and Wales has included crime victims over the age of 59.

12.5 There is only one specialist domestic abuse support service for older women in London and only one more in the whole of England and Wales.[14] The Silver Project in London has supported 175 women over the past five years. The average length of support ranges from one month to one year and the average age of service users is 67 although the oldest was 94 years old. Of these, 59% had one or more disabilities and 90% had impaired mobility.

12.6 Coercive control can manifest itself differently for older people. For example, exploiting elements of aging such as memory loss to make the victim feel the process is more advanced than it is, exaggerating the 'care burden' to elicit sympathy from others and to position themselves as the 'victim' and controlling access to medication or food. The three main tactics used against older victim-survivors are exploiting dependency to neglect, isolation and economic abuse.[15]

12.7 Advancing age can also create additional barriers to making changes. Some may feel it is too late to start over, a refuge may not be suitable for an older person and for those with care needs, going into a care home may be the only realistic option.

12.8 In the case of Pearl, however, her alcohol consumption notwithstanding, she was sprightly, healthy and not showing any signs of aging such as forgetfulness. She was active in her local community, interested in learning new things and engaged with new technology. Many previous assumptions about old age are shifting as we live longer and lead healthier lives. It should also be noted that views that in the UK might be considered to belong to a bygone era – no sex before marriage, a horror of divorce, a world where domestic abuse was not openly discussed – all of these started to be swept away by Pearl's generation.

12.9 That is not to say that age played no part whatsoever. Pearl was lonely after Henrik died and at the age of 70, her options for finding love and companionship again may have seemed very different than they might have at, say, age 30. Similarly, her experience of life and different relationships may have led her to conclude that there was no such thing as the perfect relationship and to be more tolerant of shortcomings than she may have been earlier in life.

12.10 Another way in which age may have played a part is in the age disparity between Pearl and Raymond (13 years). Pearl may have felt flattered by the attentions of a younger man or indeed there may have been a more parental dynamic between the two. Certainly, Pearl's Australian friend felt that the latter may be the case with Pearl seeing Raymond as someone she could support to achieve his stated goal of becoming sober.

12.11 Disability in the form of enduring mental ill-health was felt to be potentially relevant for Raymond. Mental health teams were not able to assess Raymond's needs due to his alcohol dependency so it cannot be definitively stated that this was a factor. He was also known to consume a range of other drugs, all of which were probable contributors to his paranoia and delusions.

12.12 Religion may have played a minor role. Family members do not believe that Pearl went to Church either regularly or at all but that is not to say that she did not have a religious belief as they think she hoped to meet her friend Henrik in the afterlife. Her

[14] Dewis Choice, founded in 2015 and based in Wales, is a co-produced service for older survivors and conducts research into domestic abuse in later life.
[15] Information from the Silver Project, Solace Women's Aid.

Australian friend said that Pearl loved to be part of the Filippino community but that she struggled with the praying given that she herself was not devout.

12.13 Raymond, on the other hand, disclosed that one of the reasons stopping him from going through with taking his life was his Christian faith. As with much that Raymond said, we cannot know how true this was.

12.14 Sex was also found to be relevant as it is a significant risk factor for being a fatal victim of domestic abuse; women are more likely than men to be subjected to abuse. Women are around twice as likely to experience domestic abuse, and men are far more likely to be perpetrators. The majority of domestic homicide victims are women, killed by men[16]. On average, three women are killed every two weeks by their current or former partner in the UK, a figure that has changed relatively little in recent years. It impacts women's health and independence, and their broader inequality limits women's ability to escape from abusive men. Women remain more likely to be threatened, raped, assaulted and murdered by men they know and, in particular, by men with whom they are having, or have had, a romantic relationship.[17]

12.15. Despite well-established under-reporting, and not every reported incident of domestic abuse being a crime, according to the National Audit Office's 2025 report[18], in the year 2022–2023**,** VAWG-related offences accounted for 20% of all police-recorded crime in England and Wales. This marks a significant increase and reinforces the scale of the issue. Additionally, the End Violence Against Women Coalition's 2025 Snapshot Report[19] highlights a 37% rise in reported VAWG-related crimes between 2018/19 and 2022/23**,** indicating that the situation is worsening, not improving.

