



SAFER LAMBETH PARTNERSHIP DOMESTIC ABUSE RELATED DEATH REVIEW Executive Summary Report into the murder of Rokel in January 2022

**Independent Chair and Author of Report: Ian Vinall
Associate, Standing Together Against Domestic Abuse
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Pen Portrait – Rokel

Rokel was described by friends as a very kind and charitable woman who was always looking out for others in need. She was a very outgoing person, very bubbly and friendly who always dressed in 'grand clothing'. She had a small group of friends in the Sierra Leonian community and was a popular person. She helped run a charity in Sierra Leone and her house was full of various items that were destined for those in need in her home country. Rokel attended the local mosque and after prayers Rokel would always serve food. Friends from the mosque described her as a 'lovely lady who was always smiling and happy, she is very giving and helpful'.

The descriptions of Rokel highlighted by family and friends was of a woman with passion, compassion, strength and care. She was very connected to friends and held a strong connection to her home country. She was highly regarded by her employer and her caring and dedicated approach to meeting the needs of others was evident.

Executive Summary

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1. Preface

1.1 The Review Process

- 1.1.1 This summary outlines the process undertaken by Safer Lambeth Partnership Domestic Abuse Related Death Review (DARDR) panel in reviewing the homicide of Rokel, who was a resident in their area. The Review Panel expresses its sympathy to the family and friends of Rokel for their loss.
- 1.1.2 The following pseudonyms have been in used in this review for the victim and perpetrator to protect their identities and those of their family members. Rokel was a Black African woman who was born in Sierra Leone and moved to the UK in 1994. She was aged 46 at the time of her death. For reference and explanation of the pseudonym "Rokel". Rokel is the largest river in Sierra Leone. The river is a path which lends itself quite well as good illustration of Rokel's life. Symbolically, the river is a source of livelihood for many (drinking water, transport, agriculture and links many communities). Rokel symbolises the irreversible passage of time and a sense of loss - the loss of a mother, a community champion and charity worker.
- 1.1.3 Joseph is a 48-year-old Black African man who originates from Sierra Leone. Rokel and Joseph were partners for approximately 18 years. Sometime prior to 2004, the couple had an Islamic wedding which was not legally recognised in the UK. Rokel and Joseph have one child together known as Child A for the review. Joseph was also in a relationship with another woman during their marriage (known as Susan) and they had a child together.
- 1.1.4 In the early hours one morning in January 2022, a fire broke out in the upstairs bedroom of the family property. The occupants of the property were Rokel, Joseph and Child A. Joseph and Child A escaped the property, with Child A calling the emergency services. Once the fire had been extinguished, Rokel's body was found in the upstairs bedroom. She was badly burnt and there were no signs that she had attempted to escape the fire. The fire investigators reported a strong smell of accelerant coming from the vicinity of her body. Forensic examination confirmed that the fire started on or around the bed. The post-mortem examination revealed that Rokel's death had not been caused by the fire. An absence of evidence of smoke inhalation confirmed that she had been killed before the fire was set. Her death had been caused by one or more stab wounds to her face, neck, and chest.
- 1.1.5 Joseph was charged with murder in 2022. The trial was held in London in October 2023. Joseph pleaded not guilty but was found guilty of murder and arson and jailed for life, serving a minimum of 29 years.
- 1.1.1 The review process began with an initial meeting of the Community Safety Partnership on 29 March 2022 when the decision to hold a DARDR was agreed. All agencies that potentially had contact with (victim/perpetrator) prior to the point of death were contacted, asked to confirm whether they had involvement with them, and instructed

to secure their records. Subsequently, the Home Office was notified of the decision in writing on 7 April 2022.

- 1.1.2 Standing Together Against Domestic Abuse (hereafter ‘Standing Together’) was commissioned to provide an independent Chair (hereafter ‘the chair’) for this review on 5 May 2022. The completed report was handed to the Safer Lambeth Partnership on 20 March 2025. In June 2025, it was tabled at a meeting of the Safer Lambeth Partnership Executive Board and signed off, before being submitted to the Home Office Quality Assurance Panel on 12 June 2025. On 3rd December 2025, the completed report was considered by the Home Office Quality Assurance Panel. On 13 January 2026, the Safer Lambeth Partnership received a letter from the Home Office Quality Assurance Panel confirming the report may be published, subject to amendments. The report was sent to the Chair on 15 January 2026, and the amended version was received from the Chair on 22 January 2026. The CSP completed its review and final amendments in June 2026.

