

**South Nottinghamshire Community Safety Partnership**

*Working together to make Broxtowe, Gedling and Rushcliffe Safer*

# **Domestic Homicide Review into the death of Rachel**

## **Executive Summary Report**

**Date of Death: April 2024**

**Report Chair and Author: Carolyn Carson**

**Report Completed: 28th July 2025**

# **‘Rachel<sup>1</sup>’ as described by those who loved her.**

## ***Our beloved ‘Rach’***

***Her boys said - Mum was the most beautiful, wonderful and strongest woman we knew and could have ever wished for. She was a best friend and had such a special bond with each one of us. No love in the world will ever come close to the love we shared with her, we will forever cherish our memories with her.***

***There are simply not enough words to describe how much we loved her and how much she will be missed.***

***Rachel was loved by everyone in her huge extended family and everyone in her community. People who knew her would describe her as a ‘friend to everyone’***

***Rachel dedicated her life to her 3 boys, and you would often find her spending time supporting them in their various activities, whether this be at school cake sales or serving hot drinks by the side of a football pitch early on a Sunday morning. Rachel was a fine cook and baker, and she often had a list of people waiting for her scones and lemon curd tarts.***

***Rachel always greeted everyone with a smile and would light up the room particularly at family events, she was truly the heart of the family. She was vibrant, selfless and the most caring person, she would help everyone she could. Rachel was the ‘little sister’ to her 2 brothers whom she had a very close bond with and was a huge part in her nieces and nephews’ life. She was the aunty that everyone would truly turn to. She had several groups of friends, some which were lifelong.***

***Once her boys left school, Rachel took up a part time job in a cafe which she loved. Her work colleagues have been left devastated by her loss and celebrated her 1st anniversary by completing a sky dive to raise money for women’s aid. Local schools and her workplace have benches in memory of Rachel and local pubs and organisations continue to hold events in her memory.***

***She is sorely missed by everyone that knew her.***

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<sup>1</sup> **Note to Home Office QA panel:** Rachels family have requested that her real name is used through out this report and are aware of the implications of that for data protection purposes and privacy, especially from the media, and that Rachels experience will be openly available for all to see, forever. The family do not wish to see Rachels name replaced with a pseudonym.

## Contents

1	Introduction.....	4
1.3	Timescales .....	4
1.4	Confidentiality.....	4
2	Terms of Reference .....	5
3	Methodology.....	6
4	Involvement of Family, Friends and wider Community .....	7
5	DHR Panel and Contributors to the Review.....	8
6	Author and Chair of the DHR and Overview Report .....	10
7	Parallel Reviews .....	10
8	Equality and Diversity .....	11
9	Dissemination .....	12
10	Background Information.....	13
11	Chronology .....	14
12	Overview of Known Information .....	19
13	Conclusions.....	21
14	Lessons Learned .....	24
15	Recommendations .....	27

CONFIDENTIAL

# 1 Introduction

1.1 This report of a domestic homicide review examines agency responses and support given to Rachel, a resident of Eastwood, Nottingham, prior to the point of her death in April 2024.

1.2 In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer for those subject to domestic abuse.

## 1.3 Timescales

This review began on the 22<sup>nd</sup> May 2024 and concluded on the 28<sup>th</sup> July 2025.

Due to a delay whilst a criminal trial was undertaken, this has extended beyond a six-month period. There followed a further short delay to ensure Rachel's family could fully engage prior to completion.

## 1.4 Confidentiality

1.4.1 The findings of each review are confidential. Information is available only to participating professionals and their line managers through the process. At the time of the homicide Rachel was 53 years of age and Dean, 60 years of age. Both are white British citizens. Rachel's family have requested that Rachel is known by her real name, Rachel, specifically asking that she is not anonymised. The review respects this and has complied with their choice. Dean, however, is anonymised, with his name chosen by the review Chair to closely align with Deans age and demographic without specifically identifying him.

## 2 Terms of Reference

- 2.1 Examine what professionals understood about Rachel's living circumstances and understand the dynamics within Rachel's immediate family, including with her estranged husband, Dean.
- 2.2 Examine how professionals reviewed wider issues within Rachel's family circumstances. Consider if the family were considered narrowly through the lens of their middle child's diagnosis of autism or were wider issues considered and explored.
- 2.3 Examine how any identified substance misuse within the family impacted on family dynamics and understand if professionals were aware of issues of paranoia that could have affected the family.
- 2.4 Examine issues relating to mental health within the family and understand how this was assessed and managed by professionals. Ascertain if mental health issues were identified and how they may have affected the family dynamic.
- 2.5 Seek to understand how Rachel may have perceived her situation as a victim of domestic abuse through the scoping period. Understand if professionals had an opportunity to help her identify as a victim and to help her to access support.
- 2.6 Seek to understand how well understood the family's / community's approach to, and /or recognition of domestic violence was throughout the scoping period.
- 2.7 Ascertain what services could have been available to the family through the scoping period had there been an identification of Rachel's abusive relationship.
- 2.8 Ascertain how well known about, accessible and responsive were support services that may have been available to the family.
- 2.9 Seek to understand how families such as Rachel's, know where to go for support and help when domestic abuse is a feature. Understand what needs to change to ensure awareness of vital protective support for victims of all forms of domestic abuse in the community.