12.16 Finally, Pearl had a particular personality trait that made her vulnerable to an abuser who wanted to control her. She was, in the words of her friend*, 'very open about disclosing about her vulnerabilities… she openly discussed her obsessive-compulsive disorder and information such as how she and [Raymond] had never become intimate'.* Sadly, freely making this information available is a gift to an abuser who will readily exploit any perceived weaknesses if it allows them to increase their control.

13. Analysis: Key Lines of Inquiry

Information provided to the Panel was analysed against each of the key lines of enquiry set out in the terms of reference.

13.1. Each agency's involvement with Pearl and Raymond.

13.1.2 This is addressed in the narrative chronology above and 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

[16] Office for National Statistics. 'Homicide in England and Wales 2021.
[17] *'Long-term partners – Reflections on the shifts in partnership responses to domestic violence'* Kirsty Welsh, International Review of Victimology March 2022
[18] *'Tackling violence against women and girls'* National audit Office 2025
[19] '*No small change: Making halving VAWG a reality'* EVAW Coalition 2025

	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.

13.2 Whether practices by all agencies were sensitive to the nine protected characteristics[20] 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.

13.2.1 Overall, there is no evidence to suggest that services were not sensitive to the nine protected characteristics. However, this needs to be understood within the context of a lack of information on which to base any confident commentary on how protected characteristics were factored into the care and support they received. In some instances, Raymond's ethnicity was not always recorded and there was not always an exploration of his vulnerabilities.

13.2.2 It was noted that Raymond had multiple mental health assessments where he appeared to be under the influence of alcohol. The predominant view among assessors was that his psychological difficulties were secondary to his alcohol problems. There is a limit to any treatment that can be offered if someone continues to use alcohol / substances (see also section 13.6 below). At times, Raymond was also not engaging well with services, frequently attending for his appointments very late or not at all. It was the view of professionals at the time that Raymond really needed to address his alcohol and substance abuse first in residential detox, but he was reluctant to do so.

13.2.3 Raymond's suicidal ideation was explored during mental health assessments, and he disclosed that one of the reasons stopping him from going through with taking his life was his Christian faith.

13.2.4 Raymond did attempt to gain a ground floor property from his housing provider on health grounds. He was informed that medical documentation would need to be provided to support this which was never forthcoming. No other agency had any records of any mobility issues.

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

13.2.5 See also section 12: Equality and diversity.

13.3 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?]

13.3.1 Pearl's family were able to confirm that the couple met on April 28th 2023 as this was recorded in Pearl's diary. Therefore, most agency contact, being before that date, is historical or at least only contextual, to the nature of their relationship

13.3.2 Only four agencies were aware that there was a relationship: LAS, Turning Point, Notting Hill Genesis and Portland Road Medical Practice. Most of what agencies knew about the relationship came from Raymond, who was a very unreliable narrator. He gave multiple different explanations of their relationship describing Pearl as his friend, his partner, his carer, his fiancé, and his girlfriend. Towards the end, Raymond was keen to stress that it was not a sexual relationship. The Viagra found in Pearl's bedside table after her death, may or may not be relevant but she did tell her Australian friend that she and Raymond had never been intimate.

13.4. 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?

13.4.1 Little was known about Raymond as a perpetrator/criminal by the various agencies which dealt with him. Instead, he was responded to as a person with addictions and / or mental health difficulties. There was nothing in place such an injunction or a DASH assessment because any domestic abuse perpetrated by Raymond was at least 15 years old and to another partner. There was nothing to suggest he was abusive towards Pearl.