1.2 Contributors to the Review

- 1.1.3 This review has followed the 2016 statutory guidance for Domestic Abuse Related Death Reviews which was issued following the implementation of Section 9 of the Domestic Violence Crime and Victims Act 2004. A total of 15 agencies were contacted to check for involvement with the parties concerned with this review. Of these, eight had only limited contact and submitted a Summary of Engagement (SoE). However, five had more contact and were asked to submit Individual Management Reviews (IMRs). A narrative chronology was also prepared. The chronologies were combined, and a narrative chronology written by the Chair. The following agencies and their contributions to this review were:

Agency	Contribution
Victim Support	SoE
Metropolitan Police Service	SoE, IMR and Panel Member
South London and Maudsley NHS Foundation Trust (SLaM)	SoE
Child A’s School	SoE, IMR and Panel Member
Refuge	SoE and Panel Member
Adult Social Care, London Borough of Lambeth	SoE
London Fire Brigade (LFB)	1 st Panel
Lambeth CSP, London Borough of Lambeth	Panel Member

Children's Social Care, London Borough of Lambeth	Panel Member
Lambeth Clinical Commissioning Group (CCG)	Panel Member
Lambeth Addictions Consortium	1 st Panel
Kings College Hospital (KCH)	1 st Panel, IMR
Named GP for Adult Safeguarding	SoE, IMR and Panel Member
Resident Services, London Borough of Lambeth	1 st Panel
Education and Learning, London Borough of Lambeth	1 st Panel
National Probation Service (NPS)	SoE
Victim Support (VS)	1 st Panel
Central London Community Healthcare NHS Trust	Panel Member, IMR

- 1.2.1 The IMRs were written by authors independent of case management or delivery of the service concerned. Most of the IMRs received were comprehensive and enabled the panel to analyse the contact with Rokel and Joseph, and to produce the learning for this review.

1.2 The Review Panel Members

Job Title	Agency
Patient Safety Lead, Mental Health	NHS England and NHS Improvement – London
Designated Safeguarding Nurse	Lambeth Integrated Care Board (ICB)
Head of Nursing Safeguarding Children and Interim Head of Evelina London Patient Safety, Quality and Assurance	Guy's and St Thomas' NHS Foundation Trust (GSTT)
Safeguarding Adults Operational Lead	Kings College Hospital (KCH)
Interim Safeguarding Adult Lead	Adult Social Care, London Borough of Lambeth
Headteacher and Deputy Headteacher	Child A's School
Violence Against Women and Girls Programme and Commissioning Manager	Safer Lambeth Partnership

Interim Head of Lambeth and Wandsworth	National Probation Service (NPS)
Specialist Crime Review	Metropolitan Police Service (MPS)
Named GP for Adult Safeguarding	ICB
Senior VAWG Workstream Lead	Safer Lambeth Partnership
Head of Operations	Refuge
Clinical Service Manager	Central London Community Healthcare NHS Trust
Interim Assistant Director	Education Learning Lambeth
Head of UK Programmes	FORWARD
Director of Safeguarding Children	Central London Community Healthcare NHS Trust

- 1.2.2 Review Panel members were of the appropriate level of expertise and were independent, having no direct line management of anyone involved in the case.
- 1.2.3 The Review Panel met a total of four times, with the first meeting of the Review Panel on the 12 September 2022. There were subsequent meetings on 23 January 2024, 10 October 2024 and 18 February 2025. The Chair of the Review wishes to thank everyone who contributed their time, patience and cooperation to this review.

1.3 Chair of the DARDR and Author of the Overview Report

- 1.3.1 The Chair and author of this review is Ian Vinall an Associate of Standing Together. Ian has received Domestic Homicide Review Chair's training from Standing Together and AAFDA and successfully completed the accredited Certificate in Chairing a Domestic Homicide Review (DHR) training. Ian has chaired and authored six reviews. Ian is a qualified social worker with over 30 years post qualifying experience. He also chairs and authors local child safeguarding practice reviews, safeguarding adult reviews and offensive weapon homicide reviews.
- 1.3.2 Ian has no connection with the Safer Lambeth Partnership or any of the agencies involved in this case.

1.4 Terms of Reference for the Review

- 1.4.1 At the first meeting, the Review Panel shared information about agency contact with the individuals involved, and as a result, established that the time period to be reviewed would be from 1 January 2019 to the date of death in January 2022. Agencies were asked to summarise any relevant contact they had had with Rokel or Joseph outside of these dates.