- 2.10 Seek to understand what barriers existed that prevented the reporting of abusive and violent incidents in Rachel's home.
- 2.11 Examine if professionals were aware of any trauma faced by Dean due to reported post childhood sexual abuse. Understand if professionals were aware of any anger issues that Dean may have exhibited. Where apparent, understand what, if any, support was offered to Dean to manage his trauma and/or anger.
- 2.12 Understand if there were any opportunities missed by professionals to spot potential indicators or abuse and/or to identify risk of harm at any stage.
- 2.13 Understand if there were any barriers to accessing support for wider issues affecting this family.
- 2.14 Examine whether communication and information sharing, within and between agencies could have been improved during the scoping period. Understand if any opportunities existed for multi-agency referrals for vulnerability or risk of harm and/or risk management meetings.
- 2.15 Examine if any professional had an opportunity to exercise professional curiosity.
- 2.16 Establish if appropriate support was offered post the domestic homicide to living relatives, in particular through the DHR process.
- 2.17 Identify examples of positive practice, both single and multi-agency through the scoping period.

### 3 Methodology

- 3.1 The Broxtowe Community Safety Partnership (CSP), were notified of the need to consider a domestic homicide review via a Potential Domestic Homicide for Consideration form received from East Midlands Serious and Organised Crime Unit on the 9<sup>th</sup> May 2024. This was disseminated to statutory partners within the CSP for information and decision to proceed, and following a majority agreement, the decision to undertake a DHR was made by the Broxtowe CSP on the 22<sup>nd</sup> May 2024, and the Home Office informed.

- 3.2 The Chair and Author were identified, engaged and contracts signed before the Initial trawl documents were requested. Due to a lack of agency information apparent initially, a decision was made to speak to Rachel's family to ascertain their insights on how Rachel engaged with agencies and to understand her lived experience, prior to a scoping meeting. A Scoping meeting (and first panel) then convened, followed by an IMR Authors briefing and reports received. A learning event (and second panel) was held on the 29<sup>th</sup> January 2025, which incorporated family information and included practitioners and specialists, and a full discussion of events was held. This resulted in the draft overview report, followed by a further panel discussion.
- 3.3 Having reviewed version 2, the panel met to specifically agree an action plan. Consequently, on the 28<sup>th</sup> July 2025, the CSP submitted the Overview Report, Summary Report, Action Plan and Data Collection Document to the Home Office.
- 3.4 The scoping period was agreed to be from January 2020, until Rachel's death in April 2024.
- 3.5 The review has been undertaken by means of an open and enquiring approach, with an emphasis on family information, and practitioner involvement at the learning event. A review panel of statutory partners and specialist domestic abuse agencies have effectively supported the process. In total, 4 panel meetings have been held, sufficient to ensure the panel were able to effectively discharge their statutory duties and support the review author to complete the overview report.
- 3.6 The Summary Report will be published on the Broxtowe CSP website<sup>2</sup> together with any comments made by the Home Office at the conclusion of the process.

## 4 Involvement of Family, Friends and wider Community

- 4.1 Rachel's Mother and eldest son were initially supported by the specialist advocacy Victim Support Homicide Service, through the Criminal Justice and

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<sup>2</sup> <https://www.broxtowe.gov.uk/for-you/crime-safety-emergencies/domestic-abuse/>

commencement of the DHR processes.<sup>3 4</sup> Once the criminal trial was complete, a caseworker facilitated a meeting between the review chair and the family in August 2024. This meeting provided valuable information that would not have been known to the review without the family's generous time to share their thoughts and perspectives at such a difficult and recent time of grieving.

4.2 Later in the process, Rachel's family were effectively supported by Advocacy After Domestic Abuse (AADFA<sup>5</sup>), who facilitated a review of the final Overview Report, and ensured the family were able to make changes where they believed it was important, with full agreement of the Chair and Panel. The family have also had an opportunity to review the Action Plan.

4.3 From within the community, the review chair has contacted the local family lawyer who supported Rachel through her divorce proceedings prior to her death, as per the interactions outlined in the chronology. The lawyer spoke generically to the review about the role of family lawyers in safeguarding but did not feel able to speak directly about Rachel. A request to seek permission from the family to allow a direct conversation was not responded to.

## 5 DHR Panel and Contributors to the Review

Members of the DHR Review panel were drawn from local agencies, both statutory and non-statutory. Some provided information from contact with Rachel, whilst others were supporting the panel in an advisory capacity. From the statutory agencies, all panel members were independent from having worked directly with Rachel and her family. It is not always possible for this to be the case with smaller non-statutory agencies due to their wider professional role, however, any information provided was subject to supervision by a line-manager.

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<sup>3</sup> [Homicide Service - Victim Support](#)

<sup>4</sup> [https://www.victimsupport.org.uk/wp-content/uploads/2023/11/P2557-1\\_Guidance-for-Domestic-Homicide-Review-Chairs\\_1023.pdf](https://www.victimsupport.org.uk/wp-content/uploads/2023/11/P2557-1_Guidance-for-Domestic-Homicide-Review-Chairs_1023.pdf)

<sup>5</sup> AAFDA - <https://aafda.org.uk> AAFDA has over a decade of experience advocating for families after the homicide, suicide or unexplained death of their family member or friend, following domestic abuse. AAFDA was established in 2008 by Frank Mullane in memory of his sister Julia Pemberton and her son Will, whose murders in 2003 resulted in the pilot Domestic Homicide Review being conducted.

