Domestic Homicide Review

Review into the murder of Jimena in March 2015

Overview Report

Chair and Report Author: James Rowlands

Date completed: December 2018

Table of Contents

Preface ***4***
1. Introduction ***4***
2. Overview ***6***
Timescales **7**
Confidentiality **10**
3. Methodology ***11***
Terms of Reference **11**
Contributors to the DHR **12**
Family, friends, work colleagues, neighbours and wider community **13**
The Review Panel members **16**
Independent Chair and Author of the Overview Report **18**
Parallel reviews **20**
Dissemination **20**
4. Background Information (The Facts) ***22***
What happened **22**
The Post Mortem **23**
Criminal justice outcome **23**
History of the relationship **23**
Family of Jimena **24**
Friends of Jimena **26**
Client of Jimena **28**
The perpetrator, his family and friends **28**
5. Chronology ***30***
6. Analysis ***33***
Domestic Violence and Abuse **33**
Addressing the Terms of Reference and Lines of Enquiry **39**
Equality and diversity ***54***
7. Conclusions ***58***
8. Lessons to be learnt ***58***
9. Recommendations ***60***
10. Appendices ***62***
Appendix A: Glossary **62**
Appendix B: DHR Terms of Refence **63**
Appendix C: Template DHR Recommendations and Action plan **64**
Appendix D: Home Office letter **68**

"Jimena and I were very close, and she was a wonderful person who loved to travel and see her friends. Jimena had gone through a lot in her life, but she was always smiling and was a family person".

Tribute to Jimena by her brother, Luis

Preface

The Independent Chair(s)[1] and Review Panel would like to begin this report by expressing their sympathy to the family and friends of Jimena[2] and thanking them, together with others who have taken part in this Domestic Homicide Review (DHR), for their involvement, contributions and patience.

The Independent Chair(s) would also like to thank the Review Panel for their participation in this DHR.

1. Introduction

1.1 DHRs came into force on the 13th April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act states that a DHR should be a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by-

a) A person to whom [they were] related or with whom [they were] or had been in an intimate personal relationship, or
b) A member of the same household as [themselves],

with a view to identifying the lessons to be learnt from the death.

1.2 Throughout this DHR, the term 'domestic abuse' is used interchangeably with 'domestic violence', and the report uses the cross-government definition of domestic violence and abuse as issued in March 2013. The definition states that domestic violence and abuse is:

"*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.*

[1] For more information on the chairing arrangements for this DHR, see 3.27 - 3.34 below.
[2] Not her real name.

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.

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."

1.3 This definition, which is not a legal definition, includes so-called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

1.4 The purpose of a DHR is to:

a) Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
b) 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;
c) Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;
d) Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;
e) Contribute to a better understanding of the nature of domestic violence and abuse; and
f) Highlight good practice.

1.5 The statutory '*Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews*' ('the statutory guidance') was revised and reissued during the course of this DHR. The Review Panel was mindful of this revision. The latter part of the DHR process have been conducted in line with the 2016 statutory guidance.

2. Overview

2.1 This DHR examines agency responses and support given to Jimena prior her death at the end of March 2015 in the London Borough of Hammersmith & Fulham (LBHF).

2.2 Jimena was a 33-year-old trans woman[3]. She was a Mexican national and was normally resident in her home country. Jimena was a sex worker[4], and regularly travelled internationally for this purpose[5].

2.3 Jimena's husband, Mario[6], was also a Mexican national. He lived with Jimena in Mexico and often travelled with her when she travelled abroad.

2.4 In January 2015 Jimena travelled to the United Kingdom (UK) with Mario. They moved into a privately rented flat in the LBHF.

Name	Gender	Age at the time of the murder	Relationship with the victim	Ethnicity
Jimena	Trans woman	33	-	Mexican
Mario	Man	24	Husband	Mexican

2.5 After Jimena was found dead, Mario was arrested. He was subsequently found guilty of Jimena's murder in October 2015 and sentenced to 14 and a half years imprisonment.

2.6 At the time of Jimena's death, she and Mario had been in the UK for just under three months. The Review Panel considered agency contact/involvement with Jimena and Mario from the 9th January 2015 (when Jimena and Mario arrived in the UK) to the end of March 2015 (when the homicide occurred). As will be discussed in this report, neither Jimena or Mario had any contact with local services prior to the homicide.

2.7 As a result, the Review Panel has considered whether there is any wider learning around this case. This DHR has examined the past to identify any relevant background or trail of abuse before the homicide, whether support was

[3] The term 'trans women' and 'trans' are used in this report. See 'Appendix A: Glossary' for definitions.
[4] The term 'sex worker' has been used in this report because Jimena described herself as such. See 'Appendix A: Glossary' for a definition. Locally, the three boroughs refer to 'women affected by prostitution' and this terminology is used in the report when discussing the local strategic context.
[5] Consideration has been given to whether Jimena had been subject to, or was at risk of, trafficking. This was not identified as an issue by either the MPS during the murder enquiry or by the Review Panel in the course of the DHR.
[6] Not his real name.

accessed within the community(s) and whether there were any barriers to accessing support. By taking a holistic approach the DHR seeks to identify appropriate solutions to make the future safer.

2.8 The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

2.9 A DHR does not take the place of the criminal or coroner's courts, nor does it take the form of a disciplinary process.

Timescales

2.10 This DHR was commissioned by the LBHF Community Safety Partnership (CSP), following notification by the Metropolitan Police Service (MPS) on the 19th May 2015. The Home Office was informed of the decision to commission a review on 26th May 2015.

2.11 There have been two Independent Chairs associated with this DHR. The first Independent Chair was appointed in September 2015, serving in this capacity until they withdrew from the chairing role in July 2018. In September 2018 a second Independent Chair was appointed with a remit to conclude the DHR, with this happening between September 2018 and December 2018. The chairing arrangements for this DHR are more fully described in 3.27 - 3.34 below.

2.12 A completed Overview Report and Executive Summary were handed to the CSP at the end of December 2018 and signed off by the CSP in March 2019. They were submitted to the Home Office Quality Assurance Panel in April 2019.

2.13 The Home Office provided notification and approval for publication in [XXX]. The Home Office letter is included in Appendix D.

2.14 DHRs should be completed, where possible, within six months of the commencement of the review. The timeframe for this DHR to be completed and handed over to the CSP has been three years and seven months.

2.15 The first Independent Chair identified the following issues as accounting for the time taken in the first three years of the DHR (i.e. between the notification that a DHR was being undertaken in May 2015 and their withdrawal from the chairing role in July 2018):

- The time taken to appoint the first Independent Chair (September 2015)
- Waiting to hold the first Review Panel meeting until the conclusion of the criminal trial (the trial was in October 2015 and the first Panel Meeting was in November 2015)
- Cancellation of one Review Panel meeting due to availability of Review Panel members (March 2017)
- The practical and logistical challenges in locating, speaking with and making enquiries with both Jimena and Mario's families, in particular as a result of a language barrier. This took some considerable time to manage, as it required both an interpreter and the support of the Mexican Consulate
- Attempts to locate and speak to Jimena's friends, all of whom were outside the UK
- The time taken to contact the perpetrator and seek his consent to participate in the review (Mario subsequently chose not to engage)
- Delays in obtaining some information relating to agency contact[7]
- Delays in receiving comments from Review Panel members on the draft Overview Report (circulated in September 2016)
- Changes in Review Panel membership during the timeframe of the DHR
- Personal issues for the first Independent Chair which meant that there were some periods of absence. Ultimately, they were unable to conclude the DHR.

2.16 It is not in the remit of the second Independent Chair to assess the veracity and management of these issues. However, taken together they have had an impact on the timeframe of the DHR, resulting in a significant delay.

2.17 During the DHR, the CSP has sought to work with the first Independent Chair to resolve the issues identified above, and when they stepped down, appointed a second Independent Chair to ensure the DHR was concluded. However, the CSP has acknowledged that the length of this delay was unacceptable.

2.18 The Review Panel would like to acknowledge the impact that the delay has had both on family and friends, as well as the opportunity to identify lessons and take actions to address these in a timely manner.

[7] The second Independent Chair sought to clarify what this related to. They were informed by the first Independent Chair that the information was obtained and included in the draft Overview Report that had been handed over. No further details were provided.

Ultimately, the commissioning CSP is responsible for the timeliness of a DHR, although this will require an ongoing dialogue with the Independent Chair. In this case, it is not clear that the CSP had sufficiently robust procedures in place to identify issues and agree mitigating actions to address them.

Recommendation 1: The CSP to develop a local procedure for the conduct of DHRs. This to include a clear process around the monitoring of progress and, where there are delays, the escalation and agreement of mitigating actions to ensure that DHRs are conducted in a timely manner.

2.19 The Review Panel also discussed the delay with regard to confidence in the DHR process more generally, noting that this could have a particular impact in a case such as this where the victim was from a minority community. It was noted that there is no requirement in the statutory guidance for CSPs to make information available on the progress of DHRs. While the Review Panel recognised the limitations on what could be shared about a DHR prior to approval by the Home Office Quality Assurance Panel and subsequent publication, it was felt that currently the DHR process is not as transparent as it could be.

The absence of a requirement in the statutory guidance for CSPs to routinely share information on the progress of DHRs is an issue.

Recommendation 2: The Home Office to amend the statutory guidance in order to improve the transparency of the DHR process by requiring CSPs to routinely report on key milestones (e.g. notification received, commissioned, commenced, submitted to the Home Office for quality assurance, approved for publication).

2.20 After September 2018, with the appointment of the second Independent Chair, the DHR was concluded. A completed Overview Report and Executive Summary were handed to the CSP in four months (being completed between September and the end of December 2018).

Confidentiality

2.21 The findings of this DHR are confidential. Information is available only to participating officers/professionals and their line managers, until after the DHR has been approved by the Home Office Quality Assurance Panel and published. Dissemination is addressed in 3.37 - 3.39 below.

2.22 As recommended by the statutory guidance, pseudonyms have been used and precise dates obscured to protect the identities of those involved.