1.4.2 The Review Panel considered both the “generic issues” as set out in 2016 Guidance and identified and considered the following case specific issues:

- Analyse the communication, procedures and discussions, which took place within and between agencies.
- Analyse the co-operation between different agencies involved with Rokel, Joseph and the wider family.
- Analyse the opportunity for agencies to identify and assess domestic abuse risk.
- Analyse agency responses to any identification of domestic abuse issues.
- Analyse organisations’ access to specialist domestic abuse agencies.
- Analyse the policies, procedures and training available to the agencies involved on domestic abuse issues.
- Understand Rokel’s role in the local Sierra Leonian Community and identify services and support to domestic abuse survivors in that community.

1.4.3 To address specific issues in this case (including in relation to equality and diversity), FORWARD – an African women-led organisation working to end violence against women and girls were invited to be part of the review due to their expertise even though they had not been previously aware of the individuals involved.

2. Summary of Chronology

- 2.1.1 Family members chose not to be involved in the review process. Rokel's friends were approached via contact with the police and for those who provided witness statements as part of the criminal trial. No contact was received from Rokel's friends. Rokel was known only to a small group of friends and primarily from the local Sierra Leonian community. The views of friends and family were represented through the witness summaries provided to the criminal trial.
- 2.1.2 The CSP has been provided with key dates to avoid at publication, including Rokel's birthday on 14 March and the anniversary of her death on 24 January. These will be taken into consideration when confirming the publication date and appropriate support will be available to the family at that time.
- 2.1.3 Rokel was a Black African woman who was born in Sierra Leone and moved to the UK in 1994. She was a qualified nurse and was working as a community nurse. Information from friends indicate that Rokel was an active member of her local mosque and supported those in need of support. Rokel and Joseph were partners for approximately 18 years. Sometime prior to 2004, the couple had an Islamic wedding which was not legally recognised in the UK. They had their first and only child that same year. Rokel was described as a very kind and charitable woman who was always looking out for others in need. She was a very outgoing person, very bubbly and friendly who always dressed in 'grand clothing'. She had a lot of friends in the Sierra Leonian community and was a popular person. She helped run a charity in Sierra Leone and her house was full of various items that were destined for those in need in her home country. Rokel had confided in a friend that it was her intention to return to live in Sierra Leone and she was building a house. The police investigation uncovered that Rokel had been building a property out in Sierra Leone for herself and a male who she was in a romantic relationship with.
- 2.1.4 Rokel had mobility issues and she tended to walk slowly and occasionally with a stick; she was on medication for the pain in her leg. The relationship between Rokel and Joseph had been described as 'volatile'. There had been several occasions where Joseph had left the family home. It was known that Joseph was having relationships with other women, one of whom he had a child with. It is understood that the couple had frequent arguments particularly over money. Friends of Rokel had described that in the weeks before her death, she feared that Joseph would kill her.
- 2.1.5 Witnesses in the criminal trial spoke of a 'troubled marriage', in which Joseph had left Rokel on several occasions and had children with other women, as well as evidence of threats made towards her and past unreported violence. Whilst not in the timeframe of this review, there is relevant information to highlight a history of domestic abuse perpetrated by Joseph.

- 2.1.6 The criminal investigation revealed that the family was very private and not only did they not discuss much with people outside, but the three of them could be in house at same time but not talk to each other. Enquiries characterised their relationships as dysfunctional. Joseph had left Rokel several times during relationship and had had children with other women. He had most recently returned in 2019, but was not welcomed back by Rokel, however the police investigation confirmed that Rokel thought it was important for Child A to have their father around and for the extra income and support. Rokel's work colleagues informed the investigation of a reported change in Joseph's behaviour; and Rokel had expressed in the last week before she was murdered, that she was worried she was going to be killed by Joseph. The police report notes a picture emerging of a 'very dysfunctional relationship' and one motive for the murder, notably Rokel asking Joseph to leave the house.
- 2.1.7 Agencies who engaged with Rokel over the review period, were not able to directly provide evidence of physical abuse. However, there were at least 2 occasions where Rokel presented to a hospital A&E department and her GP, where injuries sustained by Rokel were not subject to further enquiry.
- 2.1.8 Child A did witness their father punch their mother and they recalled that the last time Joseph left the family home, there was a 'physical altercation between their parents' with Rokel forcing Joseph to leave. Their child reported that Rokel was 'always calm'. Child A did try and intervene, and their father hit them in the face and attempted to choke them. Information provided by friends of Rokel through witness statements gave clear indications that Rokel had experienced physical abuse from Joseph. These are not documented in agency records and were not subject to further enquiry.
- 2.1.9 Child A reported that their parents often argued about money, and they believed that Joseph was in some sort of debt. There are suggestions from friends of Rokel that Joseph did not provide and support the family finances. It was reported by friends that many arguments occurred over the family finances. We know that Rokel had spent some of her own resources in ensuring that Child A was catered for financially and that Rokel was supporting herself and included building her own home in Sierra Leone. There is no agency information that highlights concerns about Rokel's experience of economic abuse.
- 2.1.10 Rokel attended King's College Hospital NHS Foundation Trust on 10 occasions over the course of approximately 10 years, including an A&E attendance in October 2022 for a soft tissue injury and a facial injury. No safeguarding considerations were made during this attendance and no evidence of communications with Rokel relating to relationships or dynamics in the family home.
- 2.1.11 Rokel saw her GP intermittently between January 2019 and February 2020, usually for face-to-face consultations. Between February 2020 and January 2021 all contacts with the surgery, with the exception of one face-to-face appointment on in July 2021, were by telephone. It is not recorded in the medical records whether Rokel's GP asked her at any point whether she was a victim of domestic abuse.