<b>NAME</b>	<b>AGENCY</b>	<b>STATUS</b>	<b>IMR, Report or Information</b>
Carolyn Carson	Independent Chair/Author	Panel	
Marice Hawley	Broxtowe Borough Council	Panel and DHR Support	
Lorna Peltell	Nottinghamshire County Council Childrens Service	Panel Member Report Author	IMR
Nick Judge	Integrated Care Board	Panel	Provided Information
Maggie Westbury	Nottingham University Hospitals NHS Trust	Panel and Report Author	
Steph Clarke	Nottingham University Hospitals NHS Trust		Advised at learning event.
Chris Harris	Broxtowe Women's Project	Panel	
Hannah Albis	Broxtowe Women's Project	Panel	
Chelsea Lambert	Victim Support	Panel	
Richard Idle	Sherwood Forest Hospitals NHS Trust	Panel	Summary Report
Kerry Sullivan	Equation	Panel	Summary Report
Joanna Elbourne	Police	Panel	
Fiona McVey	Police	Panel	
Rob Wells	Police	Report Author	IMR
Charlotte Binney	Police		Practitioner Input
Helen Pritchett	Nottinghamshire Healthcare NHS Trust	Panel	
Ginnette Smedley	Nottinghamshire Healthcare NHS Trust	Report Author	IMR

Thomas Worrell	Change, Grow, Live (Substance support)	Panel	Summary Report
Harry Lees-Manning	Broxtowe Borough Council	Panel	
Claire Konsek	Broxtowe Borough Council	Panel	
Novlette Holness	Nottingham Sexual Support Service	Panel	
Ross Leather	Nottingham County Council Adult Services	Panel	
Sam Bennett	Juno womens domestic abuse commissioned service	Panel	
Mark Beeby	Nottinghamshire Probation Service	Panel	

## 6 Author and Chair of the DHR and Overview Report

6.1 Carolyn Carson is an Independent Safeguarding Reviewer and has undertaken DHR's since 2013 across England and Wales. Carolyn retired as a Police Superintendent in 2012, having specialised extensively in Safeguarding through her service, at both a practitioner and senior manager level. Carolyn served in, and remains based in, Leicestershire. As such, she has not worked directly with any of the agencies involved with Rachel or the Broxtowe Community Safety Partnership. Carolyn has undertaken the Home Office training for DHR Chairs and recently, in February 2025, was certificated having successfully completed the revised Chairs training provided by AAFDA .

## 7 Parallel Reviews

7.1 The DHR was initially delayed awaiting the prosecution of Dean through the criminal justice system. On the 12<sup>th</sup> July 2024, Dean pleaded guilty to the murder of Rachel and sentenced to life with a requirement to serve 23 years and four months in prison before consideration of parole. The Coroner has been informed about the DHR and will be updated once the review is completed to ensure they can fulfil their duties.

## 8 Equality and Diversity

- 8.1 Rachel and Dean were married, white and British. In terms of Protected Characteristics, marriage is a specific characteristic within the Equality Act 2010 and is important to prevent direct or indirect discrimination due to being a married person.<sup>6</sup> In relation to domestic abuse, the Crime Survey for England and Wales estimates showed that a significantly lower proportion of people aged 16 years and over who were married or in a civil partnership experienced domestic abuse than those who were either cohabiting, single, separated or divorced for year ending March 2025<sup>7</sup>. In addition, Rachel was a woman, and Dean was a man. An individual's sex is also a protected characteristic within the Equality Act 2010<sup>8</sup>, important to prevent direct or indirect discrimination and to prevent victimisation and harassment due to an individual's sex. In relation to domestic abuse, both men and women can experience domestic abuse, but female victims experience higher rates of repeated victimisation and are more likely to be seriously hurt or killed than male victims.<sup>9</sup> For every three victims of domestic homicide, two will be female<sup>10</sup>.
- 8.2 Rachel and Dean lived in a former mining community, which is described<sup>11</sup> as being insular and a close-knit community by professionals who perceive that the community will often resolve their own issues without redress from agencies such as the police. Rachel lived in a family centred, close, community, predominantly white and middle class. The 2021 Census findings show clearly that Eastwood is a predominantly white community, with the UK as the primary country of birth<sup>12</sup>.

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<sup>6</sup> <https://www.equalityhumanrights.com/equality/equality-act-2010/your-rights-under-equality-act-2010>

<sup>7</sup> <https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusevictimcharacteristicsenglandandwales/latest>

<sup>8</sup>

<sup>9</sup> [https://www.bing.com/search?q=equality+act+protected+characteristics+sex&cvid=7b8f9308e7424b65bc8f57a874155ec8&gs\\_lcrp=EgRIZGdlKgYIABBFgDkyBggAEEUYOdIBCTE5NDA0ajBqNKgCCLACAQ&FORM=ANAB01&adppc=EDGEESS&PC=LCTS010/marriage-and-civil-partnership](https://www.bing.com/search?q=equality+act+protected+characteristics+sex&cvid=7b8f9308e7424b65bc8f57a874155ec8&gs_lcrp=EgRIZGdlKgYIABBFgDkyBggAEEUYOdIBCTE5NDA0ajBqNKgCCLACAQ&FORM=ANAB01&adppc=EDGEESS&PC=LCTS010/marriage-and-civil-partnership)

