LONDON BOROUGH OF EALING
SAFER EALING PARTNERSHIP

DOMESTIC HOMICIDE REVIEW
EXECUTIVE SUMMARY

'M F JONES' AGED 25

FATALLY STABBED IN SEPTEMBER 2016

REVIEW PANEL CHAIR AND AUTHOR
BILL GRIFFITHS CBE BEM QPM
11 SEPTEMBER 2018

Safer Ealing Partnership - Domestic Homicide Review Panel
'M F Jones' killed on 17 September 2016

EXECUTIVE SUMMARY

Introduction

This summary outlines the process of the Community Safety Partnership Domestic Homicide Review (DHR) Panel established in April 2017 under s9 Domestic Violence, Crime and Victims Act 2004 by the London Borough of Ealing (LBE) Community Safety Partnership, independently chaired by Bill Griffiths CBE BEM QPM, to review the homicide in Ealing of 'M F Jones'[1] aged 25, caused by multiple stab wounds in September 2016, that had been inflicted by his partner, 'Rachel'[2] aged 27, who was then acquitted of all criminal charges.

The process began with a meeting on 10 May 2017 of all agencies that potentially had contact with those involved prior to the death of M F Jones. Agencies participating in the review were:

- LBE Adult Safeguarding
- LBE Children's Services
- A2 Dominion (Ealing Housing Provider)
- West London Mental Health NHS Trust
- London North West Healthcare NHS Trust
- North West London Clinical Collaboration for Clinical Commissioning Groups
- London Ambulance Service NHS Trust
- NHS England
- National Probation Service
- Metropolitan Police Ealing Borough and Specialist Crime Review Group

Contributions and specialist advice to the Panel were also received from:

- Southall Black Sisters
- Hestia

Agencies and local voluntary organisations in Ealing were asked to give chronological accounts of their contact with M F Jones, Rachel and her two children aged 7 (from a former partner) and 2.5 (from MFJ) prior to his death. Based on an integrated chronology from when the couple first met in 2010 to the time of the homicide, Individual Management Reviews (IMR) were provided by the agencies above, except for A2 Dominion where the contact was not relevant to the review process.

M F Jones' father, step-mother and maternal aunt provided perspectives on his life and were consulted on the Terms of Reference for the review. They were given access to iterations of the overview report so as to ensure accuracy and that their concerns were properly reflected. Rachel also contributed her perspective to the review. The DHR Panel has offered condolences to the family of the deceased.

The family had issues with the conduct of the trial by the Crown Prosecution Service (CPS) and had attended a 'bereaved family meeting' when 15 questions were put forward for consideration. A copy was provided to the Chair and a response requested from the CPS which was done. The conduct of the trial is outside of the scope of the review, however, family concerns have been highlighted where relevant.

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[1] Not his real name and chosen by his family along with MFJ as a shorter version
[2] A pseudonym chosen by her

The process ended when the Safer Ealing Partnership Board approved a final version of the DHR report at a meeting on 11 September 2018.

Background information – the narrative of their relationship

M F Jones and Rachel were in a relationship from 2010, when he was aged 19 and she 21, until he was fatally stabbed by her in September 2016. She already had Child A (born 2009) from a prior relationship and they had Child B together in November 2013. Each had experienced an unsettled childhood.

MFJ's parents divorced and he lived with his father and stepmother until aged 16 when they separated and he and his father moved in with his paternal grandmother. There were 10 domestic incidents recorded by the police in the following two years, mainly over minor disputes with his father. Two resulted in convictions, for assault and affray, for which he received warnings.

Rachel's mother parted from her father before she was born. Her mother became mentally unwell with bi-polar disorder and Rachel was placed in foster care from the age of 8 to 13, then lived with her paternal grandparents in Somerset followed by an aunt and uncle in the same county. She returned to live with her mother aged 16 prior to the birth of Child A.

Each had their mental health challenges. MFJ was admitted to an Emergency Department (ED) for an overdose with suicide ideation in November 2014. He also attended in December 2015 with suicide ideation because he had been 'kicked out' by Rachel. She made calls to an ED regarding self-harm in October 2013 (when pregnant with Child B) and, in March 2016, attended the ED for an 'inadvertent' overdose. In March 2014, Rachel was diagnosed with Bi-Polar Disorder Type II, meaning she suffered from predominant depression with relatively mild hypomanic episodes. Alcohol was a factor in some of the domestic abuse incidents that occurred in their time together, including the fatal one.

