DOMESTIC HOMICIDE REVIEW - OVERVIEW REPORT

Newham Community Safety

Partnership

Report Into the Death of JUANA

October 2022

Report produced by Simon Steel – Perse Perspective Consultancy Ltd

Report Completed on

4 September 2024

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FOREWORD

Newham Community Safety Partnership (CSP) would like to express their condolences to all those affected by the sad loss of Juana. This review sincerely hopes the learning and recommendations gained from our enquiries and deliberations will help agencies to prevent similar events happening again in the future.

The independent chair of this Domestic Homicide Review panel would like to thank all agencies who contributed to the process in an open and transparent manner. The panel is confident that the learning points and recommendations will provide a platform to help national, regional, and local agencies to implement measures designed to embed a preventative approach to addressing domestic abuse and sexual violence.

Following this death, there is emerging evidence of positive change at a local level. We all must do our utmost to take immediate action to protect the victim and to deal effectively with the perpetrators of domestic abuse and the chair would urge everyone to take note and act on the findings of this review. Together we must take the threat and harm posed by domestic abuse seriously at a leadership, frontline, and community level to help prevent further murders from occurring.

1. INTRODUCTION

1.1 This Domestic Homicide Review (hereafter “the review”) was established under Sec 9(3) of the Domestic Violence Crime and Victims Acts 2004. It examines agency responses and support given to Juana who was a resident of Newham prior to her death in October 2022.

1.2 In October 2022 Police were called to the address of Juana and her daughter Lauel. It was reported that someone had been stabbed in one of the flats. On Police arrival Juana was found having sustained multiple stab wounds and subsequently was pronounced dead. Lauel also had sustained multiple stab wounds and was taken to hospital. Lauel was able to identify the perpetrator as her estranged husband, Diego.

1.3 The review will consider the agency contact and involvement with Juana and Lauel from 2019. At the initial panel meeting agency members shared a summary of their engagement with Juana and Lauel. This period was chosen to allow for an in-depth review of current methods and processes to be carried out and to ensure that

recommendations and learning would be based on existing policies, procedures, and training. As a result, this was considered a proportionate timeframe however agencies were informed, should they note anything relevant outside of that timeframe, they were to include that detail in their individual management review (IMR.) The chair would constantly monitor this information and would amend the terms of reference (TOR) if required as necessary. In addition to agency involvement, the review will also examine the past to try and identify any relevant background or trail of abuse, prior to the death, whether support was accessed, within the community. By taking this holistic approach, the review attempts to identify solutions that will make the future safer.

1.4 The key purpose for undertaking reviews of this nature is to enable lessons to be learned from deaths which occur in similar circumstances and with a related background. For these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand, fully, what happened following each death, and most importantly, what needs to change to reduce the risk of such tragedies happening in the future.

1.5 This review process does not take the place of the criminal or coroner's courts, nor does it take the form of a disciplinary process.

1.6 The review panel wishes to express its deepest sympathy to the family and friends of Juana, for their loss and thank them for their contributions and support for this process.

2. TIMESCALES

2.1 The Metropolitan Police (MPS) referred this matter to the Community Safety Partnership (CSP) on the 31ST of October 2022. The email recommended that the case be considered for a Domestic Homicide Review (DHR). the Home Office were informed by the Partnership of their intention to carry out a Domestic Homicide Review into this matter on the 18TH of November 2022.

2.2 Simon Steel was commissioned to provide an Independent Chair (hereafter 'the chair') for this review on the 16th of January 2023. The completed report was passed to the Community Safety Partnership (CSP) on 09/09/2024. It was submitted by the CSP to the Home Office Quality Assurance Panel on 10/09/2024.

2.3 Home Office guidance states that a review should be completed within six months of the initial decision to establish one. The timeframe for this review was extended for several reasons:

Since the start of this DHR process it has proved challenging to obtain the required information form the MPS for this review. This was due to their own internal misconduct investigation and as a result the MPS chose not to disclose all relevant material in this case up until the 2nd of October 2023.

Since the start of this review the chair has encountered challenges with obtaining information from the Integrated Care Board (ICB) panel member representing the GP services. The chair escalated the challenges he was facing to the Community Safety Partnership Board. This was further escalated to the chair of the CSP. Some of these challenges were unique to this review as there is a surviving victim in this case. Despite that, the period of time it has taken is not acceptable and a recommendation has been made as a result and the CSP have now completed an independent review of their DHR process and are confident that these challenges will not be faced in the future. If they are encountered there is a clear governance and escalation strategy in place.

To support engagement with family via Advocacy After Fatal Domestic Abuse (AAFDA).

3. CONFIDENTIALITY

3.1 The findings of this review are confidential and will remain so until the Overview Report and Executive Summary have been approved for publication by the Home Office Quality Assurance Panel. Information is available only to participating professionals/officers and their line managers.

3.2 Details of confidentiality, disclosure and dissemination were discussed and agreed, between member agencies during the first panel meeting and all information was treated as confidential and nothing was disclosed to third parties without the agreement of the responsible agency's representative.

3.3 Each agency representative was personally responsible for the safe keeping of all documentation that they possessed in relation to this review and for the secure retention and disposal of that information in a confidential manner.

3.4 It was recommended that all members of the Review Panel used a secure email system, and that information should not be sent in any other way and was also password protected.

3.5 This review has been suitably anonymised in accordance with the statutory guidance. The pseudonyms were agreed with the family and are used in the report to protect the identity of the individuals involved.

Pseudonym	Relationship	Age at the time of the incident	Ethnicity
Juana	Deceased	53	Evangelical Christian
Diego	Perpetrator	38	Roman Catholic Dominican Republic
Lauel	Daughter of deceased	31	Evangelical Christian Caribbean. Dominican Republic

3.6 As per the statutory guidance, the chair, author, and the review panel members are named, including their respective roles and the agencies which they represent. Agencies that provided information are also identified.

4. Terms of Reference

4.1 Following discussions at initial panel meetings the chair circulated the Terms of Reference (T0R), to the agencies that had contact with Juana and also with Lauel and Diego. Details of the Terms of Reference are contained in Appendix 1. The review aims to identify learning from Juana's death and for actions to be taken in response of that learning with a view to preventing similar deaths and ensuring that individuals and families are supported in the future.

4.2 The review panel comprised of agencies from the Newham Community Safety Partnership, as Juana lived in their area at the time of her death. They were contacted as soon as possible after the review was established to inform them of the need to identify and secure records and for their participation within this process.

4.3 Key Lines of Enquiry: During the review the chair and panel have considered the 'generic issues' as set out in the generic guidance and those relevant to this case. Various discussions have led to the following case specific issues being agreed.

- Dynamics of gender within relationships.
- Was identity, faith and/or culture a barrier to reporting Domestic Abuse.

5. METHODOLOGY

5.1 Throughout the report the term 'domestic abuse' is used interchangeably with 'domestic violence', and the report uses the cross-government definition of domestic violence and abuse. This review commenced after the Domestic Abuse Act receiving royal ascent in April 2021 and defines domestic abuse as:

- The Behaviour of a person (A) towards another person (B) if.
  - I. A and B are each aged 16 or over and are personally connected to each other and.
  - II. The behaviour is abusive
- Behaviour is abusive if it consists of any of the following -
  1. physical or sexual abuse.
  2. violent or threatening behaviour.
  3. controlling or coercive behaviour.
  4. economic abuse (see subsection (4)).
  5. psychological, emotional, or other abuse.

It doesn't matter whether the behaviour consists of a single incident or a course of conduct.

Two people are Personally Connected to each other if any of the following applies.

1. They are, or have been, married to each other.
2. They are, or have been, civil partners of each other.
3. They have agreed to marry one another (whether or not the agreement has been terminated).
4. They have entered into a civil partnership agreement (whether or not the agreement has been terminated).

5. They are, or have been, in an intimate personal relationship with each other.
6. They each have, or there has been a time when they each have had, a parental relationship in relation to the same child (see subsection (2).
7. They are relatives.

It is defined as any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence, or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse, psychological, physical, sexual, financial and emotional.

5.2 Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

5.3 Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."

5.4 This definition, which is not a legal definition, includes so called 'honour' based violence, female genital mutilation and forced marriage and is clear that victims are confined to one gender or ethnic group.[1]

5.5 This review has followed the statutory guidance. On notification of the death agencies were asked to check for their involvement with any of the parties concerned and secure their records. It was during this scoping process that chronologies were collated and combined. This document was reviewed by the chair and Individual Management Reviews (IMRs) for all the organisations and agencies that had contact with Juana were requested. IMR's were prepared by the following agencies i.e., Metropolitan Police (MPS), North East London ICB (representing General practice), North East London Health Foundation trust and Victim support.

5.6 Document Reviewed

In addition to the combined chronology and IMR's, various documents and open-source research has been carried out including:

- Website for commissioned service for domestic abuse support.

[1] https://www.gov.uk/government/news/new-definition-of-domestic-violence

- Home Office Documents referring to key Findings from analysis of previous DHR's.
- Reducing the risk report on London DHR's
- Citizens Advice document regarding "What is Public Sector Equality Duty".
- Newham CSP website – Domestic Homicide Reviews.
- The Cochrane Report – Screening Women for Inter-partner violence in Healthcare Settings
- The Royal College of Nursing – Roles and Responsibilities of Health care staff.
- North East London NHS Foundation Trust Domestic Abuse and Harmful practices policy

5.7 Panel Meetings

Review Panel meetings took place on the 2nd of March 2023, 30th of March 2023, 6th of June 2023, 31st of October 2023. The chair held several individual agency discussions with panel representatives, and authors to seek clarification on points within agency IMR's and review Key Lines of Enquiry.