13.4.2 There is a question as to whether or not high level of anti-social behaviour towards neighbours and others should have triggered some intervention. However, it is uncertain what that would have looked like and whether any independent evidence exists to support it as a possible risk factor for domestic abuse perpetration.

13.5 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?

13.5.1 No agency or family or friends had any information about this issue. The police investigation subsequently revealed that the cash was irrelevant to the circumstances of Pearl's death and belonged to her.

13.5.2 However, it was noted that Pearl was very generous in life to everyone, including Raymond who she bought many gifts. As one of her friends commented: '*Pearl really loved spoiling people. That was sort of part of her charm. She really would love to go over the odds with incredible generosity.'* With no more detail, it cannot be asserted with any certainty that financial abuse was an issue in their relationship.

13.6 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?

13.6.1 There was a lot of effort made to try to engage Raymond in addressing his alcohol dependency. He was offered a wide range of ways to engage including group work, 1-2-1 work, when he didn't turn up telephone calls were made to engage with him, and he was signposted both to other sources of support and to detox and rehab. Unfortunately, Raymond had low motivation to address his issues so there emerged a repetitive cycle of mental health and alcohol services involvement, sometimes with police too, where Raymond would request help but then did not follow through long term. Detox was necessary in order to give him a mental health intervention and the symptoms he displayed were not severe enough to warrant a forcible intervention. He was determined not to have a fundamental mental health issue and there was no evidence of a lack of capacity to override his wishes albeit that it is acknowledged that no formal capacity assessment was ever undertaken. Only a criminal justice system intervention could have forced him into treatment but even then, motivation would still have been needed in order for any intervention to be effective. When Raymond's detox broke down, this information does not appear to have been passed to his GP.

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

13.6.2 Pearl's medical records state in 1997 that she had a history of alcohol dependency. Within the temporal scope of the Review, she was admitted to St. Mary's Hospital in November 2020 due to excessive alcohol consumption. She reported drinking a bottle of vodka a day, linked to the recent death of Henrik and a safeguarding concern was raised in relation to this. This was, appropriately, not pursued as a safeguarding matter, and following detox, Pearl was discharged and referred to alcohol services.

13.6.3 Pearl had two telephone consultations in December and by mid-February 2021 was reporting that she had stopped drinking.

13.6.4 In June 2022 Pearl had a routine health check with her GP during which she stated she was not drinking alcohol and wanted to volunteer to support other people with alcohol issues. By October, she was still not drinking and volunteering with the Companion Project which supports recovery and resilience in North Kensington following the Grenfell tragedy. It was here that she would later meet Raymond.

13.6.5 At some point, Pearl fell off the wagon and began drinking again. Whilst the exact details are not known, it seems that this occurred whilst she was with Raymond. At first, she was trying to help him get his drinking under control but shortly before she died, she came to the conclusion that she was not able to help him and seemed to also come to a realisation that he was having a negative effect on her own sobriety.

13.7. Did COVID impact on this case in any way?

13.7.1 Obviously, the pandemic affected the way agencies were able to respond. The police and LAS continued to respond to calls for service, but the general move towards communication by phone or online clearly impacted on all agencies to varying degrees. Without face-to face meetings, the subtext, background or potential dangers of a situation can be more difficult to ascertain. Staff needed to be given guidance on this, particularly around asking more probing questions than they might have done in person. Medical services were very overstretched at the time, but GPs did attempt to contact people with known vulnerabilities such as asthma (given what was understood

about COVID then). The pandemic also changed the nature of domestic abuse services, who were now almost exclusively working with high-risk victims on the phone, which created obvious dangers of missing essential risks.

13.7.2 Pearl and Raymond were not in a relationship during the pandemic, so were not impacted jointly, but were affected separately. Pearl was less affected, but some of her medical appointments were not as timely as they might have been pre-COVID. The pandemic restrictions also coincided with the death of Henrik, which probably exacerbated her feelings of loneliness and thus made her more vulnerable when she met Raymond.