<sup>9</sup> Women's Aid, 2024

<sup>10</sup> <https://www.ncdv.org.uk/domestic-abuse-statistics-uk/>

<sup>11</sup> Panel discussion from locally based professionals

<sup>12</sup> [https://www.citypopulation.de/en/uk/eastmidlands/nottinghamshire/E63001910\\_eastwood/](https://www.citypopulation.de/en/uk/eastmidlands/nottinghamshire/E63001910_eastwood/) :

8.3 Assessing Rachel through the lens of Intersectionality, Rachel was a dedicated wife and mother in a middle class all-white family. She had been married to Dean for 25 years. Her family were her whole world and although she and Dean had been separated for 4 years prior to her death, she was faithful to Dean and remained hopeful of a reconciliation through most of that time, despite his abusive behaviour. She was proud of her 5-bedroom family home and did not want to lose it for her children. Rachel cared about her family remaining as a unit and was motivated to stay married. These factors help to understand Rachel and her particular situation. Sadly, they also helped to prevent her from identifying her relationship as being one of coercion and control, or that she was a victim of domestic abuse by violence.

## 9 Dissemination

- 9.1 Once agreement for the final report has been given by the Home Office Quality Assurance Board, an Executive Summary of this Domestic Homicide overview report will be available on the council website. The report will be suitably anonymised to protect the dignity and privacy of the family and to comply with the Data Protection Act 1998.
- 9.2 Upon publication, all partner agencies, locally or nationally, will be made aware, and the action plan will be shared with the agencies involved. In addition, a copy of the final report will be provided to the Office for Police and Crime Commissioner and the Domestic Abuse Commissioner.

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### Country of Birth (C 2021)

UK	18,158
EU	376
Europe (other)	32
Middle East & Asia	101
Africa	163
Other country	71
Ethnic Group (C2021)	
White	18,125
Asian	225
Black	140
Arab	18
Mixed/multiple	322
Other ethnic group	48

- 9.3 The review has been assured by Broxtowe Community Safety Partnership that the learning will be disseminated by means of partnership training and developed guidance.
- 9.4 Rachel's family have been given the opportunity to review the Overview Report and Action Plan, and comment appropriately. Prior to publication, Rachel's family have been consulted on the Home Office feedback and consulted as to actual date of publication.

## 10 Background Information

- 10.1 The victim, Rachel, lived in Eastwood, Nottinghamshire, a civil parish within the Broxtowe district, approximately 8 miles north-west of Nottingham City. Rachel was killed in the family home she had shared with Dean for their married life. They had been together since 1994, when Rachel would have been 24 years old and Dean, 33 years old. At the time of the homicide, Dean was not living in the home, instead, from early 2020 he chose to move out to reside on a narrow boat on the nearby canal network. However, he would still visit the family home daily for his meals and continued to run his business from there, thereby spending long periods of time at the family home on a daily basis.
- 10.2 Dean killed Rachel when he knew she would be at home alone in the morning. It was pre-planned, and he entered the property and strangled Rachel with a shoelace, previously modified to act as a garrotte. A shoe was subsequently found on his boat missing the lace. On leaving the address, Rachel's eldest child was just arriving home and Dean admitted having killed their mother. Dean surrendered to the police the same morning.
- 10.3 The cause of death is recorded as strangulation.
- 10.4 Living at the home with Rachel at the time of her death were her three children, aged 23 years, 21 years and 18 years respectively.
- 10.5 Dean was charged with Rachel's murder for which he subsequently pleaded guilty and was sentenced to life imprisonment.

## 11 Chronology

- 11.1 **Prior to the scoping period**, the family were known to the NHS Foundation Trust who were supporting Rachel and Dean to obtain a diagnosis for their middle child for autism spectrum. In March 2012, when their child was 11, a formal diagnosis for Autistic Spectrum Disorder was made. In addition, due to difficult behaviour, work was also undertaken on an on-going basis by the Child and Adolescent Mental Health Service (CAMHS) And Nottingham County Council Children's Service, Family Service. There was no indication of the existence of any abuse in the family at this time.
- 11.2 The family inform the review that around 2016, Dean's Dad died and that this affected him profoundly. A year later in 2017, Dean's uncle died in Ireland, and it was disclosed by an affected family member that the uncle had sexually abused them, and Dean, during family visits to Ireland when they were boys, for a period of 10 years whilst under the age of 13. From the point of disclosure, Dean's behaviour was reported to deteriorate and became erratic. He consumed large amounts of cannabis (an increase of an existing habit), but now also started to drink excessively.
- 11.3 A Paediatrician referred the middle child to the Family Service to help the family manage their symptoms of Autism Spectrum Disorder. In consequence, between August 2017 and August 2018, the child was open to Nottingham County Council Children's Service Family Service. It was reported that Rachel sought support to manage the behaviours because it was impacting her youngest child. They fought and couldn't be left home alone together. During this period, Rachel is recorded as not having a positive relationship with the child's school and Rachel and Dean removed their child from school. They felt the child was being bullied and kicked out of lessons and being left in isolation as a 'naughty child' without consideration of their issues. An Education Health Care Plan had been commenced. Rachel and Dean tried another school but that was also unsuccessful, and the child left college at 16.