5.8 Interviews Undertaken

The chair wishes to record their appreciation for the time and assistance given by Lauel who has contributed to this review.

6. Involvement of Family, Friends, Work Colleagues, Neighbours, and Community

6.1 Following the decision to conduct this DHR contact was established with both Latin American Women's Aid (LAWA) and AAFDA. Both agencies along with Victim Support (VS) were supporting Lauel. The panel would like to record their appreciation to AAFDA, LAWA and VS for their significant support throughout this DHR.

6.2 Contact with the family was always instigated via AAFDA. Updates and ongoing discussions on multiple occasions took place between AAFDA and the chair. The chair has met with Lauel in person along with AAFDA and LAWA. The chair agreed given the trauma experienced by Lauel that the chair would not ask Lauel about the events and the information supplied has been provided by those supporting Lauel in disclosures to them. AAFDA have also supported Lauel's sister throughout the process.

6.3 In 2016 Lauel rented Diego's mother house in the Dominican Republic. She lived there for a year and then Diego arrived back from abroad and they became friends. He was living abroad but they stayed in contact and friendship turned into a relationship.

6.4 In 2017 Diego went to Spain to live, he was there less than a year. Lauel believes Diego saw a psychiatrist whilst in Spain for his mental health.

6.5 In 2018 Diego returned to the Dominican Republic and the relationship continued. They subsequently married on the 19th of November 2019.

6.6 In 2021 Diego returned to live in the UK. He had family in the UK and had been over before. Lauel states that Diego was having issues with his flatmates and threatened them with a knife. She is aware he was arrested. Lauel states he was sacked from his first job. She also states that he smoked a lot of cannabis. Lauel was unaware of this until after she came to live in UK in June 2021. Whist in different countries the relationship continued via calls and messages.

6.7 Lauel states that Diego went into a mental health unit on the 23rd of March 2021 in the Dominican Republic. Lauel stated he was taking medication upon discharge, and Lauel said she never knew what it was for.

6.8 In April 2021, around 2 weeks after he was released from the mental health unit Lauel and Diego went on holiday in the Dominican Republic. Lauel says that Diego promised he would be ok and not make the same mistakes. Diego was taking drugs and there was an incident whereby he got jealous of a male receptionist who he thought he was looking at Lauel or he believed found his wife attractive. Lauel was in the lobby, and the receptionist alerted her that her husband was jealous and had said something. When Lauel and Diego went to the hotel room Diego broke items in the room and her phone, and they arrested him at the hotel. Charges were dropped as he offered to pay for damages.

6.9 On the 27th of June 2021 Lauel and her mother arrived in the UK. They stayed with Diego for less than a week before she left following an incident where a house mate called the police because he was worried about Lauel safety. Lauel states that before this he was not abusive but admits he used to break her phones and resented her having a relationship with family and friends. He was jealous of her mother, resented their relationship, but did not approach her mother or be violent to her. Diego stole some of her money and she also gave him £ 3/4000 because she was so scared of what he would do if he didn't get the money.

6.10 On the 2nd of July 2021 Lauel and her mother moved out of the address, but Lauel didn't tell him they were going. However, he found out from the landlord of the original property on the day they moved out.

6.11 In August 2021 Diego turned up at the door of their new (Lauel and her Mums) address. Lauel let him in because she was scared of what he might do if she didn't. He would call for money, he wanted her to be with him, she continually told him this would not happen. She reported this to the police (in person). She was told she could apply for a for a non-molestation order, but it was to complex a process to navigate. An independent translator was never offered, and she was given an email

address for the MPS. Lauel sent evidence to police as they requested but they never replied.

6.12 She reached out for help to a support agency Latin American Women's Rights (LAWRS) asking for support, but they could not give her an appointment outside of her working times. She was terrified she would lose her job so was unable to take an appointment.

6.13 On the 31st of March 2022 Lauel was alerted that Diego was experiencing a psychosis. A flatmate said he would contact Diego's family in Spain to come and help him. However, the police were called and ended up arresting him for 3 days at Stoke Newington police station.

6.14 On the 5th of April 2022 Diego's mother came to UK to take Diego to Spain to have him admitted to a Mental health institution. He was in the hospital for an unspecified time.

6.15 In May 2022 Diego was being normal in the WhatsApp messages. However, he was being very obsessive and wanted to reinitiate a relationship with Lauel and was overly romantic, but also accusing her of sleeping with other men.

6.16 In August 2022 Diego returned to the UK and began to stalk Lauel outside her home and he would call her and ring the doorbell. He would continuingly threaten to kill her brother in the Dominican Republic, Lauel couldn't eat she was so worried.

6.17 In the week of the 15th of August 2022 Diego asked Lauel to speak to her at his home and told Lauel that he would be leaving UK indefinitely and he wanted to see her. He spiked her drink, and she started to throw up and get diarrhoea, and the housemates called the police as they believed he had spiked her drink. He raped her. He told her not to tell the police or he would kill her brother. The police came to the flat, and checked she was ok, and Lauel denied everything as she was scared for her life and that of her brother.

6.18 On the 13th of September 2022 Lauel reports stalking to the police via email. On the 1st of October 2022 she sent screen shots to the police of the messages. Lauel says that this was very hard, everything seemed like a problem, the police did not call with a translator once and she didn't hear back from them.

6.19 Lauel went to LAWRS many times and via email but was not able to get an appointment. She did not speak to her GP as she felt Diego would kill her brother if she talked to anyone, and she believed he would find out.

6.20 Lauel showed the team working with her a video of what she recorded whilst out with her mum on the 12th of October 2022 which showed Diego harassing her in the street. Lauel can be heard stating that she wants her space, and was begging him to leave her alone, and that she didn't want problems. He would insult her threaten her and said he would report her to immigration saying she was lying about being

married. He was pulling her and shouting at her and other members of the public. Lauel went into a local shop to ask for help. AAFDA described this video is one of the scariest things they had watched. He was relentless, he was not bothered that other people were seeing this.

6.21 On the 23rd of October 2022 Lauel was present when her mother was murdered by Diego, and she suffered life changing injuries.

7. Contributors to the Review

7.1 The following agencies and their contributions to this review are:

Agency	Contribution
Metropolitan Police Serve	Chronology and IMR
Victim Support	Chronology and IMR
North East London ICB representing GP	Chronology and IMR
North East London Foundation Trust (NELFT)	Chronology and IMR

7.2 Quality and Independence of the IMR authors. The IMR's were prepared by authors who were independent of any service delivery or case management regarding Juana, Lauel and Diego. The IMR's were comprehensive and allowed the panel to analyse the contact with Juana, Lauel and Diego. The detail ensured that the panel were able to identify learning and recommendations for this review and where necessary, follow-up meetings were held, and questions sent to agencies. Responses were received, prior to, or at, subsequent panel meetings.

8 Review Panel Members

Name	Role/Job Title	Agency
Simon Steel	Independent Chair and Author	Perse Perspective Consultancy Ltd
Sharmeen Narayan	Domestic Abuse and Sexual Violence Commissioner	Public Health Commissioning

Sabeena Pheerunggee	Named GP Safeguarding lead	NHS North East London (NEL) Integrated Care Board (ICB)
Sally Pattinson	Detective Sgt Specialist Crime Review Group	Metropolitan Police Service
Rachel Nicholas	Head of Domestic Abuse Services	Victim Support
Nuru Makambo	Operational Lead/Team Manager	North East London NHS Foundation Trust (NELFT)
Emma Crivellari	Named Safeguarding lead	East London NHS Foundation Trust (ELFT)
Ed Lander	Service Manager ELFT representing Mental Health Services	East London NHS Foundation Trust (ELFT)
Farida Butt	Service Manager Hestia	Hestia DA services Newham
Clare Hughes	Associate Director of Safeguarding BARTS Health NHS Trust (representing Newham Hospital)	BARTS Health NHS Trust
Daniel Wilson	Designated Professional Safeguarding Adults, Newham (CCG)	NHS North East London (NEL) Integrated Care Board (ICB)
Dawn Henry	Specialist Pathways Team Leader Newham (housing)	Newham CSP
Katie Burgess	Adult Social Care Safeguarding	Newham CSP

Jenni Bonner	Counselling Manager Black Women's project	London Black Women's project
Yvonne Njogu	Senior social worker-Redbridge mental health & wellness team south	North East London NHS Foundation Trust (NELFT)
Carolina Gutierrez	Manager	LAWA
Sara Shakeel	Immigration Legal Advisor	London Black Women's project

9 Author of the Overview Report

9.1 Simon Steel was appointed by the Newham Community Safety Partnership as Independent Author of this Domestic Homicide Review panel. Simon is a retired Thames Valley Police Detective having retired in November 2021. He has considerable experience in the field of Domestic Abuse, Public Protection and Safeguarding. His experience includes specialist, strategic and generic investigative roles across the Thames Valley. He has also led complex Domestic Homicide Investigations.

9.2 Since retirement, Simon has established his own consultancy business and has now chaired multiple Domestic Homicide Reviews. Simon has been subcontracted by Foundry Risk Management who have a long history of chairing reviews.

9.3 Simon also has worked as the Head of Adult Support for an Autism Charity within the voluntary sector who are commissioned by Local Authorities and Integrated Care Boards (ICB). Simon also currently works as a Learning Disability and Autism Champion for an ICB. Simon believes his work alongside statutory, non-statutory and voluntary sector organisations provides him an enhancement to his policing portfolio.