2.23 Initially, pseudonyms were chosen by the first Independent Chair. However, at the final Review Panel meeting, the second Independent Chair noted that anglicised pseudonyms had been proposed[8]. As the people named in the DHR are all of Latin American origin, the Review Panel were asked to reconsider this decision. Upon reflection, it was agreed that the pseudonyms chosen were not appropriate. Subsequently, Review Panel members with expertise in relation to Mexican / Latin American communities suggested a number of potential pseudonyms and these were then cross referred with the information held by the MPS to eliminate the names of family and friends. The second Independent Chair selected pseudonyms from the remaining suggestions. Some individuals named in this report are only identified by their relationship to Jimena. The pseudonyms used are:

Pseudonym	Relationship to victim
Jimena	-
Mario	Husband
Luis	Brother
Marta	Niece
Pilar	Friend
Julia	Friend
Carlos	Friend
Friend 1	Friend
Friend 2	Friend
Client 1	Client

2.24 Unfortunately, as Jimena's family were not involved in the final stages of the DHR (see 4.20 below) it was not possible to discuss the pseudonyms used with them.

[8] There was no information in the handover received from the first Independent Chair about how the pseudonyms had been chosen and whether or not they had been discussed and / or agreed with Jimena's family.

3. Methodology

Terms of Reference

3.1 The Terms of Reference developed by the first Independent Chair can be found at Appendix B. The specific issues noted as being relevant to this case at the start of the DHR meant the Review Panel sought to identify:

- Learning around how agencies can best work with sex workers within the trans community
- Learning around how we may use trans and/or sex worker networks to highlight services available to a visiting sex worker who may be exposed to domestic abuse
- Any past features in this homicide that might indicate controlling or coercive behaviours from either perpetrator or victim.
- What barriers are there, if any, against a trans woman sex worker who is visiting the UK accessing relevant public services for advice or support.

3.2 In approaching this DHR, a key issue is that neither Jimena nor Mario had any contact with agencies during their stay in the UK and before the homicide. As a result, the Review Panel has not been able to look at the specific issue of how local professionals and organisations worked individually and together to safeguard the victim in this case. It has focused instead on identifying the lessons to be learned more broadly, and has applied these lessons to service responses, including considering any changes to policies and procedures where that may be appropriate. This is in keeping with the purposes of DHRs, which include: preventing domestic violence and homicide and improving service responses by developing a co-ordinated multi-agency approach to ensure earlier identification and improved response, as well as contributing to a better understanding of the nature of this issue. Where relevant, the Review Panel has also sought to identify good practice.

Contributors to the DHR

3.3 On notification of the homicide, local agencies were contacted and asked to check for their involvement with Jimena and / or Mario and to secure their records[9].

3.4 Those agencies that reported having no contact with either Jimena or Mario prior to the homicide included:

- Health Services (Primary Care, Community and Acute)
- LBHF (Housing, Children and Family Care, Adult Social Care)
- The local Multi-Agency Risk Assessment Conference (MARAC)
- National Probation Service / Community Rehabilitation Company
- Local Sexual Health services
- Local Specialist Domestic Abuse services
- Local Substance Misuse services.

Additionally, towards the end of the DHR, a private health clinic in South London was contacted. This was on the advice of a Review Panel member who was aware that the clinic was often used by people from the Latin American communities. The clinic reported that it had not had any contact with either Jimena or Mario.

3.5 Two agencies provided an Individual Management Review (IMR) as they were involved with Mario after the homicide:

Agency	Information provided
MPS	IMR in the form of a short report
West London Mental Health NHS Trust (WLMHT)	IMR in the form of a short report

3.6 A further three agencies provided reports, although they had not had any contact with either Jimena or Mario:

Agency	Information provided
Galop	Background report on trans women's experience of domestic violence and abuse
Hammersmith & Fulham Council Housing	Background report on response to domestic violence and abuse

[9] The second Independent Chair sought to clarify specifically which agencies were approached for information, including those that had submitted a 'nil return'. Unfortunately, this information was not provided in the handover received from the first Independent Chair and the CSP did not have a record of the requests made. The following list has therefore been reconstructed by the second Independent Chair and the Review Panel.

Hammersmith & Fulham Council Public Health	Background report on sexual health and substance misuse services

3.7 The IMRs were written by authors who were independent of case management.

3.8 The IMRs and background reports were of good quality and enabled the Review Panel to conduct its deliberations.

3.9 Reflecting the limited contact with Jimena and Mario, no recommendations were made in the IMRs or background reports.

3.10 Additional information and facts were gathered from:

- Interviews conducted by the first Independent Chair with a sex worker from the trans community, as well as a member of staff from a sexual health service for trans people and contact with the Mexican Consulate
- Research by the second Independent Chair, who contacted the Review Panel to identify any changes in service provision, referral pathways or strategy since the draft Overview Report was completed by the first Independent Chair. The second Independent Chair also undertook research more broadly into the issues raised in this DHR.

Family, friends, work colleagues, neighbours and wider community

3.11 The first Independent Chair sought to contact the family and friends of Jimena and Mario respectively[10].

3.12 Early in the DHR, the first Independent Chair successfully contacted and conducted interviews with Jimena's brother (Luis) and niece (Marta)[11]. This is described in section 4 below. Family members were provided with both the Home Office leaflet for families, as well as information on Advocacy After Fatal Domestic Abuse (AAFDA)[12]. The process of family contact required time to plan and to manage the logistics. An interpreter was used to translate documents, emails and to interpret during interviews, as Jimena's family were Spanish speaking and did not speak English. The interpreter was paid by the LBHF[13].

[10] It is not possible to describe in full who was approached to participate in the DHR. The second Independent Chair sought confirmation from the first Independent Chair as to who they had attempted to contact, when and the outcome. Unfortunately, this information was not provided in the handover received from the first Independent Chair and the CSP did not have a record of the requests made.
[11] Not their real names.
[12] For more information, go to: https://aafda.org.uk.
[13] Although the second Independent Chair was provided with a note for these interviews, there was no information in the handover received from the first Independent Chair as to whether Jimena's brother or niece were invited to confirm the accuracy of the record made. There was also no information provided as to whether they were provided with, or asked to comment on, the Terms of Reference.

3.13 Contact was only possible with the support and assistance of the Mexican Consulate in London, who received information and guidance on the DHR process from the first Independent Chair. The Review Panel are grateful to staff at the Mexican Consulate who accommodated the first Independent Chair's contact (using an interpreter) with Jimena's family outside core office hours and across time zones.

3.14 The first Independent Chair initially maintained an on-going dialogue with Jimena's family. However, when the DHR was handed over to the second Independent Chair in September 2018, it became apparent that there had been no contact with Jimena's family since November 2017. At that time, the first Independent Chair had informed them that the DHR was nearing completion.

3.15 It is unacceptable that Jimena's family were not updated for almost a year. All those involved in the conduct of this DHR would like to apologise that timely updates have not been provided to Jimena's family.

Ultimately, the commissioning CSP is responsible for the conduct of a DHR, although the Independent Chair is usually responsible for family contact during the DHR. In this case, while the initial contact was appropriate, no updates were provided to Jimena's family in the latter part of the DHR. This is despite a requirement in the statutory guidance to maintain reasonable contact with the family, directly or through a designated advocate if appropriate.

Recommendation 3: The CSP to ensure that the expectations around timely and regular family contact are reflected in the local procedure for the conduct of DHRs.

A further recommendation is made specifically in relation to the chairing role, and this is discussed in 3.27 - 3.34 below.

3.16 The CSP agreed with the second Independent Chair that the Victims Programme Coordinator from the Community Safety Unit (CSU) at the LBHF would act as the single point of contact for the victim's family. The rationale for this was because the second Independent Chair had a specific remit to conclude the DHR and would therefore only be involved for a relatively short

period of time. It was felt inappropriate to ask the family to build a relationship with the second Independent Chair, before having to do so with the CSP.

3.17 An attempt to re-establish contact with the family was made when a (translated) letter was emailed to both Jimena's brother (Luis) and niece (Marta) on the 19th November 2018.

3.18 After some deliberation between the second Independent Chair and the CSP, a decision was made to ask Jimena's family to confirm if they wanted to be involved in the DHR within a deadline of one month of the letter being sent. This was a difficult decision. All those involved recognised that requiring a response within a set time period was challenging given the issues with the timeframe of the DHR as identified above. However, setting a deadline for a response was felt to be proportionate when balanced with the need to conclude the DHR. Additionally, the letter made it clear that, if Jimena's family did want to re-engage with the DHR, this could be in a way and within a timeframe that was appropriate for them.

3.19 Unfortunately, although perhaps understandably in the circumstances, no response was received from Jimena's family. The Review Panel and the Chair have sought and received assurances from the CSP that (a) if a response is received in the future, every effort will be made to engage with Jimena's family and (b) should no response be received, a further attempt will also be made to contact Jimena's family prior to publication.

3.20 Contact was also made with a number of friends. This is also described in section 4 below.

The Review Panel members

3.21 In addition to the Independent Chair(s), the Review Panel members[14] were:

Name	Job Title	Agency
Caroline Birkett	Head of London Services	Victim Support
Catherine Bewley	Head of Sexual Violence Support Services	Galop[15] / Angelou Partnership[16]
Felicity Charles[17]	Victims Programme Coordinator	LBHF CSU
Gemma Lightfoot	Principal Anti-Social Behaviour Officer	LBHF Anti-Social Behaviour Team
Justin Armstrong	T/Detective Chief Inspector, Statutory and Homicide Review Operations Manager	MPS Specialist Crime Review Group (SPRG)
Max Hadermann	Health & Wellbeing Coach	Community Sexual Health Partnership – Support and Advice on Sexual health (SASH)[18]
Nicola Ashton	Strategic Commissioner	LBHF Public Health
Sally Jackson	Partnership Manager	Standing Together Against Domestic Violence (STADV)
Sally Kingsland	Clinical Quality Manager	NHS England
Shabana Kausar	Violence Against Women and Girls (VAWG) Strategic Lead	London Boroughs of Westminster, Hammersmith and Fulham, and Kensington and Chelsea
Victor Nene	Designated Adult Safeguarding & Clinical Quality Manager	North West London Collaboration of Clinical Commissioning Groups (CCGs)

[14] Given the delays to the DHR, a significant period of time had elapsed without a meeting of the Review Panel. On the appointment of the second Independent Chair, the Review Panel was reconstituted. This is a record of the membership at that time and for the final Review Panel meeting in November 2018.
[15] Galop is the UK's leading lesbian, gay, bisexual and trans* (LGBT+) anti-violence and abuse charity. For more information, go to: http://www.galop.org.uk.
[16] Galop is a membership of the Angelou Partnership. This is a partnership of 10 specialist organisations that have come together to support women and girls experiencing domestic or sexual violence. For more information, go to: https://www.angelou.org/about-us.
[17] Came into post in 2017, previously the LBHF CSU was represented by Kate Delaney.
[18] Initially employed by the SWISH / Terrence Higgins Trust. During the course of the DHR, sexual health services were recommissioned locally. Currently, SASH provides sexual health services to people who live in three London boroughs: The City of Westminster, the London Borough of Hammersmith & Fulham, and the Royal Borough of Kensington and Chelsea. SASH is a partnership, led by Turning Point, alongside NAZ, London Friend, METRO Charity, and Marie Stopes UK. For more information, go to: http://wellbeing.turning-point.co.uk/sexualhealth/about-us/.