- 11.4 The murder investigation has identified that between January and March 2019, Dean self-referred to a commissioned counselling service, the finer details of which are not available to the review.
- 11.5 **The scoping period commences in January 2020.** Nottingham City Council Children’s Service report that the middle child had an Education Health Care Plan still open, and remained so until October 2020, but because he had ceased to attend a college placement, it was closed with no additional detail added in this period. The situation for the middle child has been discussed by the review panel and there was no identification of, or concerns of, domestic abuse in the family through this period. As such, the children are not subject to further analysis in this review to protect their privacy.
- 11.6 In January 2020, GP records identify that Dean saw his GP and outlined his history of sexual abuse and symptoms of anxiety. He outlined that he was living on a narrow boat and separated from Rachel, although visiting the family daily. He stated he has ‘got it into his head that Rachel does not love him even though she says she does’. A few weeks later, Dean had a GP Depression interim review and having commenced medication, reported feeling a lot better.
- 11.7 In February 2020, Rachel saw her GP for HRT medication.
- 11.8 The police criminal investigation has identified that in May 2021, Rachel attended a locally based family solicitor for advice concerning her relationship, outlining that she had been separated from Dean for 18 months on a trial basis, but that Dean was still coming to the house. Rachel’s family state that Rachel wanted this to stop because of her concerns about his behaviour.
- 11.9 Between July 2021 and September 2021, Rachel saw her GP for minor ailments 7 times. In February 2022, Rachel was again seen by her GP for an HRT check, and it was noted that her blood pressure was raised. Rachel described ‘some stress’, but no further detail was recorded as to why.
- 11.10 An out of hours 111 call was made by Rachel in November 2022, but no further details are available to the review.

11.11 On the 1<sup>st</sup> of February 2023, Rachel returned to her Solicitor<sup>13</sup> and reported that Dean was still ‘coming and going’. She had been hoping for a reconciliation up to now but realised that it wasn’t going to be the case. Dean wants a divorce, and Rachel is now seeking advice on this and how to keep her house.

11.12 On the 9<sup>th</sup> of February 2023, Rachel was seen for a blood pressure check which was raised and required home monitoring. No other detail is recorded.

11.13 On the 3<sup>rd</sup> March 2023, Rachel had a GP check-up for her blood pressure and prescribed medication due to it being high. No other detail recorded as to why.

11.14 In July 2023, Rachel reported to two family members that when Rachel was at home in the garden, sitting by the firepit in the early evening, Dean rushed into the garden through the back gate suddenly, and without warning he grabbed her arm and pushed her whilst kicking the firepit. Dean accused her of ‘being a liar’ and that he would ‘have her’. Rachel immediately ran to her mother’s where she decided not to report the assault to the police, stating that it would ‘only wind him up more’ and ‘nothing would keep him away from the house’. Bad bruising to Rachel was evident.

11.15 On the 21<sup>st</sup> August 2023, Dean had a further GP consultation, during which it is recorded that:

- Dean started to forget things.
- Split up from wife 4 years previously and doesn’t have happy memories.
- States Rachel was controlling him and now controls youngest child.
- Middle child has autism, and Rachel argues with them and causes stress.
- Rachel tried to turn two children against the third.
- Dean states that Rachel has been physically abusive 3 to 4 times over 26 years; on one occasion breaking his thumb, but not in front of the children.
- Dean very emotional.

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<sup>13</sup> Information from Police criminal investigation

- Currently drinking 12 bottles of beer a night and smoking cannabis. Declined professional support for this and advised not to withdraw suddenly.
- 11.16 Rachel's family report that at some point in approximately September 2023, Dean entered Rachel's home at 7 in the morning whilst Rachel was still in bed, shouting at her that 'she was evil' and a 'narcissist'.
- 11.17 During the autumn of 2023, the family report that Dean began not paying bills, resulting in the internet being cut off in October. Rachel's family took steps to try to find a solution for Rachel to move to another house but were not successful due to a lack of mortgage ability and the belief by Rachel that 'wherever she went, Dean would get in'.
- 11.18 On the 22<sup>nd</sup> of November 2023, Rachel's solicitor sent a letter to Dean to indicate Rachel would not oppose a divorce and suggested arrangements for Rachel to keep the house. A reminder was sent in early December, but no response was received. Rachel's family strongly believe that Rachel informed the solicitor about the assault in July.
- 11.19 On the 19<sup>th</sup> of December 2023, GP records show that Rachel's blood pressure was nearly normal.
- 11.20 On Christmas Eve 2023, Rachel told her family that she wanted to try again with Dean and on the 10<sup>th</sup> of January 2024, Rachel emailed her solicitor to halt divorce proceedings as 'building their relationship as friends and seeing where it goes'. However, having gone out for a meal with him in January 2024, Rachel told her family that all he wanted was to regain control and stop her seeing a solicitor. He informed her that if you keep seeing me, 'I'll pay the bills'.
- 11.21 On the 9<sup>th</sup> February 2024, Dean saw his GP for a consultation during which he outlined his previous marital history (Rachel was second wife) and stated that Rachel was narcissistic and puts him down. He is drinking more and smoking cannabis. He disclosed his childhood abuse but no thoughts of hurting himself or others. No delusional thinking. The GP discussed 'red flags for crisis mental health'.