9.4 Simon has completed Home Office approved Training and has attended subsequent Training by Advocacy After Fatal Domestic Abuse.

9.5 Simon has no connection with Newham Community Safety Partnership.

10 Parallel Reviews

10.1 <u>Inquest:</u> The coronial hearing in this case is not yet scheduled.

10.2 Metropolitan Police This incident was subject to a Department of Professional Standards (DPS) investigation under the criteria of Death or Serious Injury following police contact and is referenced at 16.4.14.

11 Equality and Diversity

11.1 The review panel considered all 9 protected characteristics under the Equality Act 2018 i.e.

- Age
- Disability
- Gender Assignment,
- Marriage and Civil Partnership.
- Pregnancy and Maternity
- Race
- Religion and Belief
- Sex
- Sexual Orientation.

11.2 The panel reflected upon each of these in evaluating the various services provided to Lauel. It is incumbent on this review to consider the duty on public authorities to[2]; remove or reduce disadvantages suffered by people because of a protected characteristic, meet the needs of people with protected characteristics, encourage people with protected characteristics to participate in public life and other activities.

11.3 Each protected characteristic was analysed by both individual agencies and the panel, against policies and procedures that were in place at the time of the death of Juana and the attempted murder of Lauel.

11.4 The panel identifies that women and girls are disproportionally impacted by domestic abuse and forms of gender-based abuse, whilst also recognising that other genders also suffer similar issues of violence and abuse. Analysis reveals[3] gendered victimization across both intimate partner and familial homicides with females representing most victims and males representing most perpetrators.

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[2] https://www.citizensadvice.org.uk/law-and-courts/discrimination/public-sector-equality-duty/what-s-the-public-sector-equality-duty/

[3] Domestic abuse in England and Wales overview - Office for National Statistics (ons.gov.uk)

11.5 Juana and Lauel were both born in the Dominican Republic and spent the majority of their lives there. Therefore, the CSP and the chair recognised the requirement for cultural expertise on the panel and from formation of the first panel LAWA have been a subject matter expert (SME) for this DHR.

11.6 There were a number of protected characteristics that the panel agree are pertinent to this review. These include examining the circumstances through the lenses of: sex, race and religion.

11.8 Sex & Gender: Juana and Lauel were female, and Diego was male. The gendered nature of domestic abuse is reflected in a number of reports and also by specialist organisations. An analysis of DHRs[4] reveals gendered victimisation across both intimate partner and familial homicides with females representing the majority of victims and males representing the majority of perpetrators. Women's aid reports[5], "There are important differences between male violence against women and female violence against men, namely the amount, severity and impact. Women experience higher rates of repeated victimisation and are much more likely to be seriously hurt (Walby & Towers, 2017; Walby & Allen, 2004) or killed than male victims of domestic abuse (ONS, 2020A; ONS, 2020B)."

11.9 RACE: In relation to prevalence of domestic abuse, Safelives[6] in responding to the Race Report concluded, "there is clear evidence that Black and Asian women are disproportionately at risk of being killed by a domestic abuser. This is supported in recent research[7] "Identifying predictors of harm within Black, Asian, and other racially minoritised communities" that '*The proportions of Black, Asian and racially minoritised communities within the population is a statistically significant predictor of the domestic count and rate at the LSOA level along with other structural and community cohesion variables, suggesting that ethnicity matters*'.

11.10 Women's Aid note[8], "Whatever their experiences, women from Black, Asian or minority ethnic communities are likely to face additional barriers to receiving the help that they need." The same internet article directed at survivors suggests "It may be particularly hard for you to admit to having problems with your marriage, and you

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4 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575232/HO-Domestic-Homicide-Review-Analysis-161206.pdf

5 Domestic abuse is a gendered crime - Womens Aid

6 SafeLives' detailed response to the Race Report | Safelives

7 FINAL Predictors of Harm UOS report.pdf

8 Women from BME communities - Womens Aid

may experience additional pressure from your extended family to stay with your partner. You may even have been forced or persuaded into marrying him in the first place. If your marriage fails, it may be seen as your fault, and you may be blamed for damaging the family honour; and you may be afraid that, if you leave your husband, you will be treated as an outcast within your community." Two organisations that have websites with much learning and information are [9] Imkann and [10] Southall Black Sisters and the author encourages anyone who works in this field to consider further research.

11.11 RELIGION: Juana was of the Evangelical Christian faith as is Lauel. Diego was of the Catholic faith. Whilst race and religion are often together, there are areas of work that consider the implications of faith on survivors, such as the Faith & Communities Programme by Standing Together in London[11], that summarises some of the challenges confronting victims, "Many survivors with a faith feel that some specialist services and society, in general, are unable to understand their experiences of abuse, and their barriers to accessing support due to their religious identity, their faith community and any spiritual abuse that they may experience at the hands of their perpetrator".

11.12 This is supported by various studies, including[12] 'A Qualitative Systematic Review of Published Work on Disclosure and Help seeking for Domestic Violence and Abuse among Women from Ethnic Minority Populations in the UK' that drew a number of relevant conclusions including: - community influences are significant barriers to disclosure; - the cultural community influenced the disclosure and help-seeking practices of women with lived experience of domestic violence and abuse. The implication of this, is that many women will seek help from within their immediate community, either through faith-based organisations or social groups.

11.13 The United Nations gender quality observatory reports[13] that in Latin American the country that reported the highest rates of women's deaths at the hands of their intimate partner or former partner in 2021 was the Dominican Republic (1.6 per 100,000 women). The rand corporation reports [14] Intimate partner violence in Latin

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[9] Imkaan

[10] https://southallblacksisters.org.uk/

[11] Faith & Communities Programme — Standing Together

[12] A qualitative systematic review of published work on disclosure and help-seeking for domestic violence and abuse among women from ethnic minority populations in the UK (whiterose.ac.uk)

[13] Women's deaths at the hands of their intimate partner or former partner

[14] rand.org

America, just like elsewhere in the world, often occurs in the home, hidden from public view. In addition, a substantial proportion of women polled in a [15] health survey conducted in Bolivia, the Dominican Republic, Haiti, Nicaragua, and Paraguay expressed the belief that outsiders should not intervene to help abused women, and that family problems should remain private.

11.14 The panel have been fortunate to have LAWA as a Subject Matter Expert (SME) to assist the panel. LAWA [16] report the different elements of Latin women's identity overlap and define the additional challenges they face including structural racism, hostile anti-immigration environment, cultural discrimination, lack of support in interpretation services and lack of legal aid, among others. They report a key barrier for their service users to access support and statutory services is often the lack of English skills and the need for interpretation. The barrier goes beyond language and is not only the impossibility to communicate in their mother tongue but also, they lack knowledge and experience to advocate for themselves within a system that is already complex to navigate.

11.15 It is against the background of concerns raised in such reports, that the review will consider the circumstances of Juana's death and Lauel's attempted murder.

12. DISSEMINATION

12.1 Once finalised this Overview Report and the Executive Summary was presented to the CSP chairs, this was because of urgency. The report has been reviewed and agreed by the CSP Chairs so it can be sent to the Home Office for quality assurance. This reflects the delay in the overall process and the need to expedite progression in support of the survivor, her family, and HM Coroner.

12.2 The recommendations will be owned by Newham Community Safety Partnership, who will be responsible for disseminating learning through local professional networks as well as managing progress of the Action Plan which is created at the conclusion of this review and in response to the recommendations that have been made.

12.3 The following individuals and agencies have been identified as recipients of these reports.

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[15] Reproductive Health Survey

[16] https://lawadv.org.uk/wp-ontent/uploads/LAWA_ANNUAL_REPORT_DIGITAL_2021-2022..pdf

Agency
Newham CSP
Newham Safeguarding Adults board
Newham Health and Well being board
Newham CSP DHR Recommendations Working Group
Newham Children's Safeguarding Board
The Office of the Mayor of London
The Domestic Abuse Commissioner
The Family
All Panel Members

12.4 The report will be published online, on the Newham CSP website.

13 Background Information (The Facts)

13.1 At the time of her death Juana was a 53-year-old woman. At the time of this incident Lauel was a 31-year-old woman.

The Death

13.2 In October 2022 Juana was found by Metropolitan Police officers who were called to an address she shared with Lauel. Sadly, Juana who had been stabbed repeatedly was pronounced dead. Lauel was taken to hospital with multiple life changing injuries.

13.3 The investigation led the MPS to Diego as the prime suspect in this Murder and Attempted Murder investigation. He was found later in October 2022 in a canal deceased and the matter was passed to HM Coroner. The coroners hearing into her death has yet to be scheduled.

14 Combined Narrative Chronology

14.1 The following section summarises contact between Juana and various agencies. To assist the reader, the table below summarises the names of the organisations and

their role in this case. The paragraphs within the narrative chronology are pre-faced with the lead agency to identify the primary source of information and assist the reader.

Organisation	Role	Pre-Face
Metropolitan Police	Police	MPS
Victim Support	Victim Service	VS
GP	General Practioner	GP
NELFT	Hospital	NELFT

14.2 JANUARY 2014

14.2.1 **MPS.** On the 21st Diego was involved in a traffic collision. Of note as first contact with the police in this country.

14.3 FEBRUARY 2020

14.3.1 **GP.** Twice this month Diego speaks with his GP about how he is feeling.