3.22 Review Panel members were of the appropriate level of expertise and were independent, having no direct line management of anyone involved in the case.

3.23 As evidenced from above, there was representation on the Review Panel from a specialist Lesbian, Gay, Bisexual and Trans (LGBT+) service (Galop), as well as from a sexual health service (SASH). The representative from SASH also had extensive experience of supporting clients who were engaged in the local sex industry. For the final Review Panel in November 2018, an additional representative with experience in relation to the local sex industry and sexual health was also invited:

Name	Job Title	Agency
Charlotte Cohen	Consultant Genitourinary Medicine (GUM) - 10 Hammersmith Broadway (10HB)	Chelsea and Westminster Hospital NHS Foundation Trust

3.24 At the first five Review Panel meetings, there was no representation from a service that worked with Mexican or Latin American communities. On their appointment, the second Independent Chair sought to clarify whether there had been any consideration as to the involvement of a service with experience working with Mexican or Latin American communities. Galop reported proposing representation from Latin American Women's Aid (LAWA)[19], and later facilitating an introduction between that agency and the first Independent Chair. However, it appears that LAWA were not subsequently invited to be on the Review Panel[20]. The second Independent Chair discussed this with the CSP, and it was agreed that this was not sufficient and that it was important to have a representative from a Mexican or Latin American specialist service on the Review Panel. Subsequently, the CSP facilitated contact with LAWA, who attended the final Review Panel meeting in November 2018:

[19] LAWA runs the only two refuges in Europe by and for Latin American women and children fleeing gender-based violence. They provide holistic and intersectional services, providing everything a BME woman needs to recover from abuse and live empowered lives. For more information, go to: http://lawadv.org.uk/en/.
[20] The second Independent Chair sought confirmation from the first Independent Chair about what had happened. The first Independent Chair stated that they had spoken to an appropriate person regarding cultural issues (they did not identify which agency they were from) and that this had been fed into the draft Overview Report.

Name	Job Title	Agency
Yenny Tovar-Aude	Director	LAWA

3.25 During the tenure of the first Independent Chair the Review Panel met a total of five times. The first meeting of the Review Panel was on the 19th November 2015, with further meetings on 27th January 2016, 20th April 2016 (deferred from the 20th March 2016), 11th July 2016 and the 20th September 2016. A meeting was scheduled for 1st March 2017 but was cancelled.

3.26 After the appointment of the second Independent Chair, the Review Panel meet once on the 20th November 2018 to consider and agree the revised final draft Overview Report and Executive Summary. After the meeting, further information was shared, and then sign off secured, via email.

Independent Chair and Author of the Overview Report

3.27 The first Independent Chair was originally appointed to lead the review in September 2015, serving as chair until June 2018. However, in July 2018 they informed the CSP that they would have to withdraw from the chairing role for unforeseeable personal reasons.

3.28 Given the timeframe for the review at that point (as described in 2.10 – 2.20 above), the CSP felt it was important to bring the DHR to timely conclusion and also to have a subject matter expert who could address the specific issues raised by the case.

3.29 Following a recommendation from a local service, James Rowlands was approached. He was initially asked to conduct a desktop assessment of the progress of the DHR in July 2018 and was then appointed as the second Independent Chair in September 2018. James is a subject matter expert (in relation to domestic abuse in LGBT+ communities) and also an experienced DHR chair. James has no direct operational and strategic involvement with agencies in the LBHF.

3.30 However, James is an Associate of STADV, for whom he chairs DHRs in areas outside of LBHF and the other authorities included in the three boroughs[21].

[21] The three boroughs are the LBHF and Westminster City Council and The Royal Borough of Kensington and Chelsea. The three boroughs have a Shared Services VAWG Strategy.

James declared this as a potential conflict of interest when approached by the CSP. While recognising this as an issue, the CSP felt that James could be appointed as he no direct operational and strategic involvement with agencies in the LBHF. Additionally, it was agreed that James would chair the DHR without recourse to any resources or support from STADV. The CSP felt these provided sufficient assurances in relation to both independence and any potential conflicts of interests, and that the appointment was proportionate in the interests of concluding the review.

3.31 The CSP contacted the Home Office at the end of July 2018 to bring the proposed appointment of James to their attention and seek feedback on the decision. The CSP received confirmation that the appointment and proposed mitigations were acceptable.

3.32 James received a partial handover from the first Independent Chair. He sought further information in relation to a number of areas as described in the report above, including contact with family and friends. James received some but not all of the documents or correspondence associated with the DHR. As a result, it has not been possible to resolve some issues due a lack of information; where relevant, this has been noted. Additionally, a draft Overview Report was also handed over. This was partially complete and, as it had last been circulated to the Review Panel in September 2017, some of the content (particularly in relation to services and referral pathways) was dated.

This DHR has illustrated some of the issues that can arise in relation to the role of the chair, in particular in relation to family contact (discussed in 3.11 – 3.19). Additionally, the change of chair (an unusual event) necessitated a handover. Unfortunately, this was incomplete. This highlighted the difficulties that can arise if records / data are either not retained or only partially handed over.

Recommendation 4: The CSP to ensure that the expectations in relation to Independent Chairs (in particular around the role of the chair in relation to family contact and issues such as record keeping and data retention) are explicit in the terms of their engagement and reflected in the local procedure for the conduct of DHRs.

3.33 Reflecting this, it was agreed that James' remit would be to operate within the previous agreed Terms of Reference and:

- Review the information available from the handover and draft Overview Report
- Liaise with Review Panel members to identify and resolve any outstanding issues
- Produce a revised final draft Overview Report and Executive Summary, doing so in line with the statutory guidance
- Chair a final Review Panel meeting to consider and agree the revised final draft Overview Report and Executive Summary
- Handover a completed Overview Report and Executive Summary to the CSP.

3.34 The completed Overview Report and Executive Summary were re-written, and significant additional work was undertaken by James and the Review Panel. It was agreed that James would be recorded as the substantive Independent Chair of the DHR but an explanation of the circumstances around chairing, including the role and issues associated with the first Independent Chair, would be included. The first Independent Chair was offered the opportunity to community on the completed Overview Report and Executive Summary but declined. As outlined above, James did not act as the point of contact with family members.

Parallel reviews

3.35 *Criminal trial*: In October 2015 Mario was found guilty of murder and sentenced to life imprisonment with a recommendation that he serve a minimum of 14 and a half years.

3.36 *Coroner's Inquest*: An inquest was opened by Her Majesty's Coroner, adjourned pending the outcome of the criminal trial and then concluded following Mario conviction.

Dissemination

3.37 Once approved by Home Office, the Executive Summary and Overview Report will be published online at [XXX].

3.38 The Executive Summary and Overview Report will be shared with CSP Partnership Board, as well as the three borough Modern Slavery and

Exploitation Group and VAWG Strategic Board. They will also be shared with the Commissioner of the MPS and the Mayor's Office for Policing and Crime (MOPAC).

3.39 The recommendations will be owned by the CSP. The CSU at LBHF will be responsible for developing an action plan in response to the recommendations and monitoring progress, as well as hosting a learning event to bring together local partners to consider the DHR. Where appropriate, actions and / or learning events will be taken forward in the context of the wider partnership across the three boroughs. This process will be coordinated through the three borough's Risk and Review Group.

4. Background Information (The Facts)

4.1 Jimena was a trans woman. She was a Mexican national, and was normally resident in Mexico, living with her husband Mario in a flat owned by her father.

4.2 Jimena was a sex worker. Based on information obtained from the MPS during the murder enquiry, Jimena travelled internationally for this purpose. Although her income is unclear, a very large amount of cash was found at the flat, and she had a well-established business. She had, for example, her own website.

4.3 Jimena moved to Paris in October 2014, and Mario joined her there in December 2014. They moved to London in early January 2015, travelling on a Tourist Visa.

4.4 In London, they privately rented a flat in the LBHF. No one else lived at the flat. However, in addition to residing in the flat, this was also where Jimena met clients (i.e. those buying sex acts). As part of the murder enquiry, the MPS investigated who else had visited the flat during the period in the run up to the homicide. Their investigations show that a number of clients visited Jimena in the days before her death, and that other clients had also visited the flat in the preceding weeks. The MPS also conducted house to house enquiries locally but no information regarding Mario or Jimena was forthcoming, likely reflecting the short period of time they had been in the country.

What happened

4.5 On an evening at the end of March 2015, Mario flagged down an ambulance on Fulham Road. He spoke limited English but was mimicking a cut throat by moving his hand across his neck.

4.6 Mario led the ambulance crew to the flat where he was residing with Jimena. When Mario took the ambulance personnel to the flat, the flat was unlocked.

4.7 Inside the flat paramedics found Jimena lying on the floor in the lounge area beside a sofa. She had visible injuries to her face. The attending paramedic determined that Jimena was dead and the MPS were alerted.