13.7.3 The direct impact of COVID on Raymond was that he lost his income as a taxi driver (assuming he was one). This led to him drinking more and taking a cocktail of drugs. As he lived alone, his isolation was magnified during the lockdown weeks which cannot have helped his paranoia. During this time, Raymond reported the death of his father, which he said affected him greatly. He went into rehab, came out again, and was moved to new accommodation during the period of COVID restrictions. This meant he did not have the opportunity to build up a relationship with his housing officer as he might have done if they had been able to meet in person.

13.7.4 During panel discussions, agencies reflected on how provisions that were put in place during COVID had, not unreasonably, focused on protecting those who were vulnerable to catching COVID. With the benefit of hindsight, the panel felt that more might have been done to support those who were vulnerable in other ways, especially from being isolated. For example, social housing organisations could have organised WhatsApp groups to maintain social connections. It was felt that this could probably be achieved within existing resources.

Recommendation: RBKC Housing and housing associations to embed the concept of street / estate WhatsApp groups into their pandemic readiness plans.

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

13.8.1 In general, the answer to the above is yes, there being quite specific reasons why each agency became involved and most agencies being unaware of the relationship between Pearl and Raymond.

13.8.2 The one occasion identified where more might have been done was when Raymond's GP became aware that Pearl was involved in his care. There is no evidence to suggest that Pearl was ever asked if she wanted to be involved in Raymond's care and the answer to this may have potentially prompted other questions about the nature and quality of their relationship. Even if this had been done, however, it may not have resulted in any disclosures at the time Pearl would have been asked.

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.

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

13.9.1 Services appeared to be accessible to both Raymond and Pearl. In certain cases (e.g. Notting Hill Genesis, Goldborne practice) there was not enough information noted to definitively determine this, but in the absence of indications of difficulties, they are assumed to be accessible. Notting Hill Genesis was able to make appointments for Raymond later in the day as he was generally asleep in the morning (due to his drinking). In general, all services appeared to be accommodating. LAS also reported that, while not relevant in this case, they do have interpreters available to enhance accessibility of their services.

13.10 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?

13.10.1 The nature of Pearl and Raymond's relationship was unknown or unclear to family or friends let alone agencies. Most of the health services had never asked the question nor mapped family and friends, including during discharge planning from hospital when it ought to have taken place. In mitigation, unless a person is clearly vulnerable, the patient's capacity to make decisions during the discharge process has to be assumed. Ultimately, it is the patient's choice regarding who should or should not be informed about what is happening. On balance, however, the Panel felt that question should have been asked and then if Pearl had not wanted to answer, her wishes should have been respected.

13.10.2 Records about Raymond's family are patchy and inconsistent. As previously mentioned, he claimed his father died in the summer of 2020 and on another occasion. It was noted that he said he would not actually kill himself because of '*my boys'* (May 2020). In June 2020 he made reference to a partner having killed themselves '*a few days earlier'* and in November 2020 it was recorded by the police that Raymond '*stated that his mental health is suffering as both his wife and child are both dead'*. It is not known which, if any, of these statements are true but it seems likely that the majority are not.

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

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

13.11.1 Adult Social Care noted that in September 2023, mental health social care services returned to the local authority, following the end of the section 75 agreement by which they had been contracted out to the CNWL Mental Health Trust. However, it is not evident that this had any bearing on this case. Similarly, Notting Hill Genesis reflected that Raymond had a number of different housing officers managing his property. This would have meant it was harder for him to have built up a relationship with his housing officer or for the officers to have a comprehensive overview of him as a person and awareness of his spiralling mental state. However, Notting Hill Genesis goes on to note that changes in staff is not in any way unusual and was not the result of any larger organisational change.

13.11.2 All other participating agencies answered no with the exception of COVID impacts which is dealt with in section 13.7 above.