14.4 JANUARY 2021

14.4.1 GP. On 21st Lauel registers as a new patient. In the notes it is noted that consent given to share patient data with specified third-party Diego. Main spoken language Spanish and an Interpreter needed.

14.5 AUGUST 2021

14.5.1 GP. On the 5th a telephone encounter with Lauel. Lauel reports she didn't not make this call when quizzed about reason for the call for which this appointment was booked for, she said *"ok everything ok via a friend"*

14.6 September 2021

14.6.1 **GP.** On 1st Juana registers as a new patient.

14.7 OCTOBER 2021

14.7.1 **GP.** On the 22nd Juana requests medication (existing condition) via Spanish interpreter using Language line. Advised new to the UK having arrived on the 27th of June 2021.

14.8 DECEMBER 2021

14.8.1 **GP.** Juana had 2 routine interactions.

14.9 JANUARY 2022

14.9.1 **GP.** On the 20th Lauel had an interaction via language line a Spanish interpreter used. Lauel has been diagnosed with vitiligo (skin condition) in Dominican Republic and discussion around dermatology.

14.10 MARCH 2022

14.10.1 **MPS.** On the 29TH the Police were called by roommates of Diego as he was threatening them with a knife.

14.11 JUNE 2022

14.11.1 **MPS.** On the 17th Lauel attended Forest Gate Police Station to report that Diego had been harassing her and threatening to hurt her.

14.11.2 **VS.** On the 20th the case regarding the incident reported on the 17th was received at Victim Support.

14.12 AUGUST 2022

14.12.1 **MPS.** On the 7th Police called by a 3rd party to a domestic incident involving Diego and Lauel.

14.13 OCTOBER 2022

14.13.1 **GP.** On the 6th Diego registers with a new GP practice.

14.13.2 **NELFT.** On the 7th a telephone call transferred from MHS 111. Spanish interpreter arranged. Diego stated that he feels low & depressed. He reported this initially started after his relationship of 5 years with a girl who would "tell lies and talk down about him" ended a few years ago and he was prescribed antidepressants and sleeping pills by his GP. The relationship re-started about a year ago but again ended which worsened his depression and he had thoughts of ending his life. He reported that he had recently moved to his present address, where he lives alone, his parents are in Spain. He goes to work as a delivery driver in order to pay the rent but doesn't feel like working. He attempted to register with a local GP and was told he was not in their catchment, so he called 111. He is not on any prescribed medication. He uses tobacco, no reported alcohol or substance use. Reported not sleeping well, lack of appetite, low energy. Had thoughts of ending his life but denied current plans to harm himself or others. No reported hallucinations or delusional thoughts. Risk to self-rated as moderate due to suicidal thoughts.

14.13.3 **NELFT.** On the 10th Diego attended the RAABIT walk-in service, seen by duty worker, with Spanish interpreter. He reported that he had suffered from depression in the past, was prescribed antidepressants and felt better so stopped taking the medication. Now the symptoms have returned, and he would like to resume antidepressants. He reported fleeting suicidal thoughts, last suicide attempt last summer when he cut his vein. He has attempted to register with local (Waltham Forest) GP but told it will take a week so came to see NELFT as a walk in. 3 treatment options were discussed with him: 1) he can go to his old GP as he is still registered with them for a repeat prescription;2) can go to A&E if his thoughts are bad and cannot wait till tomorrow;3) can walk into Waltham Forest Mental Health service tomorrow. He said he can wait until tomorrow and walk into Waltham Forest. Contingency plans were discussed via interpreter. He was given mental health crisis number/card, told he can go to A&E, can call 999 for LAS or police if feeling unsafe.

He said he prefers to wait and walk into Waltham Forest mental health service tomorrow. Risk assessed as low: he denied active suicidal thought and said he just wants to restart his antidepressants.

14.13.4 **GP.** On the 11th Diego has a telephone consultation with his GP. Language line telephone Spanish translator was used. He reports low mood, insomnia and a suicide attempt last year in Spain. Requesting medication, can't recall the name. He has no present suicidal thoughts. And no history on the system available to the GP. Mirtazapine was issued, 15mg one at night with review in 2 weeks. He was advised if he develops thoughts of self-harm or suicide to immediately return or if out of hours to attend A&E.

15. OVERVIEWS

This section summarises what information was known to each agency, and the professionals involved, within the review period. Any other relevant facts or information is also included in this section.

15.1 METROPOLITAN POLICE (MPS)

15.1.1 The MPS has reviewed all police contacts with Juana, Diego and Lauel. Research has been conducted of both MPS and national police databases.

15.1.2 On the 29th of March 2022 one of Diego's housemate's called police stating that Diego had a knife, he was tearing the house apart and they all had to lock themselves in their rooms. Officers attended and were let in by Diego's flatmate who pointed out Diego and told officers that Diego had threatened him with a knife. Housemates told officers that Diego's mental health had been in decline for the last few weeks.

15.1.3 The victim of the threat confirmed the allegation that they had been at the bottom of the stairs talking to another house mate when Diego ran down the stairs towards them. A verbal argument took place and Diego went into the kitchen, grabbed knife and started to wave the knife around whilst shouting. The victim said that Diego wasn't making any sense, talking in a mixture of English and Spanish. The victim went back into their room and dialled 999. The victim did make a brief statement to police but did not wish to provide any more details at that time. A decision was made that no further action would be taken due to evidential reasons including no CCTV or forensic evidence being available.

15.1.4 On the 18th of June 2022 Lauel attended a Police Station to report that Diego had been harassing her and threatening to hurt her. Lauel spoke with the front office Public Access Officer (PAO) via an interpreter and told the PAO she had been married to Diego for four years but had been separated for around six months. Lauel

explained that the previous evening he had been shouting outside her address and calling her mobile phone. Even though they were separated Diego kept calling her, sending abusive voice notes and following her. Lauel said she had not blocked his number as he would then just turn up at the address.

15.1.5 The PAO created a record for Diego on the police Emerald Warrants Management System (EWMS) as wanted, to be arrested for harassment and a request was put in for him to be circulated on the Police National Computer (PNC). A Spanish interpreter was booked so a statement could be taken from Lauel later that day.

15.1.6 The PAO then asked Lauel the: Domestic Abuse, Stalking, Harassment and Honour based violence assessment (DASH) questions. Lauel said Diego was constantly aggressive and threatening, that the abuse was getting worse and happening more often and he prevented her from contacting her family. He was constantly sending abusive voice notes, that he called her a slut and said she “fucked with other guys”, that he controlled her dress and work. A month ago he said he would kill her mum as they were not together, that he smoked cannabis and that in March, he had cut his wrist. The report was graded as medium risk.

15.1.7 On 07th August 2022 police were called by a third party to a non-crime domestic incident between Lauel and Diego, no offences were alleged, and police left the incident without completing PNC checks so were unaware that Diego was wanted for harassment. This incident was picked up in the early hours of 08/08/2022 and as police then had an address for Diego police returned and arrested him. When Diego arrived at Wood Green custody centre his detention was not authorised as the custody officer did not believe it met the arrest condition under the necessity criteria of ‘prompt and effective investigation’ and ‘prevent physical harm’ (Code G PACE).

15.1.8 On the 23rd of October 2022 police were called to the home address of Juana and Lauel. Upon police arrival, Lauel was shouting out of the window. Officers were allowed into the property and went upstairs where they found Lauel who had blood on her face and multiple stab wounds to her arms and back. During a search of the house officers then found her mother, Juana in a bedroom, unresponsive with multiple stab wounds to the face, throat, and torso.

15.1.9 On 28th October 2022, whilst officers were making enquiries to the whereabouts of Diego, they viewed CCTV that showed him walking underneath the bridge camera on Blaker Road E15 2PY but not returning. Officers began searching the area towards the canal where Diego had walked and found a body in the canal. The legs were seen to be lightly tied by the ankles with a dark green lace and the hands were also lightly tied by a similar dark green lace. The body was identified as that of Diego.

15.2 VICTIM SUPPORT (VS)

15.2.1 Victim Support have been commissioned by the Mayor's Office for Policing and Crime (MOPAC) to deliver the London Victims and Witness Service (LVWS), which is a support service for London residents who are affected by or witness to crime. The service commenced on 1 April 2019 and is delivered through a number of specialist partnerships, led by Victim Support.

15.2.2 On the 20th of June 2022 Victim Support received a Metropolitan Police automatic data transfer (ADT) referral for Harassment domestic abuse (DA) into the London Victim and Witness Service (LVWS). The referral stated that the date of offence was on the 17th of June 2022 and that the crime was reported to police on the 18th of June 2022.

15.3 INTEGRATED CARE BOARD – GP SURGERY

15.3.1 There was interactions with a number of GP surgeries for all parties. Despite Lauel giving her consent for her interactions with her GP's to be disclosed this has taken a considerable time period and escalation at CSP board level. The chair requested an IMR for Diego which has been forthcoming from the ICB following a significant delay. The panel were content that there was no requirement for an IMR in relation to Juana's GP surgery given the nature of her interaction's which were very limited and not relevant. They were also not of a nature that would warrant additional exploration by a GP (routine medication).

15.4 NORTH EAST LONDON FOUNDATION TRUST (NELFT)

15.4.1 The only contact was with Diego. A triage assessment was conducted over the phone on the 7th of October 2022 via a Spanish interpreter and a decision made to invite Diego for a face-to-face assessment. He was also given advice to attend A&E or call Mental health direct over that weekend if in urgent need of support, further advised to self-refer to the improving access to psychological therapy service (IAPT) for talking therapy after the crisis is averted. Diego subsequently attended this appointment on the 10th of October 2022. That concluded the contact.