The Post Mortem

4.8 The post mortem was conducted by a Home Office Pathologist. The cause of death was recorded as blunt force trauma to the head and neck. Toxicological examination did not reveal the presence of alcohol or any other substances. However, examination of a sample of Jimena's hair showed that she had been an occasional user of cocaine and cannabis.

4.9 It has not been possible to determine the exact time of death for Jimena. Based on the evidence collected by the MPS during the murder enquiry, Jimena is likely to have died between sometime after 1.30pm (when she last spoke to a client on her mobile phone) and just before 3pm (when Mario was seen on Closed-Circuit Television (CCTV) at a supermarket).

Criminal justice outcome

4.10 Mario was arrested for her murder. He was found guilty of murder in October 2015 and sentenced to 14 and a half years imprisonment.

History of the relationship

4.11 Jimena and Mario had first been in contact via Facebook when Jimena lived in the United States of America and Mario in Mexico. They met in person in March 2013 when Jimena returned to Mexico.

4.12 Jimena was well educated and her family were wealthy. The flat where she lived in Mexico was owned by her father and she also earned a considerable income as a sex worker.

4.13 Mario's education was to a basic level and he came from a poorer background. Mario worked at a local gym and took a great deal of pride on his fitness and physique.

4.14 When Mario and Jimena met, he knew that Jimena was a trans woman, but he was initially unaware that she was a sex worker. During the murder enquiry, Jimena's niece (Marta) informed the MPS that in April 2013 Mario had discovered that Jimena was a sex worker while they were in Greece.

4.15 Mario appears to have accepted this, as he and Jimena were married in Mexico in October 2013 in a civil service, followed by a religious ceremony[22].

4.16 During the MPS murder enquiry, text messages between Jimena and Mario were reviewed. Generally, the text messages give an impression that Mario wanted to please Jimena, but at times this developed into frustration and expressions of jealousy. It is clear from the texts that Mario was not content with Jimena being a sex worker.

4.17 From interviews with family members, Mario was welcomed by Jimena's family. When he and Jimena were in Mexico, he lived with her. This was some distance from Mario's family whom he did not see regularly. Mario's main contact at this time was Jimena's 16-year-old nephew, who Mario got on well with[23].

4.18 Mario did not work, and Jimena provided income for them both from her earnings as a sex worker.

4.19 The couple lived in Mexico for about a year after their marriage before moving to Europe. Jimena moved to Paris without Mario in October 2014, with Mario joining her in December of that year. They moved to London in January 2015, travelling on a Tourist Visa.

Family of Jimena

Name	Gender	Age at the time of the murder	Relationship with the victim	Ethnicity
Luis	Man	-	Brother	Mexican
Marta	Woman	-	Niece	Mexican

4.20 Some members of Jimena's family came to the UK from Mexico for the trial. When contacted, Jimena's family asked for some time after the trial before participating in the DHR.

4.21 Ultimately, the first Independent Chair spoke with Jimena's brother, Luis, who was representing her family in the DHR process. They also spoke with her niece, Marta.

[22] It has not been possible to determine either Jimena or Mario's faith or denomination.
[23] As recorded in footnote 10, information was not provided in the handover received from the first Independent Chair about who was approached to participate in the DHR. It is not known if attempts were made to contact Jimena's nephew.

4.22 The first Independent Chair informed the second Independent Chair that in engaging with family members they drew on the principles of family involvement as contained in research[24] for involving families to ensure a sensitive, structured and well-prepared approach for initial contact, negotiation, information gathering and feedback throughout.

4.23 During the murder enquiry, the MPS were able to review texts and Facebook messages and deleted Skype videos between Jimena and a close relative, which show that beneath the surface there were considerable tensions in their relationship.

Brother

4.24 During an interview with the first Independent Chair, Luis described how he was in regular contact with Jimena. They had spoken about practical matters, like transferring money, and he was not aware of any problems in the relationship. He described Jimena and Mario as "*close"* and "*very happy to be married*".

4.25 Jimena's brother was able to provide some information about Mario, saying that he did not work, and his understanding was that Jimena paid for everything and they had a "*very wealthy lifestyle*".

Niece

4.26 During the murder enquiry, Marta informed the MPS that in around April 2013 the couple were in Greece when Mario discovered Jimena was a sex worker. Jimena had sent Mario out to buy some bread, so she could see a client. When Mario returned, he found the client with Jimena. Jimena told her niece that Mario "*was disconcerted and sad, wept and told her it was not necessary for her to do that*". Jimena is reported to have told him not to worry and said that it [sex work] was something he would have to accept.

4.27 During an interview with the first Independent Chair, Marta said Jimena had appeared very happy with Mario and that she was not aware of any problems

[24] Morris, K., Brandon, M. and Tudor, P. (2012) *Study of family involvement in case reviews: Messages for policy and practice*, York: British Association for the Study and Prevention of Child Abuse and Neglect (BASPCAN). Available at: https://www.baspcan.org.uk/wp-content/uploads/2017/06/ReportFINALsmaller.pdf (Accessed 20th October 2018).

in the relationship. Indeed, she said that "*they seemed very much in love and Mario was very romantic, and they would say lovely things about each other*".

Friends of Jimena

4.28 The first Independent Chair stated that it "*took some time to locate and speak to Jimena's closest friends as they travelled a great deal. They also reported that contact was established, and these friends were able to provide rich information*". Unfortunately, it has not been possible to locate any record of this contact[25]. Consequently, it has not been possible to identify which friends this statement refers or the information they shared.

Friends of Jimena who lived outside of the UK

Name	Gender	Age at the time of the murder	Relationship with the victim	Ethnicity
Friend 1	-	-	Friend	-
Friend 2	-	-	Friend	-

4.29 During the murder enquiry, the MPS received information from two friends who wished to remain anonymous.

4.30 The first (Friend 1) stated that Jimena and Mario had an "*argumentative relationship"*. They said that Mario would become jealous of other men looking at Jimena which caused arguments between them. They described one incident which occurred in Mexico on an unknown date when a client bought Jimena a drink. Mario became upset and is reported to have assaulted the client by punching him. They also detailed another episode when Jimena had visible bruises and said she had fallen. When Friend 1 challenged Jimena, she is reported to have admitted that Mario had assaulted her. The friend told Jimena to leave Mario, but that Jimena refused, stating she was in love with him.

4.31 Another friend (Friend 2) informed the MPS that "*alcohol made Mario jealous and argumentative*". They recounted an incident in Mexico, around October/November 2014, when Mario accused Jimena of 'eyeing up' another

[25] As described in footnote 10, information on who the first Independent Chair attempted to contact, when and the outcome was not available in the handover to the second Independent Chair.

man. Mario is reported to have pulled Jimena, causing her blouse to rip. The friend intervened and stopped the incident.

Friends who normally lived outside of the UK but who were present on the night before and morning of the homicide

Name[26]	Gender	Age at the time of the murder	Relationship with the victim	Ethnicity
Carlos	Man	-	Friend	-
Julia	Trans woman	-	Friend	-
Pilar	Trans woman	-	Friend	-

4.32 During the murder enquiry, the MPS spoke to some friends who were all visitors to the UK:

- Carlos had previously met Jimena in the United States of America and had known her for some years.
- Julia had been introduced to Jimena via Facebook by Carlos. Julia was a trans women. She had worked as a sex worker in the past. This included seeing clients at Jimena's flat
- Pilar was a trans women. She was also working as a sex worker.

4.33 Carlos, Julia, and Pilar had met up with Jimena and Mario on a number of occasions in the UK. When interviewed by the MPS, Mario described all three as Jimena's friends.

4.34 Carlos, Julia, and Pilar described having been out with Jimena and Mario on the night before she died. They had been out to a number of clubs, before returning to Jimena and Mario's flat in the early morning. They each initially failed to give the MPS a full account of events thereafter: they omitted the fact that Jimena had been visited by a client, at about 6.00am, with whom she had engaged in sexual activity and with whom they had taken cocaine. Julia saw Mario crying at one point whilst she was at the flat, shortly after he had walked into the bedroom and seen Jimena with the client.

4.35 Carlos, Julia, and Pilar left sometime after 6.30am.

4.36 Julia provided additional information to the MPS as part of the murder enquiry. Originally Mario's friend, she had been introduced by Mario to Jimena when she wanted to move to the UK. Julia had been in contact with Jimena for a

[26] Not their real names.

month or so before moving to the UK (in March 2015) and thereafter met in person.

4.37 Julia described the relationship between Jimena and Mario as one where "*she was in control of the relationship and he followed her orders and wishes*", although she also said that *"*[Mario] *was very jealous and put too much pressure on her and tried to control her"*. Julia was not sure if Mario was working or not, but said that he would ask Jimena for money.

4.38 Julia said that, in a conversation with Jimena, she said that she was going on to France alone and said of Mario "*…I don't want him around anymore, he needs to go back to Mexico*".

4.39 Julia also described an occasion when Jimena had suggested they go out, but Mario "*turn*[ed] *up*" and she felt "*really uncomfortable*".

4.40 As part of the criminal trial, Galop provided specialist support in court to Carlos, Julia, and Pilar as part of Achieving Best Evidence measures.

Client of Jimena

4.41 During the murder enquiry, the MPS spoke to the client that Jimena had been with that morning. They provided a detailed statement and gave evidence during Mario's subsequent trial. The client recalled Mario coming into the bedroom whilst they were with Jimena. The client left the flat at about 6.30am.

The perpetrator, his family and friends

The perpetrator

4.42 During the murder enquiry, Mario told the MPS that he had:

- Left the flat to go shopping, leaving Jimena in bed
- On his return, Jimena did not answer the door and he had gone to seek help at the nearby flat of a friend (Julia). Two other friends of Jimena's (Carlos and Pilar) were at the flat and attempts were made to call Jimena on her mobile telephone without success
- Mario and Carlos went back to the flat and saw Jimena lying on the floor when they looked through a window. Mario gained entry by forcing open a window and climbing in. Mario said that he believed that Jimena must have been killed by a client.

4.43 Mario is in prison in the UK, away from his family and friends in Mexico. After the murder, a worker from SWISH / THT supported Mario over a four-week period.