14. Effective practice

14.1 Notting Hill Genesis noted that there was some good practice in terms of referrals and signposting for support that was clearly needed. However, what is disappointing is the lack of follow up when these referrals were made.

14.2 LAS believed there was good evidence of professional curiosity whilst Portland MC felt that during their sessions with Raymond, he had started to reflect on his behaviour. Mechanisms to control anxiety were discussed including learning how to see the positives and to leave aside negative emotions.

14.3 ASC thought that the initial support provided to Raymond seemed flexible and person-centred. His rehab stays were extended and altered in response to his changing needs, and his concerns about his cat were addressed, to allow him to go into rehab in the first place. ASC also felt that the Council Tax Team, who were responsible for one of the referrals, deserved praise for identifying that Raymond was in need of additional support and making the appropriate contacts.

14.4 ICHT noted that both Pearl and Raymond were listened to, their wishes respected, and good history documentation was evident. They also praised LAS staff for providing good background information on Raymond.

14.5 Turning Point identified that their Friends and Family Lead responded promptly to the referral, offering both emotional and practical support to Pearl. He continued to follow up to engage Pearl, providing guidance on navigating the challenges of being a loved one of an individual struggling with alcoholism. He encouraged her to attend the support groups through follow-up communications via text, email, and phone calls.

14.6 With respect to Raymond, there was good communication between agencies he was offered regular key working, the offer of treatment options, including harm minimisation and abstinence-based recovery goals, detox and rehab.

15. Key findings by the DARDR Panel

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

15.2 Loneliness and isolation

15.2.1 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.

15.2.2 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.

15.2.3 It is well established that loneliness can kill[21]. What is less acknowledged is that the desperation to escape loneliness can result in people accepting unhealthy, even

[21] 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

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*[22] *and background'.*

15.2.4 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.

15.2.5 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…'*

15.2.6 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.

15.2.7 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'.*

15.2.8 *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.*

15.2.9 *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.'*

15.3 A lack of clarity about the relationship

15.3.1 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

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

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.

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

15.4 Domestic abuse is not just physical

15.4.1 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.

15.4.2 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.

15.4.3 It is now firmly established that coercive control is a far more common antecedent to domestic homicide than a history of physical violence[23]. 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.

15.5 Drugs and alcohol

15.5.1 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.

15.5.2 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.

15.5.3 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.[24]

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

[24] Information from Zoe Ladbroke's (Change Grow Live) presentation to the Panel

15.5.4 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[25]. 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.

15.5.5 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.'*

15.6 Raymond's anti-social behaviour

15.6.1 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.

15.7 Raymond's fantasy life

15.7.1 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.

16 Recommendations

16.1 Each agency who provided an IMR to this process identified their own lessons and these single agency recommendations can be found below and in the action plan at appendix E.

16.2 Notting Hill Genesis

[25] 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

16.2.1 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.

16.3 Portland MC

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

16.4 ICHT

16.4.1 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.

16.4.2 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.

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

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

16.5 Turning Point

16.5.1 Implement more domestic abuse training.

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

17. Conclusion

17.1 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.

17.2 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.

17.3 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.

Appendix A: Terms of reference

DOMESTIC ABUSE RELATED DEATH REVIEW
(DARDR)
INTO THE DEATH OF PEARL
TERMS OF REFERENCE

Overarching aim

The over-arching intention of this review is to learn lessons from the homicide in order to change future practice that leads to increased safety for potential and actual victims. It will be conducted in an open and consultative fashion bearing in mind the need to retain confidentiality and not to apportion blame. Agencies will seek to discover what they could do differently in the future and how they can work more effectively with other partners.