16. ANALYSIS

HINDSIGHT BIAS

16.1 As the report author, the chair has attempted to view this case, and its circumstances as it would have been seen by the individuals at the time. It would be foolhardy not to recognise that a review of this type will undoubtedly lend itself to the application of hindsight. Hindsight always highlights what might have been done differently and this potential bias or 'counsel of perfection' must be guarded against.

There is a further danger of 'outcome bias' and evaluating the quality of a decision when its outcome is already known. However, I have made every effort to avoid such an approach wherever possible.

16.2 The analysis of the combined chronology, IMR's and discussions with panel members and IMR authors revealed themes that are further explored within the individual agency analysis that follows.

16.3 *Domestic Abuse*

Pattern of Abuse

16.3.1 Considering the government definition of domestic violence and abuse, which describes a pattern of incidents of controlling, coercive or threatening behaviour, the Review Panel was able to determine there was a history of reported Domestic Abuse. This conclusion is based on all the information provided however in particular the information provided by the Metropolitan MPS.

Agency Involvement

In the period January 2019 up until the death of Juana there were numerous agencies involved with Lauel and Diego.

16.4 Metropolitan Police (MPS)

16.4.1 On the 29th of March 2022 officers were called to an address when Diego had a knife and was tearing the house apart so much so, his housemates had to lock themselves in their rooms. It is noted that housemates told officers that Diego's mental health had been in decline for the last few weeks. Diego was arrested for Affray however due to the mental health concerns Diego was taken to Hospital for a mental health assessment where they said Diego was under the influence of alcohol and drugs and should be taken into police custody.

16.4.2 The victim of the threat confirmed that they had been at the bottom of the stairs talking to another house mate when Diego ran down the stairs towards them. A verbal argument took place and Diego went into the kitchen, grabbed the knife, and started to wave the knife around whilst shouting. The victim said that Diego wasn't making any sense, talking in a mixture of English and Spanish. The victim went back into their room and dialled 999. The victim did make a brief statement to police but did not wish to provide any more details at that time. Police made further contact with the victim requesting a picture of the knife used, but ultimately received no response. Other housemates were spoken to but said they did not witness the incident and did not provide statements.

16.4.3 Diego was interviewed by police and said it was an argument over food and cleaning and denied threatening anyone with a knife or machete. A decision was made that no further action would be taken due to evidential reasons including no CCTV or forensic evidence being available. The victim would not provide a full statement to police and none of the other housemates witnessed the incident. Unlike domestic abuse incidents where police would consider evidence led prosecution this incident would not fit those circumstances. Due to the concerns around Diego's mental health, a MERLIN Coming to notice (CTN) was created and shared with partner agencies.

16.4.4 On the 18th of June 2022 Lauel attended a local police station and reported that Diego had been harassing her and threatening to hurt her. Lauel spoke with the front office Public Access Officer (PAO) via an interpreter and told the PAO she had been married to Diego for four years but had been separated for around six months. Lauel explained that the previous evening he had been shouting outside her address and calling her mobile phone. Even though they were separated Diego kept calling her, sending abusive voice notes and following her. Lauel said she had not blocked his number as he would then just turn up at the address. The PAO created a record for Diego on the police Emerald Warrants Management System (EWMS) as wanted, to be arrested for harassment and a request was put in for him to be circulated on the Police National Computer (PNC). A Spanish interpreter was booked so a statement could be taken from Lauel later that day.

16.4.5 The PAO then asked Lauel the Domestic Abuse, Stalking, Harassment and Honour based violence assessment (DASH) questions. Lauel said Diego was constantly aggressive and threatening, that the abuse was getting worse or happening more often and he prevented her from contacting her family. He was constantly sending abusive voice notes, that he called her a slut and said she "fucked with other guys", that he controlled her dress and work. A month ago, he said he would kill her mum as they were not together, that he smoked cannabis and that in March he had cut his wrist. The report was graded as medium risk. *Comment: There is clear evidence here of escalation, isolation, control, stalking, MH and a threat to kill. Lauel stated to AAFDA she remembers this being done but it wasn't explained to her she did not know what it was for. Agencies should ensure that clients understand the purpose of a DASH risk assessment*

16.4.6 Checks were carried out by the PAO for any previous DA incidents however nothing had been reported and the only one other report that was found detailed the affray reported at 16.4.1. *Comment: Which would have contained the MH concerns and use of a weapon.* The PAO advised Lauel not to answer calls or messages and to apply for a non-molestation order. Lauel was also referred to victim support, however they were unable to contact Lauel, they closed the request and asked the investigating officer (IO) to pass on their details. From research it does not appear that the victim support details were ever passed on.

16.4.7 A statement was taken from Lauel however she did not feel able to sign it or support a criminal prosecution and stated she just wanted Diego to leave her alone. However, it was decided due to the amount of times Diego had contacted Lauel he needed to be arrested and put through the judicial process as the supervisor felt intervention was required rather than a warning. *Comment: It is noted the good practice here that the supervisor wished for an evidence led prosecution. Lauel stated to AAFDA She didn't know that could lead to a potential arrest.*

16.4.8 On the 15th of July the Investigating Officer (IO) was able to contact Lauel via language line and she confirmed she was willing to provide police with a statement as Diego's behaviour had escalated and he was visiting when she didn't want him to. The IO asked for Lauel to email her any voice notes or text messages so they could review them and have them translated into English. The IO arranged to call Lauel the following week to arrange a time for the statement to be taken. *Comment: There is clear evidence of escalation here however the risk assessment was not reviewed. Lauel stated to AAFDA They didn't get a statement this never happened.*

16.4.9 On the 7th of August 2022 the police were called by a third party to an address where the caller said that a friend was shouting and fighting. When police attended the address the informant, Lauel and Diego were all sitting outside, and police spoke with everyone separately. The informant appeared intoxicated or otherwise impaired, but he explained to police he lived at the address with Diego and Lauel had come to visit. He told police Lauel and Diego had been talking in Spanish, which he could not understand, but that he had not seen them shouting or fighting.

16.4.10 Lauel and Diego were spoken with separately and they explained they were married but separated although kept in touch and where not aware why police had been called. Both answered "no" to all DASH questions. Two additional witnesses were spoken to at the time who confirmed the accounts of Lauel and Diego. Police graded this incident as standard risk, but it was subsequently raised to medium (language line was used). *Comment: Lauel later informed her advocate at AAFDA that she denied DA in the DASH questions as her husband had made threats to kill her brother.*

16.4.11 The Police left this incident without completing PNC checks so were unaware that Diego was wanted for harassment. This incident was picked up in the early hours of the next day and as police then had an address for Diego they returned and arrested him. When Diego arrived at the custody centre his detention was not authorised as the custody officer did not believe it met the arrest condition under the necessity criteria of 'prompt and effective investigation' and 'prevent physical harm' (Code G PACE). He suggested Diego should be dealt with by means of voluntary interview if the criminal matter was still to be investigated. Lauel was contacted via language line when she told police she did not want Diego arrested and that since making the report to police she had been in a relationship with Diego and did not wish for any police action. Lauel was asked if she would like to be referred to outside agencies,

but this was declined. Diego was then de-arrested. No voluntary interview took place, the crime report was still open and ongoing at the time of the murder. *Comment: The panel are concerned that no interview of Diego took place and amount of time this investigation seemed to be taking. Lauel stated to AAFDA she had real genuine fear for her brother who lived in the Dominican Republic.*

16.4.12 On the 7th of September 2022 the IO spoke with Lauel via language line and Lauel confirmed she has since ended the relationship with Diego after giving him another chance. Lauel requested help in obtaining a non-molestation order which the IO provided and asked Lauel to email any messages or voice notes she had from Diego. Due to evidential difficulties in proving the offence of harassment, only incidents from the 8th of August 2022 were considered due to Lauel being with Diego prior to that date. No further entries were made on the crime report until after the murder of Juana, however it was recorded in the subsequent DPS investigation, that Lauel sent further information to the IO on the 13th of September 2022 and the 1st of October 2022. In general, these messages were contact between Diego and Lauel about various things but did not contain threats of violence. During this period Lauel did block and unblock Diego regularly and he used different SIM cards. Comment: *Lauel stated to AAFDA during this time a lot of this harassment was for sex and money he would feel entitled to have sex with her he would say get some free time so you can come and please me (sexually) if she did not go he would say there would be consequences which she had a genuine fear.*

16.4.13 On the 15th of September 2022 the IO received a response from the National Centre for Domestic Violence (NCDV) rejecting a referral they had made to obtain support for Lauel to obtain a non-molestation order, however this was not recorded on the crime report. The reason for the NCDV restraining order referral refusal was due to the fact that an interpreter was not available. It was the intention of the officer to follow this up but due to her duties at the time this was not done. *Comment: Lauel stated to AAFDA she had no recollection of this event.*

16.4.14 Incident was subject to a Department of Professional Standards (DPS) investigation after a referral from the local Borough Command Unit (BCU) under the criteria of Death or Serious Injury following police contact. An investigation was conducted with a finding of no misconduct but one learning recommendation. Four police officers were investigated over failing to identify and deal with a threat to kill allegation from the DASH questions provided by Lauel and the IO was also investigated for failing to record timely investigation updates on the crime report. The IO, had they still been employed by the MPS, (they have since resigned from the organisation) would have been placed on Unsatisfactory Performance Procedures (UPP/2) for failing to update a crime report and failing to update a victim. One supervisor received reflective practice for lack of supervision.