4.44 During the tenure of the first Independent Chair, Mario was approached to participate in the DHR and offered support to do so. He was given time to consider if he would be willing to take part. After some months of negotiation around this he declined. He maintained he did not murder Jimena.

Family

4.45 Mario's sister came to the UK from Mexico for the trial.

4.46 The first Independent Chair also sought to speak with Mario's family. After a great deal of deliberation and attempts to speak to Mario's family in Mexico, they conveyed that they did not wish to be involved in the DHR.

4.47 During MPS enquiries, Facebook messages from Mario to his sister were found. These showed that Mario felt vulnerable and that he was scared that Jimena might leave him.

5. Chronology

5.1 On the night before the homicide, Jimena and Mario and some friends (Carlos, Julia, and Pilar) decided to go out for the evening. Before this, Jimena had seen a number of clients at the flat, the last being at about 11pm. They then all went to a nightclub.

5.2 CCTV at the nightclub shows the group arriving at just before 2am and leaving after 4am (i.e. the morning of the homicide). After leaving, the group went back to one of the friend's flats. The plan had been to go to another club but, when this proved too expensive, they went instead to Jimena and Mario's flat. They all sat in the lounge area and drank alcohol. Jimena and Mario spent time in both the bathroom and bedroom together.

5.3 Telephone records show that Jimena was contacted by a client just before 5am. They arrived at around 6am. The others were all present in the lounge, and he went alone to the bedroom with Jimena.

5.4 The client offered Jimena cocaine that he had brought with him. Although she declined, she invited the others to partake (including Mario). The group were also drinking alcohol. Whilst Jimena and the client were engaged in sexual activity, Mario went into the bedroom. He is reported to have glared at them. There was brief conversation in which Mario said he wanted his keys. The client left at 6.30am.

5.5 At about this time, CCTV footage shows Mario leaving the flat and going to a nearly shop where he purchased cigarettes and cans of beer. He then headed back to the flat shortly before 7am.

5.6 Carlos noted that Mario's mood changed after the client's visit. He became more serious. Carlos remonstrated with Jimena that she was working when her husband was present, and Mario is reported to have said to her "*It's like you don't take me seriously*". Mario then started to cry. Jimena and Mario spent a period of time in the bathroom together at this time. Julia had the impression from their behaviour that they were not as happy as they said they were.

5.7 Shortly thereafter, Carlos, Julia, and Pilar went back to Julia's flat nearby.

5.8 Mario made a trip to a local supermarket shortly before 8.30am, and then again at around 10.30am when he was accompanied by Carlos. The receipt for the

first of these purchases shows that in addition to beer, he purchased a bottle of wine. He made a third visit to the supermarket to buy more beer shortly before 11.30am.

5.9 It appears that after the first visit to the supermarket Mario had gone on to join Carlos, Julia, and Pilar at Julia's flat to share the alcohol. It had been noted previously by Carlos that Mario was attracted to Pilar. Whilst Mario was in the flat Julia saw him unbuckling his belt, pulling down his zip and trying to pull Pilar's leggings down whilst she was lying down to sleep. Shortly after the shopping trip that he made with Carlos, Mario was asked to leave, and he did so.

5.10 Mario left the flat he shared with Jimena just before 3pm. He was carrying a sports bag. He made his fourth visit of the day to the supermarket. There he spoke to a member of staff, who noted that Mario had a large sum of money in £50 and £20 notes in his jacket pocket. The staff member also noted that Mario had fresh scratches to his cheek. Mario then travelled by cab to a shopping centre nearby and went to a mobile phone shop there. Mario purchased a new mobile phone, for which he paid in cash.

5.11 Mario walked back from the mobile phone shop in the direction of his home address, still carrying the sports bag. Shortly before 5pm, he made a cab journey and went to a sex work establishment, still carrying the sports bag. Whilst there he had sex with the two sex workers. He left, still with the sports bag, shortly before 7pm.

5.12 Mario was later captured on CCTV at about just after 7pm. He was then captured by CCTV shortly after 7.30pm, heading back to the flat. He was no longer carrying the sports bag.

5.13 Shortly after that CCTV sighting of the Mario, he went back to the friend's flat. He asked about the whereabouts of Jimena, saying that she was not answering the door. Carlos tried to contact Jimena via Facebook and tried to call her; she did not respond to Facebook and did not answer her phone. Julia noticed that Mario had marks or scratches to his face and neck and commented on them. Mario would later say that these had been caused by Jimena during an argument, and that he had then gone out to a shopping centre. He had brought with him a tablet-type computer.

5.14 Mario asked Carlos to come back to the flat with him. Mario climbed on top of a refuse bin in order to reach a partially open window. Mario said Jimena was on the floor and that something had happened to her. He did not appear emotional. Mario entered the flat via this window and let Carlos in through the door. Jimena was in the position in which she was later seen by the ambulance staff. Carlos was reluctant to involve the authorities himself, though he told Mario that he should do so. He left the flat.

5.15 Shortly before 9.30pm, Mario flagged down an ambulance. They were joined by the MPS, who arrived 5 minutes later. Mario was arrested on suspicion of murder. The results of toxicological examination of Mario suggested that he had consumed alcohol and cocaine, but it was not possible to determine how much or when.

5.16 An analysis of Jimena's mobile telephone showed that it last received an incoming voice call at 2pm. Although cell site information for her mobile telephone showed it to move location during the course of day, there was no CCTV footage showing Jimena to have left the flat.

5.17 A number of items belonging to Jimena (including her mobile telephone) had gone missing from the flat by the time that it was searched by the MPS. These also included an Apple Mac laptop computer and Jimena's passport. CCTV footage showed Mario shortly before 3pm walking in Fulham with a sports bag. When he was captured by CCTV footage later that day, he no longer had the bag.

6. Analysis

Domestic Violence and Abuse

6.1 The absence of agency contact, and the short period of time that Jimena and Mario were resident in LBHF, meant there was a very limited amount of information available to the Review Panel. Consequently, the Review Panel is grateful to friends and family of Jimena who have helped build a picture of the relationship that would otherwise have been unknown.

6.2 Tragically, it is not possible to know Jimena's perspective on her relationship with Mario. However, Jimena had a close relationship with her family, particularly her brother and niece. In their contact with the first Independent Chair, both described their shock at the homicide, and neither were aware of any problems in the relationship.

6.3 However, during the murder enquiry the MPS reviewed text and Facebook messages and deleted Skype videos between Jimena and a close relative. These show that beneath the surface there were considerable tensions in the relationship. Additionally, friends gave the following accounts:

- Two friends who would not give evidence at the trial described the relationship as *"argumentative".* Both also described incidents where Mario assaulted Jimena in public places. Significantly, both these incidents are reported as being triggered by Mario's jealousy of other men. One of these friends also said that on one occasion Jimena had admitted to a friend that Mario had assaulted her
- Another friend also described Mario as jealous. They additionally said he was controlling and recounted an occasion when Mario "*turned up*" and they felt "*really uncomfortable*".

6.4 The Review Panel has also had limited information about Mario, because both he and his family declined to participate in the DHR. However, during the murder enquiry the MPS reviewed Mario's social media. He had sent messages to his sister that showed he felt vulnerable and that he was scared that Jimena might leave him.

6.5 It is not possible to establish if and for what purpose Jimena was going to leave Mario (i.e. either by way of geographical distance or in terms of the end of the relationship). However, Mario's fears that Jimena might leave him may have

been well founded: a mutual friend (Julia) told the MPS that Jimena was intending to go back to Paris alone.

6.6 This same friend also told the MPS that they thought Jimena was in "*control*" of the relationship, saying that Mario "*followed her* [Jimena's] *orders and wishes*". She said Jimena was the primary earner in the relationship, and that Mario had to ask her for money. This was echoed by Jimena's brother (Luis) and is consistent with other accounts that suggested that Mario did not have a job.

6.7 However, Julia also said that "[Mario] *was very jealous and put too much pressure on her* [Jimena] *and tried to control her*". Julia explained that this was because Mario was unhappy about Jimena's sex work, as well as his jealousy in relation to other men (including clients).

6.8 The Review Panel sought to determine whether there was domestic violence and abuse in the relationship. Clearly Jimena died as a result of a fatal incident of domestic violence. However, because of the lack of information available to the Review Panel, it is difficult to determine whether Jimena was the victim of a pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse, as set out in the national definition. Nonetheless, at the very least, there was some history of relationship conflict and this could be considered as potential evidence of previous domestic violence and abuse.

6.9 Indeed, in considering this evidence, a number of risk indicators (largely behaviours by Mario) can be identified from the account of family and friends:

- *Assault* – at least two occasions when there are reports that Mario was physically violent towards Jimena
- *Jealousy* – there are reports by several members of Jimena and Mario's informal network that Mario could be jealous of Jimena
- *Control* – one friend reported that Mario put pressure on Jimena and tried to control her
- *Separation* – Jimena might have been preparing to move to France without Mario, and Mario appears to have been aware of this having confided his fears to his sister

6.10 It is of note that all of these behaviours are correlated with domestic violence and abuse. In particular, extreme jealousy[27] and the period shortly before or after separation are often associated with domestic homicide[28].

6.11 Two other issues also featured in early Review Panel meetings:

- Firstly, Jimena was a sex worker
- Secondly, Jimena's status in the relationship: at least one friend described Jimena as "*in control*" of the relationship, with the same friend and a family member also talking about Mario being dependent on Jimena financially.

6.12 *Sex Work:* Sex work, including how it is conceptualised and approached as a social issue, is complex and contested. On a small scale, that is evident in this report by the contrast between the use of the term 'sex worker' (used because Jimena described herself as such) and the local strategic approach (whereby Jimena would be described be someone 'affected by prostitution').

6.13 While it is beyond the scope of this DHR to examine this debate further, it is of note that at some early Review Panel meetings there was a focus on whether Jimena was a 'high status' sex worker. This prefix was suggested given her likely income (a very large amount of cash was found at the flat), and because she had a well-established business operating across international boundaries.