- 11.22 On the 12<sup>th</sup> of March 2024, Rachel had her final GP appointment, for a blood pressure check, which was slightly raised.
- 11.23 Rachel's family report that In March 2024, Dean started to reduce his payments towards the household bills. He cancelled Rachel's car insurance and tax, and Rachel could not afford to pay these bills as she was now paying for more household bills. This resulted in her having to sell her car. Dean continued to pay £140 per week for food shopping as he ate all his meals at the home address and also made his lunch there each morning. He threatened to cancel this once the youngest child turned 18. Whilst Rachel had always contributed to the bills, her monthly income from her waitressing job was not enough to cover all the household bills on her own. At the time her youngest son was only 17 and still studying.
- 11.24 On the 19<sup>th</sup> of March 2024, Rachel emailed her solicitor to say that reconciling is no longer what she wanted, and Dean had unexpectedly had the house valued which had disconcerted her. Three days later, on the 21<sup>st</sup> of March, Rachel informed her solicitor that Dean had cancelled insurance direct debits and sought advice. Also, asked how she stood in relation to him coming and going. The solicitor recorded that Dean is allowed 'reasonable access', but that attending without notice and using facilities is unreasonable and she could ask him to change his habits to ensure her right to privacy.
- 11.25 On the 26<sup>th</sup> March 2024, Dean was seen by his GP and reported that since the 9<sup>th</sup> February disclosures, he had been getting flashbacks and vivid memories whilst sleeping. He is unsure as to why but worse at night and struggling to sleep. He reports having post-traumatic stress disorder from a previous abusive relationship. Dean was referred to the practice specialist mental health practitioner and was waiting to be allocated an appointment at the time of the homicide.

- 11.26 Later the same day, Dean's GP followed up by sending him a text message to provide a link to mental health support services.<sup>14</sup>
- 11.27 In April 2024, Rachel was murdered by Dean. Rachel's family report that on reflection it appears that there were significant signs of planning by Dean. In February he became upset that he could not have 'one last holiday' with the boys. He also started sending text messages to his eldest son late at night which was out of character. 2 weeks prior to the incident Dean had approached his friend and made arrangements for his dog to be taken care of 'should anything happen to him.' On the morning of the 19th April Dean arrived at the house and sent his employees out on a job as usual. He spoke with his middle son about the purchase of some equipment that morning but then parked up the road until his youngest son left the house. He then entered the house and completed his invoices before proceeding to kill Rachel.
- 11.28 Following Dean's arrest for murder, he was seen in custody by the NHS Foundation Trust Liaison and Diversion Scheme where it was noted that Dean was calm and showed no signs of paranoia. He stated he had been drinking 16 cans of beer a night and the primary risk identified was one of alcohol withdrawal.

## 12 Overview of Known Information

- 12.1 The key source of information known about Rachel and Dean during the scoping period by statutory agencies was the GP surgery, where both Rachel and Dean were registered. It is notable that Rachel's notes are very sparse whereas Deans are comprehensive. Dean had been forthcoming about his past issues of being sexually abused as a child and was diagnosed with anxiety and depression. He disclosed heavy use of alcohol and cannabis. Dean also reported an unhappy marriage with Rachel; alleging having been abused by her to the extent of emotional and physical abuse. At the time of the homicide, Dean was waiting for

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<sup>7</sup> <https://mind.org.uk/informnation-support/types-of-mental-health-problems/post-traumatic-stress-disorder-ptsd-and-complex-ptsd/treatment/>

an appointment to see a mental health specialist. Rachel's family would like to attest that at no time did friends or family see Rachel being abusive to Dean.

- 12.2 A key source of information known about Rachel comes from recorded interactions with a family divorce lawyer. Rachel disclosed financial abuse, and reports on three occasions that Dean kept entering her home after he had moved out. Rachel's family believe Rachel informed her solicitor about the physical abuse.
- 12.3 Rachel's family describe Rachel and Dean as originally a happy couple who met and lived together quickly, moving into Dean's previous married home, before marrying a few years later, with no fuss because Rachel was a 'practical person'. Dean's first marriage ended acrimoniously after his wife left with his money, for someone else, after a year of marriage. Dean and Rachel would regularly spend time together without the children, going out every Saturday evening. Rachel was very close to her mother, children, family members and friends, and turned to them for support. She kept them updated on her relationship with Dean, telling them directly about his behaviour whilst also observing controlling, and violent, behaviour themselves.
- 12.4 In addition to information in the chronology, Rachel's family report that Dean has always been intransigent, for example, always deciding where the family would holiday (a friend's caravan in Devon), and without fail, he spent every Friday evening with his friends in one of the friends shed.
- 12.5 When Rachel had concerns about their middle child's development Dean would not allow him to be seen because he was ashamed of his issues and the family report that this caused arguments between them. Rachel was very concerned about their child being bullied at school and not developing properly and proactively worked to prevent the bullying and with support from a paediatrician team, she was able to commence the child's diagnosis.
- 12.6 The family described Dean as once having been a 'perfect Dad', taking care of the family, and providing for them. He was described as very loyal and protective and would deal with any issues that arose with the family, such as arguments his

children may have had with others, in a 'calmy aggressive manner' in that he always remained calm but would determinedly challenge in a focused and planned way. He would do anything for his family, but he would not call the police, preferring to resolve any matters himself. However, the family saw a big change after his father died and his experiences of sexual abuse became known. He consumed cannabis all the time and began to drink. Dean told the family that he had undertaken counselling and saw the Nottingham Sexual Violence Unit. The family state that Rachel emphatically did not want Dean to tell the boys about the abuse, but he did so, sitting them down to explain; an event the children describe as a strange evening, with a belief that he only told them because Rachel didn't want him to, to take control back.