Principles of the Review

1. Objective, independent & evidence-based
2. Guided by humanity, compassion and empathy with the victim's voice at the heart of the process.
3. Asking questions, to prevent future harm, learn lessons and not blame individuals or organisations
4. Respecting equality and diversity
5. Openness and transparency whilst safeguarding confidential information where possible

Key lines of enquiry

The Review Panel (and by extension, any IMR / chronology authors) will consider the following:

1 Each agency's involvement with Pearl of address 1 and Raymond of address 2 (a 25 minute walk from address 1) between January 2020 and June 2024.

2 Whether practices by all agencies were sensitive to the nine protected characteristics[26] 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?]

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

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 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?

Panel Membership

Advance
Age UK Kensington and Chelsea
ASC
CNWL NHS Foundation Trust
ICB
ICHT
LAS
NHG
RBKC Housing
MPS
Turning Point

This may be amended if new information comes to light.

Family involvement

The review will seek to involve the family of the victim in the review process, taking account of who the family wish to have involved as lead members and to identify other people they think relevant to the review process.

We will seek to agree a communication strategy that keeps the families informed, if they so wish, throughout the process. We will be sensitive to their wishes, their need for support and any existing arrangements that are in place to do this.

We will identify the timescale and process and ensure that the family are able to respond to this review endeavouring to avoid duplication of effort and without undue pressure.

Contact with the family and other members of their social networks will be led by the Chair.

Disclosure & Confidentiality

- Confidentiality should be maintained by organisations whilst undertaking this process. This means details of the case should not be discussed with colleagues and consistent attendance is highly encouraged rather than using delegates.
- The independent chair, on receipt of an IMR, may wish to review an organisation's case records and internal reports personally, or meet with review participants.
- A criminal investigation is running in parallel to this Review, therefore all material received by the Panel must be disclosed to the SIO and the police disclosure officer.
- The criminal investigation may result in a court hearing. Home Office guidance instructs the Overview Report will be held until the conclusion of this case. Records will continue to be reviewed and any lessons learned will be taken forward immediately.
- Individuals will be granted anonymity within the Overview Report and Executive Summary and will be referred to by a pseudonym / job title. However, Panel members will be named.
- Where consent to share information is not forthcoming, agencies should consider whether the information can be disclosed in the public interest. Decisions not to provide information should be supported by a rationale and this will be recorded in the final report.

Timescales

Statutory guidance encourages DARDRs to be completed within six months notwithstanding any period of suspension required to allow legal processes to conclude.

After the initial meeting, the process will not continue until all agency reports have been submitted. Failure to meet deadlines therefore, delays everyone and incurs additional costs for Safer Kensington and Chelsea Partnership.

To avoid this, there will be an extended period of time for each agency to prepare their reports.

Media strategy

Panel members are reminded that they are representing their agency rather than being an individual. Therefore, no media comments should be made by either panel members or anyone else in their agency on this death until permission to publish has

been granted by the Home Office. This includes posting on social media. Any media enquiries in the meantime should be referred to the Chair.

Appendix B: Statutory definition of domestic violence

This statutory definition was introduced via the Domestic Abuse Act 2021 and is taken from the statutory guidance[27].

Definition of “domestic abuse”

(1) This section defines “domestic abuse” for the purposes of this Act.

(2) Behaviour of a person (“A”) towards another person (“B”) is “domestic abuse” if—

(a) A and B are each aged 16 or over and are “personally connected” to each other, and

(b) the behaviour is abusive.

(3) Behaviour is “abusive” if it consists of any of the following—

(a) physical or sexual abuse;

(b) violent or threatening behaviour;

(c) controlling or coercive behaviour;

(d) economic abuse (see subsection (4));

(e) psychological, emotional or other abuse; and it does not matter whether the behaviour consists of a single incident or a course of conduct.

(4) “Economic abuse” means any behaviour that has a substantial adverse effect on B’s ability to —

(a) acquire, use or maintain money or other property, or

(b) obtain goods or services.

(5) For the purposes of this Act, A’s behaviour may be behaviour “towards” B despite the fact that it consists of conduct directed at another person (for example, B’s child).