Their relationship appeared to be an 'on/off' one throughout, with MFJ moving out to live with his father in Bournemouth from February 2015. Rachel would say that they were "together, just not living with each other all the time". Following a relatively peaceful period from October 2015, MFJ had returned to live with her and the children for about three weeks before the homicide in September 2016.

The reported incidents of domestic abuse started in February 2012 at a social gathering when MFJ assaulted Rachel and two men who tried to intervene. He admitted the charges and was given a Community Order with a domestic abuse prevention programme. MFJ was not good at keeping to instructions from his Probation Officer and twice was brought back to Court in breach of the Order, which eventually was modified to a requirement to carry out Unpaid Work.

There were four other occasions when the police were contacted:
June 2012 – by Rachel to eject MFJ from her mother's home after a verbal argument. MFJ left before police arrived. A risk assessment was completed and a multi-agency referral form (MERLIN) sent to Ealing Children's Services (ECS) regarding Child A.
February 2014 – by MFJ because Rachel had refused him access to collect his clothing. She claimed that she had purchased the clothing for him but would not let him have it so that he could

see other women behind her back. MFJ walked off. The officer noted the presence of Child B and completed a MERLIN report.
January 2015 – by Rachel after MFJ had assaulted her by body punching and biting her nose after she asked him to leave. He also made a threat to kill her when talking by phone to his father. He left before police attended. When he was subsequently arrested in Bournemouth, Rachel declined to assist a prosecution and the CPS did not proceed
October 2015 – by Rachel's mother because MFJ had damaged property trying to gain entry and made threats to kill. Again, MFJ absconded before police arrived. He drew £30 cash using a bank card and returned the next day and took belongings. The risk assessment level was heightened and protective measures put in place, with an arrest plan for MFJ. The case was referred to the Ealing MARAC (Multi-Agency Risk Assessment Conference) in December. When arrested and interviewed, MFJ provided his account and the CPS directed no further action.

There was an additional incident that was not brought to the attention of the police at the time:
December 2013 – by Rachel calling the London Ambulance Service (LAS) to the flat because MFJ was complaining of chest pains. She disclosed she had struck him with a candlestick. Bruising across MFJ's back was noted, the symptoms subsided, and MFJ declined treatment.

Another unreported incident identified by MFJ's family occurred in:
June 2014 – by MFJ's family noticing a cut on his upper arm they believed was caused by Rachel. The lack of inclusion at the trial was an issue for them with the CPS. Rachel has suggested that MFJ was the aggressor, the injury was caused in a struggle and was more of a scratch than a cut. No scar was noted by the pathologist who examined him two years later.

There were other unreported incidents of abuse by MFJ identified by Rachel at her trial.

MFJ had been staying with the family for about 3 weeks prior to the fatal domestic incident on 17 September 2016. They had argued about Rachel's overnight stay with a friend the night before but conversations were 'courteous' as, that afternoon, Rachel took Child A to a family party and MFJ took Child B to a football match. When Rachel returned that evening, she woke up MFJ to continue the argument. He objected and then attacked her, at which she seized a kitchen knife to defend herself and stabbed him three times. On arrival of police and paramedics MFJ was beyond saving.

Witness statements gathered from friends and family during the homicide investigation and interviews with his close family provided conflicting views of MFJ and Rachel's relationship. MFJ's family members say that Rachel was jealous and controlling of MFJ. They cited a number of occasions when Rachel would throw MFJ out of the flat as his name was not registered there and she had full control. MFJ would be told to leave, often late at night, essentially with nowhere to go. The children would be used as 'emotional blackmail' to ensure his return. They have speculated that he did not wish to be seen as 'unmanly' by reporting instances of abuse by Rachel.

On the other hand, Rachel's friends and family were aware of unreported violent and controlling behavior by MFJ against her. Rachel referred to this when interviewed about the homicide and said she had not reported the incidents as she did not want Social Services to become involved and then consider taking her children into care.

One feature of their relationship that emerged at the trial was the extensive text traffic between them. An impression gained from this evidence is that Rachel suffered from low self-esteem and needed a great deal of reassurance. If MFJ did not respond to a call or a text, she would send an 'essay' of a rebuke. MFJ could be critical also in his text messages to Rachel, commenting how difficult she was to be with. It seems that neither could leave 'unfinished business'; much of the squabbling was so as to have the last word in the argument.