6.14 Whatever Jimena's 'status' as a sex worker, it is important to note that sex workers face significant risks. Worldwide, it is estimated that 45-75% of sex workers have experienced violence, with those working indoors (i.e. not on the street) generally being safer[29]. Additionally, sex workers may also face a range of criminal justice sanctions depending on the legal jurisdiction in which they operate.

6.15 Moreover, simply because someone is a sex worker, this does not mean they cannot be at risk of domestic abuse. Indeed, taken together, these two issues could increase someone's risk (e.g. because they are exposed to potential violence or abuse from both clients and / or an intimate partner), while

[27] Campbell, J.C., Glass, N., Sharps, P.W., Laughon, K. and Bloom, T. (2007) 'Intimate partner homicide: review and implications of research and policy', *Trauma, Violence & Abuse,* 8(3), pp. 246-269.
[28] Brennan, D. (2017) *The Femicide Census: 2016 findings - Annual Report of Cases of Femicide in 2016*. Available at: https://www.womensaid.org.uk/femicide-census-published/ [Accessed: 20th October 2018].
[29] Deering, K.N., Amin, A.., Shoveller, J., Nesbitt, A., Garcia-Moreno, C., Duff, P., Argento, E., and Shannon, K. (2014) 'A Systematic Review of the Correlates of Violence Against Sex Workers', *American Journal of Public Health,* 104(5), pp. 42 - 54

restricting someone's options in relation to help and support (e.g. they may be less confident to report violence or abuse for fear of criminalisation related to their sex work, or because they are concerned about coming to the attention of criminal justice agencies because of another issue such as their immigration status).

6.16 *Jimena's status in the relationship:* Reports of Jimena's "*control*" of Mario are based on very limited information. This is impossible to test because the Review Panel cannot speak with Jimena to seek her views, while Mario declined to participate in the DHR.

6.17 However, the Review Panel felt the suggestion that Jimena was 'controlling' in the sense that either she was 'in control' (and therefore could not experience domestic violence and abuse) or was 'controlling' (towards Mario, up to and including exercising power and control towards him) seems unlikely.

6.18 Firstly, there was some discussion in the Review Panel as to whether Jimena could be described as 'withholding' information about her sex work from Mario, and what this might mean. The facts are as follows: Jimena and Mario met in March 2013 and Mario became aware of Jimena's sex work a month later in April. While the nature of the disclosure (Mario found Jimena with a client) was undoubtedly dramatic and potentially distressing, it is also possible to imagine why one month into a new relationship Jimena may not have yet told Mario about her sex work. What is more, it is not possible to know when and how Jimena might have chosen to tell Mario if he had not found her with a client. Consequently, to describe a delay of one month as 'withholding' is to verge on the judgemental when there is simply insufficient information available to make such a loaded assessment.

6.19 Secondly, Mario's financial dependence on Jimena does not necessarily mean she was controlling. Jimena may have used money purposively (i.e. to control Mario), but as within the previous discussion, there is simply insufficient information available to determine this. Additionally, that perspective does not take account of the fact that while Mario is reported to have been unhappy about Jimena's continued sex work, he decided to stay in a relationship with her and benefited financially. As a result, other explanations seem more likely: there may have been an agreement between Jimena and Mario about what he might provide to her for this money (e.g. protection), or Mario could be seen as

benefitting from Jimena's sexual labour (i.e. he may have capitalised on, or had an expectation in relation to, this income).

6.20 Thirdly, if Mario was concerned that the relationship might end, this would mean he would probably also have lost his income. As with Mario's behaviours discussed above, it is of note that issues around financial and economic abuse are associated with domestic violence and abuse. For example, there is an increasing understanding of how financial and economic abuse may operate in abusive relationships, including economic exploitation[30]. There is also good evidence that the risk of homicide is higher when coercive control operates alongside financial abuse[31].

6.21 Given the limited information available to the Review Panel, it is not possible to resolve this issue. However, while Jimena's income may have afforded her some 'control' this does not mean she could not have been the victim of domestic violence and abuse and Mario clearly benefited financially from the relationship.

6.22 One way to accommodate both the potential for domestic violence and abuse and these aspect of the reported dynamic between Jimena and Mario is to consider specifically the issues around domestic violence and abuse in relationships where one partner is a sex worker.

6.23 No data is available on trans sex workers specifically. However, more broadly, a recent study examined domestic violence among female sex workers who use drugs and their (intimate rather than commercial) male partners in Mexico[32]. It reported that: half of all couples reported perpetrating and experiencing at least one type of domestic violence behaviour in the past year, with psychological aggression being the most common form of intimate partner violence, followed by physical assault and sexually coercive domestic violence behaviours. In addition, the researchers found that a third of the couples reported that both partners engaged in some form of domestic violence.

[30] Judy L. Postmus, Sara-Beth Plummer, Sarah McMahon, N. Shaanta Murshid, Mi Sung Kim (2012) 'Understanding Economic Abuse in the Lives of Survivors', *Journal of Interpersonal Violence,* 27(3), pp. 411 - 430.
[31] Websdale, N. (1999) *Understanding Domestic Homicide*, Boston, MA: North Eastern University Press.
[32] Ulibarri, M.D., Salazar, M., Syvertsen, J.L., Bazzi, A.R., Rangel, G., Orozco, H.S. and Strathdee, S.A. (2018) 'Intimate Partner Violence Among Female Sex Workers and Their Noncommercial Male Partners in Mexico: A Mixed-Methods Study', *Violence Against Women,* pp. 1-23.

6.24 Importantly, the study considered the social context in which these behaviours occurred. It concluded that men and women had different reasons for engaging in domestic violence. With regard to the male partners, the study reported that they engaged in domestic violence behaviours when they felt that their masculinity was threatened; this was tied to non-traditional divisions of labour and power within relationships, economic insecurity, and shifting gender roles around women's earning potential (i.e. their partner was a sex worker and was able to earn an income).

6.25 This research has some relevance to this DHR both generally (as it was conducted with respondents from the same country of origin) and specifically (because of reports of Mario's view of Jimena being a sex worker). This research could therefore frame Jimena's decision to initially withhold information about her sex work and then to continue with it, as well as Mario's perspective (as illustrated by his comment shortly after Jimena had seen a client: "*It's like you don't take me seriously"*).

6.26 Before concluding this section of the analysis, there is one feature of the events on the day the homicide that should be noted. This relates to Mario's reported sexual behaviour*:*

- Julia told the MPS during the murder enquiry that later that morning when everyone bar Jimena was in her flat, she had seen Mario unbuckling his belt and pulling down his zip, then trying to pull Pilar's leggings down. Julia gave a witness statement to the MPS and said she had challenged Mario about this and told him to leave. She later asked Pilar why she had allowed Mario to touch here and said that Pilar told her that she "*was asleep and didn't notice*". In her witness statement, Pilar confirmed this to be the case, telling the MPS that she had been asleep at the time
- Later in the day, Mario visited a sex work establishment and had sex with two sex workers there.

6.27 As Mario has not participated in this DHR, it has not been possible to explore these two events with him, but they raise two issues. Firstly, Mario is reported to have attempted to have sex with Pilar while she was asleep. The MPS representative on the Review Panel confirmed that, if this set of circumstances were reported as an allegation, they would be investigated as either an attempted sexual assault or a sexual assault. Secondly, there appears to be a double standard in play: while Mario was expressing jealousy of Jimena (for

engaging in sex work from which he financially benefited), he clearly felt able to attempt to have sex with Pilar, and then later visit a sex work establishment. Although Jimena's time of death is unknown, Mario's visit to the sex work establishment likely occurred after Jimena was dead.

6.28 In the context of the events prior to Jimena's homicide, whereby Mario had walked in on Jimena having sex with a client, his actions could be framed as an assertion of sexual proprietariness or an act of retaliation. In light of the research discussed above relating to masculinity, his actions could also be seen as an example of Mario attempting to assert his masculinity. Indeed, men's violence has been described as an extreme exercise of power and control; as a recent study of femicides across Europe has observed, "homicide [is]… the ultimate means to degrade, silence and subjugate"[33].

Addressing the Terms of Reference and Lines of Enquiry

Decide whether in all the circumstances at the time, any agency or individual intervention could have potentially prevented Jimena's death

6.29 Given that there was no known contact with either Jimena or Mario by any agency before the homicide, there was no information that could allow the Review Panel to consider this aspect of the Terms of Reference.

Review current responsibilities, policies and practices in relation to victims of domestic abuse – to build up a picture of what should have happened and review national best practice in respect of protecting adults from domestic abuse

6.30 There is relatively little research or practice literature available in relation to trans people's experience of domestic violence and abuse. One of the few studies available in the UK was conducted in Scotland by LGBT Youth Scotland and the Equality Network: from a sample of 60 trans respondents, 80% reported they had experienced emotional, sexual or physical abuse from a partner or ex-partner (although only 60% of these had recognised the behaviour as domestic

[33] Weil, S., Corradi, C., Naudi, M. (2018) *Femicide across Europe: theory, research and prevention*, Bristol: Polity Press.

abuse)[34]. Another more recent study by Stonewall reported that, of trans people participating in a national survey, a quarter (28%) of those in a relationship in the last year had faced domestic abuse from a partner[35].

6.31 This suggest that trans people experience high levels of domestic abuse. However, there a range of wider factors that may influence someone's experience, risk and help seeking. A recent report published by SafeLives[36], with Galop and Stonewall, summarised some key issues for LGBT+ communities, including:

- Statutory and non-statutory services missing opportunities to identify LGBT+ victims, survivors and perpetrators of domestic abuse
- LGBT+ victims and survivors experiencing high levels of risk and complex needs before they access support
- LGBT+ victims and survivors needing support tailored to their needs and circumstances
- A victim's sexual orientation or gender identity being targeted as part of the abuse
- Societal attitudes and lack of inclusion preventing LGBT+ victims and survivors from accessing the support they need to get safe and recover.

6.32 While it is not possible to reach a view as to whether Jimena experienced a pattern of domestic violence and abuse (and if so, how she understood this or would have sought help), the Review Panel felt it appropriate to consider what help and support she would have been able to access locally.

