DOMESTIC HOMICIDE REVIEW EXECUTIVE SUMMARY

Report into the death of Juana

October 2022

Independent Chair and Author: Simon Steel

Date of Completion: 04 September 2024

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1. THE REVIEW PROCESS

1.1 This summary outlines the process undertaken by the London Borough of Newham Community Safety Partnership (CSP), Domestic Homicide Review panel in reviewing the circumstances of the death of Juana.

1.2 The following pseudonyms have been in used in this review to protect their identities.

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

1.3 The inquest into the death of Juana is yet to be heard.

1.4 The Newham CSP reviewed the circumstances against the criteria set out in the Multi-Agency Statutory Guidance for the conduct of Domestic Homicide Reviews and the chair of the CSP determined that a DHR should be undertaken. The chair ratified the decision, and the Home Office was notified on 18th of November 2022.

1.5 Agencies that potentially had contact with Juana, Lauel and Diego prior to the point of death were contacted and asked to confirm whether they had involvement with them.

2. CONTRIBUTORS TO THE REVIEW

2.1 Agencies were asked to check for their involvement with any of the parties concerned and secure their records. The approach adopted was to seek Individual Management Reviews (IMRs) for all the organisations and agencies that had contact with Juana.

2.2 The following agencies who had contact and their contributions are shown below.

Agency	Nature of the contribution
Metropolitan Police	Chronology and IMR
North East London ICB representing GP's	Chronology and IMR
Victim Support	Chronology and IMR
North East London Foundation Trust (NELFT)	Chronology and IMR

2.3 IMRs were completed by authors who were independent of any prior involvement with Juana, Lauel and Diego.

2.4 The authors and panel members assisted the panel further, with a number of one-to-one meetings and answering follow up questions as necessary.

3. THE REVIEW PANEL MEMBERS

3.1 The review panel members included the following agency representatives.

Name	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	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

3.2 The review panel met on 4 occasions.

3.3 Agency representatives were of appropriate level of expertise and were independent of the case.

4. AUTHOR OF THE OVERVIEW REPORT

4.1 The Chair of the Review was Simon Steel. Simon has completed his Home Office approved Training and has attended training by Advocacy After Fatal Domestic Abuse. He completed 20 years-service with Thames Valley Police retiring at the rank of Detective Superintendent. During his service he gained experience in response to Domestic Abuse, Public Protection and Safeguarding.

4.2 Simon has no connection with the Newham Community Safety Partnership, or any agencies involved in this case.

5. TERMS OF REFERENCE FOR THE REVIEW

5.1 The primary aim of the DHR was defined as examining how effectively Newham's statutory agencies and Non-Government Organisations worked together in their dealings with Juana.

5.2 The purpose of the review is specific in relation to patterns of Domestic Abuse and/or Coercive Control, and will:

- Conduct effective analysis and draw sound conclusions from the information related to the case, according to best practice.
- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic violence including their dependent children.
- Identify clearly what lessons are both within and between those agencies. Identifying timescales within which they will be acted upon and what is expected to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and
- Contribute to the Prevention of Homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.
- Highlight any fast-track lessons that can be learned ahead of the report publication to ensure better service provision or prevent loss of life

5.3 Case specific key lines of enquiry included the following:

- Dynamics of gender within relationships.

- Was identity, faith and/or culture a barrier to reporting Domestic Abuse.

The Death

5.4 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.

5.5 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.

6. SUMMARY CHRONOLOGY

Family Perspective

6.1 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.

6.2 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.

6.3 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.

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

6.5 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.

6.6 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.

6.7 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.

6.8 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.

6.9 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.

6.10 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.

6.11 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.

6.12 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.

6.13 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.

6.14 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.

6.15 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.

6.16 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.

6.17 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.

6.18 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.

6.19 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.

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

METROPOLITAN POLICE (MPS)

6.21 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.

6.22 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.

6.23 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.

6.24 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.

6.25 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.

6.26 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).

6.27 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.

6.28 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 body was identified as that of Diego.

VICTIM SUPPORT (VS)

6.29 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.

INTEGRATED CARE BOARD – GP SURGERY

6.30 There was interactions with a number of GP surgeries. 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 IMR's for Diego and Lauel's interactions 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 GP surgery given the nature of her interaction's which were very limited. They were also not of a nature that would warrant additional exploration by a GP in terms of DA questioning.

NORTH EAST LONDON FOUNDATION TRUST (NELFT)

6.31 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.

7. CONCLUSIONS AND KEY ISSUES ARISING FROM THE REVIEW

7.1 Tragically it has not been possible to build a picture from Juana's perspective. However, this review has had the most valuable insight from Lauel.

7.2 In relation to when Lauel attended a local police station on the 18th of June 2022. Lauel 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.

7.3 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.

7.4 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.

7.5 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

7.6 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.

7.7 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.

7.8 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).

7.9 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.

7.10 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.

7.11 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.

7.12 This 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.

7.13 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. 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

7.14 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.

7.15 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 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.

7.16 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.

7.17 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.

7.18 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.

7.19 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.

7.20 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.

7.21 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.

7.22 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.

7.23 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.

7.24 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.

7.25 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.

7.26 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.

7.27 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.

7.28 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. 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.

7.29 In regard to contacts pertaining to Juana with her GP, 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.

7.30 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.

7.31 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.

7.32 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.

7.33 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.

7.34 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.

7.35 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.

7.36 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.

7.37 In regard to contact with NELFT 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

7.38 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.

7.39 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.

7.40 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.

7.41 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 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.

7.42 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.

7.43 There is evidence to suggest that gender played a contributory factor in this review. 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.

7.44 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.

8. LESSONS LEARNED

8.1 The review identified several learning points that build upon agency IMRs. Information provided by the agencies involved in this review would appear to demonstrate that there is a theme that needs to be considered because of Juana's death. This has 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.

8.2 The theme identified:

- 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.

8.3 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.

8.4 The Review Panel would like to extend their deepest sympathy to all those affected by Juana's death.

9 GOOD PRACTICE

9.1 Expected practice was identified in some areas like when translation services were utilised by some professionals on occasions however no good practice was identified.

10. RECOMMENDATIONS

10.1 Home Office Recommendation:

The following recommendation has been agreed by the panel.

Home Office

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

10.2 Local Recommendations:

The following local recommendations have been agreed by the panel.

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 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.