As parents, however, each was observed to be loving to the children. MFJ treated Child A as his own and she regarded him as her father. Nonetheless, there were some concerns recorded in safeguarding reports highlighting the impact on the children of observing parental arguments. They were openly and jointly concerned that contact with any kind of statutory service might lead to their children being taken into care. This manifest in avoidance behaviours such as missing appointments and ignoring attempts at contact by professionals.

Conclusions from the review

This review has identified that M F Jones and Rachel were in a volatile relationship that was characterised by strife, both face to face and remotely via private text messaging. Some of this led to physical assault and associated allegations, such as burglary, to retrieve possessions and, for MFJ, appearances at Court and the imposition of probation orders.

They frequently separated and were probably apart as much as they were together, with MFJ staying with his father in Bournemouth for most of the time apart and sometimes with his step-mother or aunt. They were generally held to be loving and supportive parents to Child A, whom MFJ treated as his own, and to their Child B and there were few concerns for the health and well-being of the children, save for the potential impact of witnessing aggressive arguments between their parents.

Contributing factors were a relationship in which neither could let a matter rest without having the final word and that either could 'snap' and lose control when arguing. Their respective mental health states could have been relevant and, in the case of Rachel, alcohol may have impaired her decision making and exacerbated her response to the situation on the evening of the fatal incident.

There is a lengthy time-gap between the sixth known domestic abuse incident in October 2015 and that event in September 2016. The relationship between MFJ and Rachel seems to have settled into a more peaceful state. The known trail of domestic abuse, such as it was, had apparently subsided and none of the family featured in extant safeguarding activity during that time-gap.

The Panel's overall assessment is that the level of detail provided by hindsight was not available to agencies at the time and conclude that what was available would not have enabled services to predict and prevent this particular tragedy. Nonetheless, the review has exposed individual and systemic shortcomings that provides helpful learning to improve the system for safeguarding adults and children.

The seven IMRs prepared by agencies identified a total of twenty internal recommendations to improve the system for safeguarding (appendix 3 to the overview report). The Panel are satisfied that these improvement commitments are complete or have work in progress.

The IMR recommendations for wider improvements were analysed by the Panel and three strategic learning points were identified:

A. There is a need to improve the effectiveness of the Ealing MASH (Multi-Agency Safeguarding Hub)
B. There should be a review of the impact on the quality of care caused by lack of continuity of health professionals
C. There is a need to review training and awareness of the wider definition of controlling and coercive domestic abuse and to develop a 'healthy scepticism, an open mind and, where necessary, an investigative mindset'[3] about the real situation in relationships

Recommendations from the review

In response to these learning points, the Panel have prepared recommendations and an Action Plan (appendix 4 to the overview report) for the Safer Ealing Partnership to oversee:

1. The Ealing MASH (Multi-Agency Safeguarding Hub) should improve and reinforce the protocol for sharing of critical information, such as the ECS sending CP information to the GP and the GP not being informed of the homicide. Probation should also ensure that when information is received that a perpetrator has moved back in with a victim of abuse and their family the appropriate referral is made to Vulnerable Adult and/or Children's Social Care (Learning Point A)
2. London North West University Healthcare NHS Trust Community 0 – 19 Service should look at issues arising from this case to establish if the lack of continuity of health professionals has impacted on the quality of care (Point B)
3. Although safeguarding training is mandatory for all health and social care staff, there remains a gap in the provision of training in relation to Domestic Abuse (including the impact on both victim and perpetrator) (Point C)
4. That all agencies are alert to the need to balance positive observations of parenting and children's well-being with detailed observation, direct work and research evidence to determine the impact on children of domestic violence (C)
5. That all staff working with domestic violence are familiar with the cycle of violence. Workers and Managers in all agencies must challenge repeated assurances that relationships are over. Claims about relationships ending need to be backed up with solid evidence about what has changed (C)
6. That an unwillingness to engage with family support services is explicitly treated by all agencies as an indicator of higher risk (C)
7. That when parents are minimising or denying concerns and where their non-engagement places children at increased risk of harm, all agencies evidence more challenging dialogue with parents (C)
8. That when there are counter-claims or observations of abuse between partners, including controlling and abusive behaviours, a 'culture of inquiry' is developed to challenge stereotypical perspectives and assumptions (C)

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[3] Source: The Victoria Climbie Inquiry Report 2003