6.33 In LBHF, the core specialist domestic violence service offer is commissioned from the Angelou Partnership, although there are also other separately funded projects provided in a range of settings locally. Within the Angelou Partnership, Galop provides services for LGBT+ victims and survivors. The Review Panel was informed Galop's has a close and productive working relationship with other agencies in the partnership.

[34] A. Roch, G. Ritchie, and J. Morton. (2010) *Out of sight, out of mind? Transgender People's Experience of Domestic Abuse*, Edinburgh: LGBT Youth Scotland and the Equality Network, Available at https://www.scottishtrans.org/wp-content/uploads/2013/03/trans_domestic_abuse.pdf (Accessed 20th October 2018).
[35] Bachmann, C. and Gooch, B. (2018) *LGBT+ in Britain: Trans Report*, London: Stonewall. Available at: https://www.stonewall.org.uk/sites/default/files/LGBT+-in-britain-trans.pdf (Accessed 20th October 2018).
[36] SafeLives. (2018) *Free to be Safe*, Bristol: SafeLives. Available at: http://www.safelives.org.uk/knowledge-hub/spotlights/spotlight-6-LGBT+-people-and-domestic-abuse (Accessed 20th October 2018).

6.34 Strategically, it is positive that the local Shared Services VAWG Strategy 2015-2018[37] includes a number of specific actions in relation to LGBT+ victims and survivors, including training, publicity and referral pathways, as part of the provision of specialist support.

6.35 Despite these positives, only a relatively small number of trans victims and survivors are reported to be accessing support locally. In 2017/18 a total of seven trans clients (of whom two were trans men and five were trans women) accessed support from the Angelou Partnership (of these, three were from the LBHF and included one trans man and two trans women). Victim Support London also provided data for trans clients experiencing domestic violence and abuse, showing only six clients in 2017 and 2018, of whom one came from the three boroughs (although not LBHF). However, it is worth noting that reporting appears to be higher to a specialist LGBT+ service: of those accessing Galop's domestic abuse advocacy service in London, Hammersmith and Fulham is one of the areas that has the highest level of reporting: 41 clients from the borough accessed support between January 2013 and August 2017 (around 7% of those receiving advocacy support[38]).

6.36 Unfortunately, it is not possible to place this level of reporting in context i.e. whether this is in line with the proportion of the trans population living, working or visiting the LBHF who may be affected by domestic violence and abuse or whether there is unmet need locally. This is because, when approached for data on the local trans population, the CSP was unable to provide any data, while the 2018 Borough Profile[39] does not include any population estimates for the local trans (or indeed more generally the LGBT+) population. The absence of this data or estimate of need is not uncommon and reflects the position nationally. Nonetheless, that LBHF has little data on estimated need is clearly an issue.

[37] Hammersmith & Fulham, The Royal Borough of Kensington & Chelsea and The City of Westminster. (2015) *Shared Services Violence Against Women and Girls (VAWG) Strategy 2015-2018*, London: The Royal Borough of Kensington & Chelsea. Available at: https://www.rbkc.gov.uk/pdf/VAWG_Strategy2015.pdf (Accessed 20th October 2018).
[38] Magić, J. & Kelley, P. (2018). LGBT+ Londoners' experiences of domestic abuse: A report on Galop's domestic abuse advocacy service use. Available at: https://www.galop.org.uk/lgbt-peoples-experiences-of-domestic-abuse/ (Accessed 3rd November 2018).
[39] Insight and Analytics Team (2018) *Hammersmith and Fulham Borough Profile 2018*, London: London Borough of Hammersmith & Fulham. Available at: https://www.lbhf.gov.uk/sites/default/files/section_attachments/borough-profile-2018.pdf (Accessed 20th October 2018).

The absence of data on the local trans population means it is difficult to consider need and provision in the local area in relation to trans people's experience of domestic abuse.

Recommendation 5: The CSP to ensure it has a picture of the size and needs of the local trans community, in order to inform local commissioning and strategy decisions.

6.37 Since the homicide of Jimena, the public profile of issues in relation to trans communities has considerably increased. The matter of access to domestic and sexual violence services for trans women has also garnered increased attention, particularly during the debate around the UK government's 2018 consultation in relation to the reform of the legal recognition process for transgender people[40]. It is beyond the scope of this DHR to examine this issue in depth. However, it is important to note two issues. Firstly, as summarised by the Fawcett Society[41], the law as it currently stands says that people operating women-only services (such as refuges or rape crisis centres) should treat according to the gender identity they present. Secondly, the law also provides for exceptions where service providers can restrict access to single-sex spaces both in the provision of services and in terms of employment.

6.38 With this in mind, the Review Panel sought to understand local practice. The Review Panel were informed that local specialist providers (Hestia (the refuge provider) and the Angelou Partnership) support trans women. The Review Panel felt this was positive but noted the issues discussed above about barriers to help and support, in particular concerns about a lack of inclusion and access to services. If Jimena had sought help, she may have done so in LBHF. But she may also have gone outside the borough. The Review Panel noted that this raises the issue of the accessibility of specialist service provision for trans victims and survivors more generally.

[40] Government Equalities Office (2018) *Reform of the Gender Recognition Act 2004,* Available at: https://www.gov.uk/government/consultations/reform-of-the-gender-recognition-act-2004 (Accessed: 20th October 2018).
[41] A Fawcett Society (2018) *Sex, Gender, and Gender Identity Q&A*, London: Fawcett Society, Available at: https://www.fawcettsociety.org.uk/sex-gender-and-gender-identity-qa (Accessed: 20th October 2018).

To ensure that trans victims and survivors, as well as specialist services, can be confident that services are accessible, it is important that there is clear national guidance on access to single sex services**.**

Recommendation 6: The Government Equalities Office to ensure that, alongside the reform of the GRA, there is guidance on how to lawfully implement the discretion held by single-sex service providers under the Equality Act.

6.39 The CSP and its partners will no doubt be mindful of the outcome of the GRA consultation and any changes to the law and / or guidance in due course. However, prior to and alongside that national process, they should also consider how to build on the existing good relationships locally to develop best practice in relation to trans victim and survivors of domestic abuse. Some of this work is already in place. For example, Galop has provided other agencies in the Angelou Partnership with training about working with the trans people who experience violence and abuse.

6.40 Further work should include: considering if generic domestic violence and abuse specialist services are accessible; the availability of trans specific provision from providers like Galop; how to ensure that staff can play a part in ensuring everyone accesses the services they need; and guidance in relation to monitoring. As an example of some of the steps agencies can take, a range of resources are available to inform any discussions (including the Scottish Women's Sector response to the GRA consultation in Scotland[42], and research commissioned by Stonewall[43]) and Galop has developed an online LGBT+ DV Resource Library with resources for service providers working with LGBT+ victims and survivors of domestic violence and abuse[44].

[42] Scottish women's sector (2018) *'Review of the Gender Recognition Act 2004: A Consultation*, Edinburgh: Scottish women's sector. Available at: https://www.engender.org.uk/content/publications/Scottish-Womens-Sector-response-to-the-consultation-on-proposed-changes-to-the-Gender-Recognition-Act.pdf (Accessed 20th October 2018).
[43] Stonewall (2018) *Supporting trans women in domestic and sexual violence services: Interviews with professionals in the sector*, London: Stonewall. Available at: https://www.stonewall.org.uk/sites/default/files/stonewall_and_nfpsynergy_report.pdf (Accessed 20th October 2018).
[44] For more information, go to: https://www.galop.org.uk/lgbt-dv-library/.

Commissioners and service providers need to have an open and transparent discussion around appropriate and effective ways to enable the inclusion of trans victim and survivors of domestic abuse locally.

Recommendation 7: The CSP to undertake an audit of local agency practice in relation to domestic abuse to identify whether this is trans inclusive, including considering the training available to staff to meet the needs of trans victims and survivors.

Recommendation 8: The CSP to work with domestic abuse and LGBT+ specialist services to ensure there are appropriate referral pathways, provision and publicity material in place to meet the needs of trans victims and survivors of domestic abuse.

Examine the roles of the organisations involved in this case, the extent to which Jimena had involvement with those agencies, and the appropriateness of single agency and partnership responses to her case to draw out the strengths and weaknesses

Establish whether there are lessons to be learnt from this case about the way in which organisations and partnerships carried out their responsibilities to safeguard Jimena's wellbeing and identify clearly what those lessons are

6.41 Given that there was no contact with either Jimena or Mario by any agency before the homicide, there was no information that could allow the Review Panel to consider these aspects of the Terms of Reference.

Identify whether, as a result, there is a need for changes in organisational and/or partnership policy, procedures or practice in order to improve our work to better safeguard victims of domestic abuse.

6.42 Various aspects of the local partnership arrangements, both within the LBHF and across the three boroughs, have been described in this report. Aspects of the operational partnership, in particular as delivered by the Angelou Partnership, have also been addressed. Given that there was no contact with either Jimena or Mario by any agency before the homicide, there was no

information that could allow the Review Panel to consider organisational and/or partnership policy, procedures or practice more specifically.

Consider if this homicide raises any learning around how agencies can best work with sex workers within the transgender community

6.43 There is no evidence to indicate that Jimena accessed any services for sex workers locally. Nonetheless, as with the discussion around domestic violence services above, the Review Panel agreed it was appropriate to consider what services Jimena would have been able to access locally in this context. This is important because if she had sought support in relation to sex work, that could also have been an opportunity for her to seek help and support around domestic abuse. Consequently, the Review Panel considered the services that are available for sex workers, in particular in conjunction with the trans community.

6.44 There are a number of generic sexual health open access services that can be accessed across the three boroughs, through both GUM (hospital based sexual health clinics) and community sexual health services (General Practice (GP) sexual health services and other community-based support). Services include screening, treatment, Human Immunodeficiency Virus (HIV) support, contraception services and specialist support (e.g. for sex workers, men involved in the Chem Sex scene, those living with HIV, learning disabilities etc).