- 12.7 The eldest children describe their relationship with Dean to be generally good but could also be up and down because he often started arguments. Dean had a more difficult relationship with his youngest child who would challenge his behaviours and attitude to Rachel. The children feel a late trigger for Dean may have been the fact at the end of March, they were taking the youngest child on a holiday abroad on turning 18, as a first friend's trip. Dean asked if he could go, and they tried to explain that it was a young person's trip and so he couldn't. Dean appeared depressed by this and whilst they were away sent strange text messages. The family stated that at times, they have been worried about Dean having suicidal thoughts.
- 12.8 Prior to her death, the family report that Rachel had taken steps to get divorced and started planning to do things with friends and family. Although short of money, she still cared about herself. At the time of her death, Rachel had only £2.50 in her purse and no other money. She had put her last £20 in her niece's birthday card.

## 13 Conclusions

- 13.1 Rachel had been in a family centred, long marriage to Dean, during which they had three children, all of whom were living with Rachel at the time of her death. They lived in what had previously been a mining community, in their own 5 bedroomed property.

- 13.2 There were early signs of control in the family, with Dean making all major decisions and being in control of much of the finances. Dean changed after disclosures, 8 years before the homicide, that he had been sexually abused by an uncle as a young boy. This impacted Dean leading to an increase in cannabis use and a high level of alcohol consumption. Dean chose to end the marriage and moved out of the family home 4 years prior to the homicide. His mental health suffered, and he was treated for depression. He was referred for support for his mental health and was waiting for an appointment, three weeks prior to the homicide.
- 14.3 Post-separation abuse was a feature of Rachel and Dean's relationship prior to the homicide. Dean continued to visit Rachel as he wished. He reduced the monies available to Rachel, and cancelled direct debits, leading to the loss of internet and Rachel's car. She had very little money of her own. Dean stated his intention to divorce but controlled Rachel by taking steps to prevent her doing so. He entered Rachel's home uninvited and was abusive and on one occasion, was violent, causing injury to Rachel. This was unreported to agencies.
- 13.4 Throughout, Rachel stayed loyal, demonstrating a parallel to the features of a trauma bond, a situation that is very hard to break from, and often needs specialist help to do so. Rachel did not believe Dean would ever hurt her. A key issue for the review is the fact that Rachel did not identify as a victim of domestic abuse, and she did not wish to report abuse to the police when physically harmed. Rachel relied on her family for support and as a family, and reflected in the community, did not always want to involve the police. Had a report been made and abuse identified, there were many opportunities to directly support Rachel, and through the application for civil orders, prevented Dean from being in the family home.
- 13.5 Dean has demonstrated a classic homicide timeline, with his behaviour escalating. His timeline to the homicide continued uninterrupted and he remained in control until Rachel took steps to progress a divorce and move on with her life, at which point he killed her.

- 13.6 No agency was aware of the domestic abuse suffered by Rachel and so were not able to interrupt Dean's behaviour. Her only contact was with her GP, and she did not disclose her abusive situation even though she was well known at the surgery. This reflects the hidden nature of domestic abuse.
- 13.7 Dean, however, disclosed to his GP that his marriage had been unhappy, and alleged that Rachel had been abusive to him. This is contrary to all the information available to the review that overwhelmingly show Rachel to have been a dedicated wife and mother. Given the nature of his allegations, a referral should have been considered, or signposting, to a specialist support agency. Had a referral been made, this would have been an opportunity for an assessment of the relationship to take place, with the potential to identify Rachel as a genuine victim.
- 13.8 Another opportunity existed to disrupt DEAN, through Rachel disclosing information to her local family solicitor that amounted to financial abuse and coercive and controlling behaviour, including seeking advice about Dean continually coming to the home. Sadly, domestic abuse was not discussed and identified and direct support to protect Rachel not considered. Family solicitors do not have to contribute to a DHR, and this is a missed opportunity to understand Rachel's interactions with the solicitor, or to highlight the role of family solicitors as the eyes and ears of divorcing individuals, in a unique position to support directly through application of civil orders. In particular, Occupation and Non-Molestation orders, available free of charge to domestic abuse victims, and designed to prevent access by an abuser, can be swiftly applied for through the solicitor where risk is identified.
- 13.9 Dean murdered Rachel in a planned way. He had opportunities to manage his mental health and substance use but he chose to kill Rachel before a vital mental health appointment was available. Agencies did not have an opportunity to work with him and in consequence his risk of harm was not able to be identified and managed.

- 13.10 It is vitally important that victims of domestic abuse understand the situation they are in and understand that support and help is available. Being able to relate to abusive actions outside of the concept of domestic abuse is necessary to recognise their situation. Victims need to see the risks they are facing, and understand the potential for harm from their abuser, and to know how to access the wide support networks available in the community. The value of reporting to the criminal justice system and the police should be publicised to promote confidence to do so and for victims to know steps will be taken to protect them.
- 13.11 Agencies and professionals need to take every opportunity to identify abuse by being professionally curious. Victims, and their families and friends, need support to know how to identify abuse and to know where to go for support, and have confidence that they will be helped and their wishes valued, to prevent this tragedy happening to someone else in Rachel's position.