16.4.15 A MARAC referral was considered in this incident and within the MPS it was agreed that it did not hit the criteria by the PAO and the Risk Management Team (RMT),

however the RMT and IO said this would be reviewed when they received details from Lauel's phone, and this was flagged accordingly. This was also reviewed by the Appropriate Authority, and they agreed from the information provided on the crime report and DASH risk questions that the criteria were not met.[17] *Comment: The panel do not agree with this assessment by the MPS - this case should have been referred to MARAC there is clear evidence of control , stalking, MH, weapons, separation, threats to kill and continued escalation made this a case for MARAC and the panel are concerned how many other cases are not being referred . Comment: Lauel stated to AAFDA she did not know this or understand the system it was not explained to her regarding MARAC.*

Learning Consideration: all agencies should use the DASH as a risk assessment tool when addressing DA factors/referrals and establish 'whether they are assessing risk effectively and referring into MARAC and ensure that clients understand the purpose of a DASH RA and the purpose of a MARAC.

16.4.16 Under the MPS current domestic abuse policy the decision to not authorise detention could have been challenged "*Police officers have a duty to take positive action when dealing with domestic abuse incidents*." *Comment: The panel are concerned about the decision not to authorise detention in this case and concerned what is the culture within the MPS when detention is not authorised in DA cases. Once detention was refused there was not then a voluntary interview undertaken.*

Learning Consideration: The MPS should review DA cases when there has been a delay in an arrest and be satisfied that positive action is being taken.

16.4.17 Diego was circulated as wanted on the EWMS system and stayed circulated for just over seven weeks before being arrested. There are no recorded entries on EWMS system or crime report indicating that attempts were made to locate or arrest Diego. Under the offender management policy dated the 24th of August 2020 it is the IO

- [17] **Professional judgement:** involves an assessment of dangerousness based on an individual officers consideration of a situation (ie officers make an assessment of risk gained through their experience, reflection and deliberation of all the known factors)

- **Visible High Risk:** the DARA risk assessment will provide a risk grading and the DARA definition of high risk is "There is an extreme level of control of one person by another and/or very frequent and severe physical violence. There is a serious threat of harm posed to the victim by the perpetrator. The potential event could happen at any time and the impact would be serious."
- **Potential Escalation:** the number of police callouts to the victim as a result of domestic violence in the past 12 months. It is common practice to start with 3 or more police callouts in a 12 month period.

responsibility to review and to complete checks every 28 days. The Detective Chief Inspector (DCI) for Public Protection on North East (NE) has confirmed that they have introducing a dedicated team to coordinate arrest enquiries for the Community Safety Unit (CSU) who deal with all domestic abuse incidents. Also, with a change regarding CONNECT (The CONNECT programme, formerly known as the MPS integrated policing solution delivers an integrated core policing IT solution, which will enable the transformation of operational policing services within the MPS. Having been in creation for several years it went live in February 2024) warrants will now work differently across the MPS in that there will be an action in an officer's or unit work tray "Execute Court Warrant" or "Suspect POA" so these will be visible and not hidden away as they were previously, previously they were on a completely separate system that didn't sit in any officer's work tray.

16.4.18 THRIVE+, a decision-making framework, was completed by both the PAO and investigating officer however a DASH/2 assessment did not take by the IO. DASH Part 2 Risk Assessment Questions must be used in all medium or high-risk DA incidents, in addition to the standard DASH questions. By completing the further assessment more information can be brought to light, and this is a mandatory requirement in the latest DA policy, updated June 2023.

16.4.19 The arrival of connect is a complete overhaul of police computers across the MPS. Connect is a major change being introduced later this month. An example for a domestic incident is as follows:

Initial officer will record DARA.

Supervising officer can compete a review of that Risk grading and amend or ratify as needed.

Allocated to CSU if Medium or High

Reviewing CSU Supervisor can action completion of DASH 2 as part of secondary investigation to allocated CSU OIC.

All officers are spoken to regarding DASH 2 on the CSU course and it is in the latest DA policy. NE BCU have already implemented guidance as per the local recommendation.

16.4.20 The panel sought reassurance from the MPS regarding their TTK policy, it is clear there is a policy. The internal investigation found that due to the time frame when reported (a month old) and a condition was attached to the threat it was acceptable to investigate the threat as part of the Domestic abuse investigation.

16.5 VICTIM SUPPORT (VS)

16.5.1 The only contact that Victim Support had been on the 20th of June 2022 when they received a Metropolitan Police automatic data transfer (ADT) referral for Harassment domestic abuse (DA) into the London Victim and Witness Service (LVWS). The referral stated that the date of offence was on the 17th of June 2022 and that the crime was reported to police on the 18th of June 2022.

16.5.2 Victim Support have been commissioned by the Mayor's Office for Policing and Crime (MOPAC) to deliver the London Victims and Witness Service (LVWS), which is a support service for London residents who are affected by or witness to crime. The service commenced on 1 April 2019 and is delivered through a number of specialist partnerships, led by Victim Support. The LVWS is commissioned to bring together five key stands to provide support to victims and witnesses through a single integrated service:

- The service will provide support to adult (18+) victims of crime
- Provide specialist support for victims and survivors of domestic abuse (aged 16+)
- Provide access to Restorative Justice
- Deliver Pre-Trial and Outreach Support for prosecution and defence witnesses all crime types.
- Provide support for people affected by major crime incidents.

Exclusions of the LVWS are non-crime Anti-social behaviour, Sexual Violence outside of a Domestic Abuse setting, due to other services being commissioned to provide these in London. The LVWS operates in a pan London way to flex to the varying demand from across the whole of London. This is in place to help mitigate the reasons for the delay in contact. From referral, the contract requires the service to make contact within 72 hours of referral receipt with financial penalties in place should they fail to do this.

Domestic abuse (DA) referrals into the LVWS have different pathways for initial contact dependent on risk level. DA referrals into the LVWS with no risk assessment where the crime type is known, which is the case for all DA cases referred through the MPS Automatic Data Transfer process, will be assigned for *initial contact* as follows:

- Crime Type: Inflicting GBH, domestic Rape, Attempted Murder, Threats to kill, Stalking, Endangering Life, Arson endangering life, Wounding or carrying out an act to endanger life, malicious wounding: wounding or inflicting GBH, Assault with intent to cause serious harm will be assigned to the Independent Domestic Violence Advocate (IDVA) section of the LVWS by the case management system.

- All other crime types will be assigned by the case management system into the Independent Victim Advocate (IVA) section that triages all cases and conducts the risk and needs assessment.

16.5.3 In this case the Victim Support's case management system (CMS) identifies the correct service (LVWS) based on victim contact address and the triage section of the LVWS due to the crime type. It is shown as allocated on the 21st of June 2022 at (08.38) this was in line with London Victim & Witness Service allocation methodology, to allocate to a caseworker within 24 hours of referral.

16.5.4 It was then re-allocated on the 22nd of June 2022 at (08.40). This demonstrates safe practice as no contact was attempted the previous day. The manager picks up on this and re-allocates within contracted timeframes.

16.5.5 On the 22nd of June 2022 at (12.34) an initial telephone contact is attempted however when Lauel answers it is established that a Spanish interpreter is required. It was agreed that VS would call back with an interpreter. The initial contact attempt was inside of the 72 hours VS are contracted for, and in line with the 48 hours in their DA policy.

16.5.6 On the 22nd of June 2022 at (12.38) VS call back via language line with an interpreter the line connected however there was no response. Shortly after at (12.58) VS call again via language line and this time Lauel's telephone goes straight to voice mail and no voice mail was left. Later that day at (19.07), following 3 unsuccessful contact's an email is sent to the police explaining Victim Support had been unsuccessful in making contact. The case is then closed. *Comment: the panel are deeply concerned that the first contact (when it was established a translator was required) was classified as a contact and that all contacts took place over the period of 24 minutes.*

16.5.7 The LVWS changed its DA contact methodology for non-high risk DA cases in October 2021, so that initial contact was pre-empted by a text message (where mobile telephone was indicated) that is automated by the case management system. The text message is followed up by one call attempt and a further text message if contact was not established, providing details of how to access support if required. The automated SMS feature of VS CMS has an override command for anything that is DA flagged. The SMS feature in DA flagged cases needs to be activated by a worker once all the information they have on the referral has been read and an assessment is made as to the safety of proceeding with a SMS. So, if there is any indication that the victim and suspect are in contact/living together no SMS would take place and the Independent Victim Advocates who triage the case would proceed to attempt first contact by telephone as they did in this case. *Comment: This change does not reflect the diverse language needs of victims of crime in London*

who are of various cultural heritage and where English is not a first language. This method assumes that everyone can read English.

16.5.8 The IDVA Operating Procedure sets out the mandatory service parameters for managing and delivering Victim Support's (VS) Independent Domestic Violence Advisor (IDVA) services safely, effectively, and always to the highest standards.

Victim Support LVWS Contact attempts policy:

For standard and medium risk cases there are three contact attempts. The first contact is the SMS, then a call will be attempted within three working days, if no contact is established then victims will be sent a final SMS letting them know Victim Support have tried to make contact and if they require support to call the London Inbound service or Support-line/Live Chat. The referring agency is also made aware if no contact is established.

High risk cases receive 3 phone calls over 5 days at different times of the day. The first phone call should be within 48 hours of receiving the referral.