(6) References in this Act to being abusive towards another person are to be read in accordance with this section.

(7) For the meaning of “personally connected”, see section 2.

Section 2: Definition of “personally connected”

(1) Two people are “personally connected” to each other if any of the following applies —

(a) they are, or have been, married to each other;

(b) they are, or have been, civil partners of each other;

(c) they have agreed to marry one another (whether or not the agreement has been terminated); Domestic Abuse Act 2021 Statutory Guidance 22

(d) they have entered into a civil partnership agreement (whether or not the agreement has been terminated);

(e) they are, or have been, in an intimate personal relationship with each other;

[27] Domestic Abuse Statutory Guidance (publishing.service.gov.uk)

(f) they each have, or there has been a time when they each have had, a parental relationship in relation to the same child (see subsection (2));

(g) they are relatives.

(2) For the purposes of subsection (1)(f) a person has a parental relationship in relation to a child if —

(a) the person is a parent of the child, or;

(b) the person has parental responsibility for the child.

(3) In this section — “child” means a person under the age of 18 years; “civil partnership agreement” has the meaning given by section 73 of the Civil Partnership Act 2004; “parental responsibility” has the same meaning as in the Children Act 1989; “relative” has the meaning given by section 63(1) of the Family Law Act 1996.

Section 3: Children as victims of domestic abuse

(1) This section applies where behaviour of a person (“A”) towards another person (“B”) is domestic abuse.

(2) Any reference in this Act to a victim of domestic abuse includes a reference to a child who –

(a) sees or hears, or experiences the effect of, the abuse, and

(b) is related to A or B.

(3) A child is related to a person for the purposes of subsection (2) if –

(a) the person is a parent of, or has parental responsibility for, the child, or

(b) the child and the person are relatives.

(4) In this section – “child” means person under the age of 18 years; “parental responsibility” has the same meaning as in the Children Act 1989 (see section 3 of that Act); “relative” has the meaning given by section 63(1) of the Family Law Act 1996.

Appendix C: Further information about the chair and report author

Davina James-Hanman has been an independent Violence Against Women Consultant since 2015. She was formerly the Director of AVA (Against Violence & Abuse) for 17 years (1997-2014), which she took up following five years at L.B. Islington as the first local authority Domestic Violence Co-ordinator in the UK (1992-97). From 2000-08, she had responsibility for developing and implementing the first London Domestic Violence Strategy for the Mayor of London. A key outcome of this was a reduction in domestic violence homicides of 57%.

She has worked in the field of violence against women for almost four decades in a variety of capacities including advocate, campaigner, conference organiser, crisis counsellor, policy officer, project manager, refuge worker, researcher, trainer and writer. She has published innumerable articles and three book chapters and formerly acted as the Department of Health policy lead on domestic violence (2002-03). She was also a Lay Inspector for HM Crown Prosecution Service Inspectorate (2005-10).

Davina has authored a wide variety of original resources for survivors and is particularly known for pioneering work on the intersections of domestic violence and alcohol/drugs, domestic violence and mental health, child to parent violence, developing the response from faith communities and primary prevention work.

She acted as the Specialist Adviser to the Home Affairs Select Committee Inquiry into domestic violence, forced marriage and ‘honour’ based violence (2007-08) and Chairs the Accreditation Panel for Respect, the national body for domestic violence perpetrator programmes. From 2008-09 she was seconded to the Home Office to assist with the development of the first national Violence Against Women and Girls Strategy. Davina was also a member of the National Institute of Health & Care Excellence group which developed the domestic violence recommendations and subsequent Quality Standards. She was subsequently an Expert Adviser to NICE for six years.

Davina is also a Trustee of the Centre for Women’s Justice and a research Fello at Trinity College Dublin. She has chaired and authored over 60 DARDRs.

Appendix D: Merged spot check report (see separate document)

Appendix E: Action Plan (see separate document)