- 2.1.12 Southwark Children's Social Care had contact with Joseph between 2018 and 2021, primarily because of Susan's parenting. This was the period where Joseph and Rokel had separated. The family were subject to an assessment under Section 17 of the Children Act 1989 due to concerns relating to allegations of domestic abuse and sexual assault by Joseph against Susan.
- 2.1.13 The Metropolitan Police have six contacts related to Rokel and/or Joseph prior to the review period and are relevant in that they highlight a history of Joseph dating back to 2002 displaying aggressive and abusive behaviour towards Rokel and other women. The allegation of rape of Susan is particularly concerning as well as the subsequent involvement of children's social care as a result.
- 2.1.14 Rokel's primary contact with any agency was via her GP and occasional visits to the local hospital. There is no other information available from agencies that had contact with her during the review period.

3. Conclusions and Lessons to be Learnt

3.1 Conclusions

- 3.1.1 The descriptions of Rokel highlighted by family and friends during the criminal trial were of a woman with passion, compassion, strength, and care. She was very connected to friends and held a strong connection to her home country. She was highly regarded by her employer and her caring and dedicated approach to the meeting the needs of others evident. Her conversations with friends painted a picture of hurt, distress, fear, and anxiety in her relationship with Joseph, including the foreboding reality that Joseph would kill her. This must have been deeply frightening.
- 3.1.2 The Review Panel extends its sympathy to the family and friends of Rokel. This review has highlighted how the domestic abuse experienced in Rokel's relationship over a number of years remained under the radar of agencies and yet was well known to her friends. It underlines the barriers to disclosing domestic abuse for women from different cultures and faith groups and how it places the responsibility on agencies, both statutory and voluntary to adapt their approaches to engagement. Accessibility of support services for women in this context requires action on agencies part to truly engage with local communities and commission 'by and for' services or engage women from the community with lived experience to develop informal and trusted support networks.
- 3.1.3 The story and lived experience of Rokel is based upon the evidence in the agency records and the friends reports to police. We do not have a full picture of her lived experience from those who were closest to her.
- 3.1.4 The descriptions of Rokel shine a light on the person she was, and her death cannot be the factor that defines her.

3.2 Key Themes and Learning Identified

- 3.2.1 Theme 1 – Colleagues within health seeking assurance that practitioners ask the question of patients regarding their experiences of domestic abuse.
- 3.2.2 Theme 2 – Commissioned domestic abuse services alongside the Safer Lambeth Partnership and the voluntary and community sector to have a strategy to address the needs of survivors from diverse backgrounds, including engaging those with lived experience.
- 3.2.3 Theme 3 – For practitioners to have a better understanding of clients' religious beliefs and spiritual experiences and how they might influence their ways of coping.

- 3.2.4 Theme 4 – The behaviour of perpetrators and their engagement in assessment and intervention and how practitioners seek comprehensive histories.
- 3.2.5 Theme 5 – How agencies should follow up referrals and assure themselves that appropriate support is in place as well as detailed risk assessment and contingency planning.