16.5.9 In this case due to the understandable overriding of the SMS system, it left Lauel with no message, as a voicemail was also not left. Again, this would be on the same rationale as the SMS but in effect leaves the victim without any message. However also in this case it is noted all the attempts to contact Lauel were made within 24 minutes on the same day. It is the view of the panel that the first contact was not a contact as that simply established that a translator was required. The MPS acknowledge that they did not make VS aware that a translator was required, however the panel are reassured that the option is available on a referral, and this was individual error. *Comment: At this time Lauel informed AAFDA she was working full time- hours 2am – 7am, 8am – 4pm or 7.30pm – 10pm, she always told agencies this when trying to get support – she kept asking for a time that they would call (an appointment).*

Learning Consideration: – Victim Support need to update their policy and make the 3 different attempts on different days to avoid a one-time only series of contacts on the same day all around the same time.

Learning Consideration: – If it's recognised in the first call that a translator is required then that should not count as a contact.

16.6 INTEGRATED CARE BOARD – GP SURGERY

16.6.1 In regard to contacts pertaining to Juana, there are no recommendations as the contacts had the required outcomes. Juana had only brief interaction with the GP and given the nature of that presentation and the fact she was the mother of Lauel

an IMR was not deemed as required. They were also not of a nature that would warrant additional exploration by a GP in terms of DA questioning.

16.6.2 Diego was registered with his GP since the 6th of October 2022. Prior to this he was registered with a practice elsewhere and the review has not been supplied with this information. Diego had 5 encounters with the practice, with 3 being consultations, 2 of which were telephone consultations and one an e consult. Following this e consult the surgery made 2 attempts of contacting him by phone which were unsuccessful.

16.6.3 During his two telephone consultations, language line phone translation was used. The first consultation was in relation to low mood, insomnia, he shared he had a suicide attempt the previous year in Spain. He wanted medication and couldn't recall the name of medication he had been prescribed in the past. Medication was prescribed and also safety net advice provided. His follow up consultation 2 days later was a request to increase the dose of his medication. Then one day later an e-consult is submitting requesting a consultation regarding his medication.

16.6.4 It is important to understand the limitations of record transfer from GP to GP. GP record transfer from one practice to another needs to happen on the first attempt otherwise there is a delay, and the current surgery will not be able to see previous medical records. Mirtazapine is not necessarily a first line for treatment of depression. However, it will help with insomnia and low mood. Therefore, reducing the need for sleeping tablets. The consultation records do not indicate reason for his low mood and insomnia, stress factors and who else was at home as a source of support for him. It is noted there was no offer of signposting to psychological / talking therapies. However good practice is noted in the use of an independent translator.

16.6.5 The interactions with the GP were in a short time frame. Awareness about risk of homicide and suicide, needs to be considered. There is a question on whether do practitioners feel skilled to even consider this especially in the context of not knowing a patient very well. In most instances family and friends are asked about and considered source of support not as potential victims. In addition, when spouses are registered at a different practice it is likely to make these considerations even harder given the full context may not be known to the GP.

16.6.6 Lauel registered with her Newham GP in January 2021, prior to this she was registered elsewhere in London. From the point of registration to her attack Lauel had 3 contacts with the surgery. The first contact was when she registered and in line with a new patient health check. She provided consent for her records to be shared with her partner (Diego). No risk assessment has appeared to have taken place in relation to this action. The next encounter was via telephone and via a friend- which appears to be a mistake.

16.6.7 The last encounter was in January 2022, in relation to a skin condition and needing her Smear test. For this encounter the GP used Language line which was expected practice and a reasonable adjustment for a non-English speaking patient. It does

not appear that the records from her previous GP transferred to her Newham GP. This is an issue that can occur with GP records and as already highlighted is a national challenge.

16.6.8 It is noted that at the point of registration Lauel provided consent for her data to be shared with her NOK Diego. There would have been no prior understanding of her Risks when this registration has taken place. It brings into question the risk assessment that takes place when NOK are given consent to access to patient records. Therefore, it has been considered should access only be provided once GP surgeries have this information and seen the patient several times to allow risk assessment and communicate the risks. It has been considered was this request fully understood and does this disproportionally effect those whose first language is not English. This would require exploration of registration processes and national guidance in relation to risk assessment regarding consent to data sharing in these circumstances.

Learning Consideration: The ICB need to upskill staff in recognising the risk of perpetration of domestic abuse in the context of mental health.

Learning Consideration: The ICB need develop a DHR policy that enables GP to share information for DHR.

Learning Consideration: Named ICB leads can be identified to escalate missing actions to.

Learning Consideration: ICB needs to explore the registration process of new patients in regard to sharing data with third parties to ensure a process is in place that appropriately risk assess this element of registration in regard to DA victims and those whose English is not their first language.

16.7 NORTH EAST LONDON FOUNDATION TRUST (NELFT)

16.7.1 A triage assessment was conducted over the telephone on the 7th of October 2022 in relation to Diego via a Spanish interpreter and a decision made to invite him for a face-to-face assessment. Diego stated that he felt low & depressed. He reported this initially started after his relationship of 5 years with a girl who would "tell lies and talk down about him" ended a few years ago and he was prescribed antidepressants and sleeping pills by his GP. The relationship re-started about a year ago but again ended, which worsened his depression, and he had thoughts of ending his life. He reported that he had recently moved to his present address, where he lives alone, his parents are in Spain. He goes to work as a delivery driver in order to pay the rent but doesn't feel like working. He attempted to register with a local GP and was told

he was not in their catchment, so he called 111. He is not on any prescribed medication. He uses tobacco, no reported alcohol or substance use. Reported not sleeping well, lack of appetite and low energy. Had thoughts of ending his life but denied any current plans to harm himself or others. No reported hallucinations or delusional thoughts. Risk to self-rated as moderate due to suicidal thoughts. *Comment: What about the risk to others, mentions partners and also threats to end his own life*

16.7.2 On the 10th of October 2022 he attended a face-to-face appointment which was conducted with a Spanish interpreter, and he was referred to a similar service in Waltham Forest, his home borough, to seek treatment and further support. Diego was assessed as not having active thoughts to end his life and discussed he preferred to wait until he was seen in Waltham Forest to be commenced on anti-depressant medication, that he felt he needed. Waltham Forest Access assessment & brief intervention team, when contacted, advised Diego to call before attending preferably in the mornings not afternoons. Diego was provided with Waltham Forest Access assessment & brief intervention team address and crisis card that provided all the contact details required if in crisis.

16.7.3 Diego was triaged and assessed on the two occasions that they had contact with RAABIT in accordance with the RAABIT standard operational policy and procedure for duty calls or walk-ins. He was seen with an interpreter on both occasions in accordance with the NELFT equality and diversity policy in recognition of cultural diversity and was signposted to the local service in his catchment area in accordance with RAABIT/NELFT out of area policy.

16.7.4 From the review it would seem that the staff who had contact with Diego on both occasions followed the standard operational policy and procedure for duty calls or walk-ins. Additionally, it was good to see an interpreter was used to assist the interactions. Diego was subsequently signposted to the local service in his catchment area in accordance with RAABIT/NELFT out of area policy. In conclusion, RAABIT as a service, acted accordingly in supporting this client to access support.

16.7.5 However it is noted Diego never went to Waltham Forest for follow up and as he was deemed not in crisis it was not a requirement of RAABIT to follow this up. Waltham Forest MH service was contacted in Diego's presence, and he was advised to call the next day before attending preferably mornings not afternoons. He was given the contact number but did not call or attend. Waltham Forest Single Point of Access (SPA) did not follow up Diego up as at time of referral, he was not in crisis. It is noted he went to the GP on the 11th of October 2023 and a discharge letter would have been emailed to the GP as per standard procedure but there's no evidence this happened.

16.7.6 Of note is on presentation his partner is mentioned as significant contributing factor to his mental health. There appears to be no evidence of any understanding on how this risk factor could impact on partners current or former.

Learning Consideration – Particular scrutiny should be applied to DA perpetrators who self-harm and or express suicidal ideation as a possible risk factor to the safety of the victim.

Key Lines of Enquiry

16.8 Dynamics of gender in a relationship

16.8.1 There is evidence to suggest that gender played a contributory factor in this review. 11.4 & 11.8 the panel identifies that women and girls are disproportionally impacted by domestic abuse and forms of gender-based abuse, whilst also recognising that other genders also suffer similar issues of violence and abuse. Analysis reveals gendered victimization across both intimate partner and familial homicides with females representing most victims and males representing most perpetrators.

16.9 Was identity, faith and or culture a barrier.

16.9.1 There is direct evidence within this review that shows language was a barrier. The issue is highlighted in the service given by Victim Support where, as a result of not being able to speak English and the failure of the MPS to alert victim support to this fact, Lauel received one less opportunity than those that speak English. However, throughout their interactions with Lauel the MPS did use language line/interpreters and the use of language line is commonplace for officers within the MPS given the spectrum of different languages spoken across London.

17. CONCLUSIONS

17.1 Juana was a loving mother, and her untimely death was a tragedy and has affected her family deeply, not least Lauel.

17.2 This review has been unique in terms of being able to see it through the lens of Lauel a survivor of the most dreadful of acts.

17.3 The Review Panel would like to extend their sympathies to all those affected by Juana's death.

LESSONS TO BE LEARNT

17.4 The review identified several learning points that build upon agency IMRs. However, if an agency has already introduced the learning into their practices as a result of the review process, then the need to include a formal recommendation in this review isn't deemed to be necessary.