## 14 Lessons Learned

### 14.1 Lesson 1

Rachel's lived experience is demonstrably that as a victim of domestic abuse through violence, financial abuse, coercive and controlling behaviour and ultimately as a homicide victim. The perpetrator behaviour of Dean paralleled the recognised '8 step domestic homicide timeline'.

### 14.2 Lesson 2

Rachel did not see herself as a victim of domestic abuse which was a barrier to having an opportunity to seek support from agencies.

### 14.3 Lesson 3

Research indicates that only 20% of victims report abuse. Like many, Rachel did not report a physical assault to the police thereby preventing direct identification of domestic abuse.

### 14.4 Lesson 4

Rachel faced barriers to reporting abuse, namely the likelihood of a trauma bond with Dean and that she preferred to seek support from within her family and not agencies, including the only agency to have come into contact with Rachel, her GP surgery where she was well known.

#### 14.5 Lesson 5

Dean alleged domestic abuse to his GP but there was a lack of professional curiosity and this was not explored, resulting in a missed opportunity for Dean to be referred to a specialist service.

#### 14.6 Lesson 6

To enhance the identification of domestic abuse and to reassure partners, GP surgeries should ensure staff receive up to date domestic abuse training to identify risk factors and understand the importance of wider safeguarding referrals and professional curiosity.

#### 14.7 Lesson 7

A barrier to management of domestic abuse for Rachel was the lack of understanding that her situation was abusive, a fact mirrored nationally. Research identifies that many victims do not relate to the concept of domestic abuse as that which they are experiencing.

#### 14.8 Lesson 8

Reporting to the criminal justice system has the potential to be transformative for victims and survivors of domestic abuse – potentially a place to find justice, safety, and support. A direct report to the police opens a range of support to victims and risk assesses the need for immediate and on-going protection from harm.

#### 14.9 Lesson 9

There is good advice available to local safeguarding agencies through the DASH Risk assessment guidance which if utilised, can enhance the identification and management of domestic abuse.

#### 14.10 Lesson 10

The situation in relation to the risks posed by Dean through the impact of childhood trauma and excessive use of substances cannot be properly established. Efforts were made by his GP to help Dean manage his issues through direct support and an appropriate referral, but agencies were not able to engage with him prior to the homicide through choices he made. As such, Dean did not engage with mental health services and continued to rely on substances with no apparent awareness of the impact this may have had on his potential for risk.

#### 14.11 Lesson 11

A referral to Equation for Dean by the GP, or information provided, where accepted, could have been an opportunity to support the family and identify and manage risk to Rachel, and risk from Dean.

#### 14.12 Lesson 12

Due to the number of factors affecting Rachel's family, the GP could have considered a 'Think Family' approach as a means of speaking directly to Rachel to discuss the impact on the family which would have been an opportunity to assess risk.

#### 14.13 Lesson 13

Family solicitors are the eyes and ears of divorcing individuals in the community. They are in a unique position to identify abuse, in particular, post-separation abuse, and take active steps to protect victims. Updated training in domestic abuse would enhance their ability to identify and protect victims.

#### 14.14 Lesson 14

The contributions of wider professionals to a DHR, such as family solicitors, working with domestic abuse victims in the community would greatly enhance learning for the future prevention of harm.

#### 14.15 Lesson 15

DHR's should plan effectively and work with specialist support professionals to ensure that families can engage fully and with confidence to a DHR, with the effects of secondary trauma mitigated as much as possible.

#### 14.16 Lesson 16

A referral to AAFDA is necessary at the commencement of every DHR to ensure families have access to appropriate advice and support.

## 15 Recommendations

### 15.1 Recommendation 1

Broxtowe Borough Council should review and revise domestic abuse procedures to ensure messaging to the public incorporates an understanding of what situations are abusive, to enhance identification and management of domestic abuse by victims and agencies.

### 15.2 Recommendation 2

The Nottinghamshire Domestic Abuse Board should review and revise how the domestic abuse victims in the community report abuse, to enhance confidence in the benefits of the criminal justice system and/or support agencies.

### 15.3 Recommendation 3

Broxtowe Borough Council to commission the development of a community domestic abuse package to share with non-agency professionals who work with domestic abuse victims locally, to directly enhance victim safety.

### 15.4 Recommendation 4

Home Office to consider a national review of professionals in the community who work with victims of domestic abuse and evaluate how best to engage to enhance contributions to a DHR.

### 15.5 Recommendation 5

Home Office to consider a national campaign to raise awareness aimed at helping victims to realise that the presenting and tangible features of their

relationship may be domestic abuse and that where identified, there is help available to victims in their community.

#### 15.6 Recommendation 6

Broxtowe Borough Council should make a recommendation to the South Nottinghamshire Community Safety Partnership that a specific 'learning the lessons' event is held locally for safeguarding partners and key stakeholders with a focus on the homicide timeline which led to Rachel's death, to promote learning and wider awareness raising arising from the tragic circumstances of Rachels death.

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## Appendices

### App 1 Single Agency Recommendations

- 1 The ICB to support GPs to consider self-reflection on professional curiosity and to ensure staff receive current domestic abuse training to ensure identification of risk factors and a Think Family approach.
- 2 Equation to ensure that their team are reminded of the importance of recording date of birth and address details at first contact where possible, or record where not possible.

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