4. Recommendations

4.1 Multi Agency Recommendations (Developed by the Review Panel)

- 4.1.1 **Recommendation 1** – King’s College Hospital NHS Foundation Trust should urgently test the practice of routine enquiry regarding domestic abuse to assure themselves it is effective. The Safer Lambeth Partnership Board with partner agencies should devise a multi-agency protocol regarding routine inquiry for domestic abuse and supported by all agencies especially in cases of unexplained injuries or repeat health visits.
- 4.1.2 **Recommendation 2** – Southwark Children’s Social Care should consider the recommendations noted in the analysis and take action to assure itself that the developments highlighted are impacting on children, young people and families.
- 4.1.3 **Recommendation 3** – The Lambeth Violence Against Women and Girls Team should target the promotion of the forthcoming Champions Network to local faith groups and communities.
- 4.1.4 **Recommendation 4** – The Lambeth Violence Against Women and Girls Team should engage its ‘Survivor Forum’ in activities aimed at survivors from faith communities to enable learning from those with lived experience in those communities and include awareness raising for friends and family. Support could be provided by Standing Together Against Domestic Abuse Faith and VAWG expert by experience group.
- 4.1.5 **Recommendation 5** – The Safer Lambeth Partnership should task the Lambeth Violence Against Women and Girls Team to work alongside ‘Faiths Together’ in Lambeth to offer joint training to local faith groups from all denominations and specifically engage men and boys from faith groups.
- 4.1.6 **Recommendation 6** – The Lambeth Violence Against Women and Girls Team should work alongside the newly commissioned Gaia Centre Service to promote a specific communication strategy targeting faith groups when the newly commissioned Gaia service is launched and to include domestic abuse awareness for family and friends in the community.
- 4.1.7 **Recommendation 7** – The Safer Lambeth Partnership should review the impact of the previous DHR recommendation with a specific focus on hard to reach or unrepresented communities in Lambeth.
- 4.1.8 **Recommendation 8** – The Integrated Care Board should encourage all GP surgeries to use the South East London Integrated Care System domestic abuse policy template guidance document to assist in developing a practice policy on domestic abuse.
- 4.1.9 **Recommendation 9** – Southwark and Lambeth Children’s Social Care should be encouraged to follow up referrals made to specialist domestic abuse support services when it is considered appropriate to do so, particularly where survivors have struggled to engage in a criminal investigation or social care intervention.

- 4.1.10 **Recommendation 10** – The Academy Trust is encouraged to update its safeguarding policy in light of recent legislative changes and local policy and procedure.
- 4.1.11 **Recommendation 11** – To ensure that duplication of service support and provision for domestic abuse survivors is avoided, the Lambeth Violence Against Women and Girls Team should consider a review into how those support services actively work together and how together they address the diverse needs of the community.
- 4.1.12 **Recommendation 12** – The Lambeth Violence Against Women and Girls Team should continue to seek advice and guidance from those with lived experience of domestic abuse and particularly from the Muslim community.
- 4.1.13 **Recommendation 13** - NHS Trusts and NHS Providers across Lambeth should assure themselves that staff (including agency staff) have knowledge, understanding and access to the culturally appropriate policies and procedures regarding the safe disclosure of domestic abuse.

4.2 Single Agency Recommendations (Identified by Individual Agencies)

- 4.2.1 **GP**
- 4.2.2 The general practice should exercise professional curiosity when consulting with people who have unexplained symptoms e.g., chest pain or who have sustained physical injuries. It is important to ask about domestic abuse when patients present with these symptoms.
- 4.2.3 The local GP practice in this case should develop a domestic abuse policy.
- 4.2.4 **Kings College Hospital NHS Foundation Trust**
- 4.2.5 The universal adoption of routine enquiry can be revisited within emergency departments. We would welcome greater consideration as to whether there were missed opportunities.
- 4.2.6 **Central London Community Healthcare**
- 4.2.7 Associate Director of Safeguarding to share information on domestic abuse at key events to further promote support available and build awareness.
- 4.2.8 To ensure posters are in place across all staff and patient facing sites to further raise awareness of support available.
- 4.2.9 Engage with Domestic Homicide Review process and ensure feeding back of any further learning outside of this IMR within the Trust.
- 4.2.10 **Southwark Children's Social Care**
- 4.2.11 London Borough of Southwark continues to think about how we work with fathers, particularly those who present with abusive and harmful behaviours, embedding this within our learning and development offer.

- 4.2.12 London Borough of Southwark to develop practice in relation to contingency plans for children and families.
- 4.2.13 Although the assessment reviewed is historical (>5yrs), learning around engaging fathers and multi-agency checks and contingency planning will be shared.