17.5 It was noted at the start of this review that the home office leaflet that explains DHR's for family members is translated into a number of languages. However, Spanish is not an option, which came as a surprise to the chair and panel given the prevalence of Spanish as a first language. The partnership translated the leaflet for the family in this case however this does lead to a recommendation.

17.6 Information provided by the agencies involved in this review would appear to demonstrate that there are several themes that need to be considered because of Juana's death. There are various themes within the review, each of these have been explored, during this process and the various learning points and recommendations are intended to support victims and survivors facing similar difficulties and challenges. In approaching these learning points and recommendations the Review Panel has sought to try and understand what happened and recognise the issues in the life of Juana and Lauel.

The themes identified are:

- All services need to ensure they meet the requirements of the Equalities Duty and work to ensure that their servicers are made accessible to everyone.

18. RECOMMENDATIONS

Home Office

Recommendation 1: the home office leaflet that explains DHR's for family members is translated into Spanish as an option.

All

Recommendation 2: all agencies should review their use of translators and ensure they meet the requirements of the Equalities Duty and work to ensure that their servicers are made accessible to everyone.

Recommendation 3: all agencies should use the DASH as a risk assessment tool when addressing DA factors/referrals and establish ‘whether they are assessing risk effectively and referring into MARAC and ensure that clients understand the purpose of a DASH risk assessment and the purpose of a MARAC.

MPS

Recommendation 4: The MPS should review DA cases when there has been a delay in an arrest and be satisfied that positive action is being taken.

VS

Recommendation 5: – Victim Support need to update their policy and make the 3 different attempts on different days to avoid a one-time only series of contacts on the same day all around the same time.

Recommendation 6: – If it’s recognised in the first call that a translator is required then that should not count as a contact.

NELFT

Recommendation 7: – Particular scrutiny should be applied to DA perpetrators who self-harm and or express suicidal ideation as a possible risk factor to the safety of the victim.

ICB

Recommendation 8: The ICB need to upskill staff in recognising the risk of perpetration of domestic abuse in the context of mental health.

Recommendation 9: The ICB need develop a DHR policy that enables GP to share information for DHR.

Recommendation 10: Named ICB leads can be identified to escalate missing actions to.

Recommendation 11: ICB needs to explore the registration process of new patients in regard to the question that relates to the sharing of data with third parties. This is

to ensure a process is in place that appropriately risk assesses this element of registration to ensure that DA victims and those whose English is not their first language are not placed at further risk.

APPENDIX 1

Terms of Reference

Domestic Homicide Review

1 Commissioner of the Domestic Homicide Review

1.1 The chair of the Newham Community Safety Partnership has commissioned this review, following notification of the death of Juana.

1.2 All other responsibility relating to the review, namely any changes to these Terms of Reference and the preparation, agreement, and implementation of an Action Plan to take forward the local recommendations in the overview report will be the collective responsibility of the Review Panel.

1.3 The resources required for completing this review will be secured by the independent chair commissioned by Newham Community Safety Partnership.

2 Aims of Domestic Homicide Review Process

2.1 Establish what lessons are to be learned from this domestic abuse related death regarding the way in which local professionals and organisations work individually and together to safeguard people in similar circumstances to those of Juana & Lauel.

2.2 Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

2.3 To produce a report which:

- summarises concisely the relevant chronology of events including:
  - the actions of all the involved agencies.
  - the observations (and any actions) of relatives, friends, and workplace colleagues relevant to the review.
- analyses and comments on the appropriateness of actions taken.
- makes recommendations which, if implemented, will better safeguard people experiencing domestic abuse, irrespective of the nature of the domestic abuse they've experienced.

2.4 Apply these lessons to service responses including changes to policies, procedures, and awareness-raising as appropriate.

3 Timescale

3.1 Aim to complete a final overview report by Oct 2023 acknowledging that drafting the report will be dependent, to some extent, on the completion of individual management reviews to the standard and timescale required by the independent chair.

4 Scope of the review

4.1 To review events up to this domestic abuse related death of Juana and the attack on Lauel. This is to include any information known about their previous relationships where domestic abuse is understood to have occurred.

4.2 Events should be reviewed by all agencies from 2019. However, if any agencies have any information prior to that they feel is relevant, then this should also be included in any chronology/IMR.

4.3 To seek to fully involve the family, friends, and wider community within the review process.

4.4 Consider how (and if knowledge of) all forms of domestic abuse (including the non-physical types) are understood by the local community at large – including family, friends, and statutory and voluntary organisations. This is to also ensure that the dynamics of coercive control are also fully explored.

4.5 Consider how (and if knowledge of) the risk factors surrounding domestic abuse are fully understood by professionals, and the local community – including family and friends, and how to maximise opportunities to intervene and signpost to support.

4.6 Determine if there were any barriers faced in both reporting domestic abuse and accessing services. This should also be explored against the Equality Act 2010's protected characteristics.

4.7 Whether organisations were subject to organisational change and if so, did it have any impact over the period covered by the DHR. In particular what were the effects of the Covid-19 pandemic on relevant organisations? Had it been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively.

4.8 Review relevant research and previous domestic homicide reviews (including those in Newham) to help ensure that the Review and Overview Report is able to maximise opportunities for learning to help avoid similar homicides occurring in future.

5 Key Lines of Enquiry

5.1 The following themes have been prepared by the chair and discussed with the panel. Their purpose is to focus the review upon areas of learning and opportunities to improve service. They have been reviewed and discussed at various stages of this review.

- Dynamics of gender within relationships
- Was identity, faith and/or culture a barrier to disclosure of Domestic Abuse.

6 Role of the Independent Chair

- Convene and chair a review panel meeting at the outset.
- Liaise with the family/friends of the deceased or appoint an appropriate representative to do so. *(Consider Home Office leaflet for family members, plus statutory guidance (section 6))*
- Determine brief of, co-ordinate and request IMR's.
- Review IMR's – ensuring that reviews incorporate suggested the outline from the statutory Home Office guidance (where possible).
- Convene and chair a review panel meeting to review IMR responses
- Write report (including action plan) or appoint an independent overview report author and agree contents with the Review Panel
- Present report to the CSP

7 Domestic Homicide Review Panel

7.1 Membership of the panel will comprise:

Simon Steel	Independent Chair and Author	Perse Perspective Consultancy Ltd
Sharmeen Narayan	Domestic Abuse and Sexual Violence Commissioner	Public Health Commissioning
Sabeena Pheerunggee	Named GP Safeguarding lead	NHS North East London (NEL) Integrated Care Board (ICB)
Sally Pattinson	Detective Sgt Specialist Crime Review Group	Metropolitan Police Service
Rachel Nicholas	Head of Domestic Abuse Services	Victim Support
Nuru Makambo	Operational Lead/Team Manager	North East London NHS Foundation Trust (NELFT)
Emma Crivellari	Named Safeguarding lead	East London NHS Foundation Trust (ELFT)
Ed Lander	Service Manager ELFT representing Mental Health Services	East London NHS Foundation Trust (ELFT)

Farida Butt	Service Manager Hestia	Hestia DA services Newham
Clare Hughes	Associate Director of Safeguarding BARTS Health NHS Trust (representing Newham Hospital)	BARTS Health NHS Trust
Daniel Wilson	Designated Professional Safeguarding Adults, Newham (CCG)	NHS North East London (NEL) Integrated Care Board (ICB)
Dawn Henry	Specialist Pathways Team Leader Newham (housing)	Newham CSP
Katie Burgess	Adult Social Care Safeguarding	Newham CSP
Jenni Bonner	Counselling Manager Black Women's project	London Black Women's project
Yvonne Njogu	Senior social worker-Redbridge mental health & wellness team south	North East London NHS Foundation Trust (NELFT)
Carolina Gutierrez	Manager	LAWA
Sara Shakeel	Immigration Legal Advisor	London Black Women's project

The above was confirmed at the first DHR Review Panel Meeting held on the 2nd March 2023.

7.2 Each Review Panel member to have completed the DHR e-learning training as available on the Home Office website *before* joining the panel. (online at: https://www.gov.uk/conducting-a-domestic-homicide-review-online-learning)

8 Liaison with Media

8.1 Newham Community Safety Partnership will handle any media interest in this case.

8.2 All agencies involved can confirm a review is in progress, but no information to be divulged beyond that.

8.3 **Confidentiality**

All panel members are bound by the agreed confidentiality agreement.

APPENDIX 2

Glossary of Terms

Advocacy After Fatal Domestic Abuse	AAFDA
Adult Social Care	ASC
Automatic Data Transfer	ADT
Coming To Notice	CTN
Community Mental Health Team	CMHT
Community Safety Partnership	CSP
Department of Professional Standards	DPS
Domestic Homicide Review	DHR
Domestic Abuse, Stalking, Harassment and Honour based violence assessment	DASH
Emerald Warrants Management System	EWMS
North East London Foundation Trust	NELFT
General Practitioner	GP
Individual Management Reviews	IMR

Investigating Officer	IO
Latin American Women's Aid	LAWA
Latin American Women's Rights	LAWRS
London Ambulance Service	LAS
London Victims and Witness Service	LVWS
Mayor's Office for Policing and Crime	MOPAC
Mental Health Social Care Team	MHSCT
Metropolitan Police	MPS
Multi-Agency Risk Assessment Conference	MARAC
Multi Agency Safeguarding Hub	MASH
Police National Computer	PNC
Public Access Officer	PAO
Risk Management Team	RMT
Single Point of Access	SPA
Subject Matter Expert	SME
Terms of Reference	TOR
Threat Harm Risk Investigation Vulnerability Engagement	THRIVE*
Victim Support	VS