6.45 SASH offer sexual health services to people across the City of Westminster, the LBHF, and the Royal Borough of Kensington and Chelsea. This includes sexual health promotion and psychosocial support services and is part of the whole system for adult sexual and reproductive health services, with a focus on:

- Sexual health promotion with an ethos of behaviour change at its core
- Care planned support to residents living with HIV or identified as having poor sexual health.

6.46 In regard to interventions and support, SASH offer and deliver support to residents around the following needs:

- Advocacy Advice – Legal Advice, benefits, immigration issues, sex worker rights and the law, National Insurance support, Education, Training and Employment, and financial issues – debts related to sex work

- Links to clinics – advice and information around Sexually Transmitted Infections (STIs)/HIV, risks, chaperoning to clinics, testing and vaccination
- Trans support/advice – NHS/Private, signposting to specialist services
- Partnership work – link in with the MPS and Ugly Mugs scheme[45] to follow guidelines/policies in relation to sex work laws
- 1:1 and group work/drop in support – drop ins for male and female sex workers
- Support and advice – reporting violence and abuse to the police safely and gaining support from Ugly Mugs where appropriate
- Chemsex support/advice – clinics across the boroughs to provide the following: harm reduction, triggers/cravings, boundaries, reduction in use, cycle of change, referrals to clinics
- Outreach support – visits to sex work establishments (flats and brothels) in the City of Westminster and the Royal Borough of Kensington and Chelsea.

6.47 The Review Panel sought to clarify why there was no outreach support in the LBHF in contrast to the provision of outreach in the City of Westminster and the Royal Borough of Kensington and Chelsea. This situation appears to have arisen because there had previously been outreach in the City of Westminster and the Royal Borough of Kensington and Chelsea but not LBHF. When SASH was commissioned that arrangement was carried over in the new contract. Locally, attempts have previously been made to identify sex work establishments in LBHF, but none have been identified, although there is a recognition that sex workers in the borough travel to the City of Westminster and the Royal Borough of Kensington and Chelsea for support.

There is no outreach support (visits to sex work establishments) in the LBHF and there is evidence that sex workers are travelling to neighbouring boroughs to access to support.

Recommendation 9: Public Health Commissioners to review the need for sex work outreach in the borough.

6.48 SASH also offer sexual health training to front line staff/professionals which can include issues for trans people and / or sex workers.

6.49 'Platinum' is a project run by SASH that provides support to sex workers, and which has specific capability around trans sex workers. Additionally, there are

[45] National Ugly Mugs (NUM) is a national organisation which provides greater access to justice and protection for sex workers who are often targeted by dangerous individuals but are frequently reluctant to report these incidents to the police. For more information, go to: https://uknswp.org/um/.

a number of specialist support services based in the three boroughs relating to sex workers and the trans community:

- 10HB – Sexual health clinic, offering screening, testing, treatment and management of STIs, as well as clinical advice and support. 10B is inclusive and able to see trans individuals and sex workers[46]
- Clinic Q – Trans sexual health and wellbeing clinic, run by Dean Street in Westminster[47]
- John Hunter Clinic – Sexual health clinic, offering a similar service to 10HB. Runs a specialist clinic for the trans community run weekly called 'Refresh' [48]
- Spectra – offers a support group for trans individuals and LGBT+ support[49].

6.50 These are all open access services that would have been accessible to either Jimena or Mario if they had sought help.

6.51 While this range of support is positive, and while the SASH website (http://wellbeing.turning-point.co.uk/sexualhealth/about-us/) and the individual clinic websites noted above are available, the council website does not include any information on sex work or sources of help and support. Indeed, a search of 'sex work' on the LBHF website returns no hits with support information[50]. It is not possible to know whether Jimena did or would have sought such information. However, given Jimena's online profile and international travels, she may have sought help online, via NHS or private health providers, or other routes such as informal networks (her own, or via sex worker or trans community networks locally for example).

It is important to ensure that there is a range of information on the law, help and support available.

Recommendation 10: The CSP to work with partners to develop resources with information on the help and support for sex workers locally and to develop a comprehensive dissemination strategy.

[46] For more information, go to: http://www.chelwest.nhs.uk/services/hiv-sexual-health/clinics/10-hammersmith-broadway.
[47] For more information, go to: https://cliniq.org.uk.
[48] For more information, go to: http://www.chelwest.nhs.uk/services/hiv-sexual-health/clinics/john-hunter-clinic-for-sexual-health.
[49] For more information, go to: https://spectra-london.org.uk.
[50] Hammersmith and Fulham (2018) *Search results,* Available at: *https://www.lbhf.gov.uk/search?collection=lbhf-web-website&query=sex%20work* (Accessed: 20th October 2018).

6.52 The local Shared Services VAWG Strategy 2015-2018[51] includes 'prostitution and human trafficking' as a priority, with actions in relation to training, referral pathways, and the provision of specialist support. However, when approached for information on the local sex industry in the borough, the CSP was unable to provide any specific data.

The absence of data on sex work in the LBHF means it is difficult to consider and understand need and provision in relation to the local sex industry.

Recommendation 11: The CSP to work with partners (in particular Public Health) to ensure that the LBHF has a picture of the size and needs of the local sex industry, in order to inform local commissioning and strategy decisions.

6.53 It is less clear from the CSP what specific actions are being taken to ensure that sex workers, regardless of their gender identity, are able to access domestic abuse services (although there are a range of actions taken by specific agencies as described above, while STADV provide training to local sexual health services in relation to domestic abuse). Additionally, a Modern Slavery and Exploitation Coordinator (employed in the Royal Borough of Kensington and Chelsea but who will share best practice across the three boroughs) has recently come into post and their remit includes work in relation to women affected by prostitution.

Commissioners and service providers need to have a discussion around appropriate and effective ways to enable support for sex workers who are experiencing domestic abuse locally.

Recommendation 12: The CSP to undertake an audit of local agency practice in relation to sex workers at risk of domestic abuse, including considering the training available to staff to meet the needs of victims and survivors.

[51] Hammersmith & Fulham, The Royal Borough of Kensington & Chelsea and The City of Westminster. (2015) *Shared Services Violence Against Women and Girls (VAWG) Strategy 2015-2018*, London: The Royal Borough of Kensington & Chelsea. Available at: https://www.rbkc.gov.uk/pdf/VAWG_Strategy2015.pdf (Accessed 20th October 2018).

Recommendation 13: The CSP to work with domestic abuse and sexual health services to ensure that there are appropriate pathways and provision in place to meet the needs of sex workers at risk of domestic abuse.

Consider if there any learning around how we may use transgender and/or sex worker networks to highlight services available to a visiting sex worker who may be exposed to domestic abuse?

6.54 The specific issues in relation to trans victims, as well as sex workers, are considered above, with the issue for those visiting the UK being discussed from 6.30 below.

6.55 In relation to the issue of networks and how these might be used to disseminate information, the Review Panel felt this was an important consideration. As with many other aspects of this DHR, there is limited information available. However, several aspects are of note:

6.56 Firstly, Jimena's social network as described in this DHR was comprised of people who, like her, did not live in the UK. Several of her friends were also trans women and were or had been sex workers. This is a salutary reminder that it is important to be mindful of the informal networks people may turn to for help and support.

6.57 Secondly, this raises issues in the dissemination of information. Partnerships and services need to be aware of the target audience(s), identifying appropriate spaces and mediums for sharing information, as well as addressing other considerations such as language.

6.58 Specific recommendations are made elsewhere in the analysis section of this report in relation to these issues.

Consider if there are any past features in this homicide that might indicate controlling or coercive behaviours from either perpetrator or victim.

6.59 This in the considered in the analysis of domestic violence and abuse above.

What barriers are there, if any, against a transwoman sex worker who is visiting the UK accessing relevant public services for advice or support.

6.60 Both Jimena and Mario were Mexican and were in the UK on a Tourist Visa. Given this, and the short period of time they were in the UK before the homicide, it is relevant to consider how Jimena's cultural expectations and experiences in her home country may have affected her situation. However, in considering these issues it is important to note that domestic abuse affects all racial and ethnic groups.

6.61 There is limited data available on trans women's experience of domestic abuse in Mexico. For example, a 2016 report by Cornell University's Transgender Law Centre[52] noted that violence against women is prevalent in Mexico, particularly in the forms of domestic violence and murders. The report does not however include an estimate of prevalence for trans women. Providing a more general picture, the most recent report of the United Nations Special Rapporteur on violence against women cited data that one in four women in Mexico has been the victim of physical violence at least once in their lifetime[53].

6.62 It is also important to place this in a UK context, considering Jimena's potential experiences as a visitor to the UK. Information provided by LAWA notes that Latin American women affected by domestic violence and abuse may be:

- Unfamiliar with their rights in the UK
- Speak only limited or no English
- Feel quite isolated from support
- Be financially dependent on a partner/husband
- Depend on a husband for their immigration status in the UK.

6.63 Thinking specifically of Jimena's experiences, she does not appear to have accessed any services in the UK. But, if she had wanted to access services, the short period of time she was in the country and/or her specific immigration status, may have meant to was unaware of, felt unable or indeed would have been unable to access services. Additionally, language may have been an issue as English was Jimena's second language.

[52] Transgender Law Centre (2016) *Report on Human Rights Conditions of Transgender Women in Mexico*, Oakland, CA: Transgender Law Center and Cornell University Law School, Available at: https://transgenderlawcenter.org/wp-content/uploads/2016/05/CountryConditionsReport-FINAL.pdf (Accessed: 1 October 2018).
[53] Ertürk, Y. (2006) *Report of the Special Rapporteur on violence against women, its causes and consequences: Mission to Mexico*, New York, NY: United Nations, Available at https://documents-dds-ny.un.org/doc/UNDOC/GEN/G06/101/95/PDF/G0610195.pdf?OpenElement (Accessed: 1 October 2018).

6.64 In summary, there are multiple reasons why Jimena might not have known about, felt able to access services or believed that services would be responsive to her circumstances and needs as a Mexican national.

6.65 Many of these observations are also relevant to Mario as a perpetrator: for example, it became apparent to agencies in contact with Mario after Jimena's murder that his English was limited.

6.66 The Review Panel considered the implications of this for the LBHF. The Review Panel were informed that the Angelou Partnership has good working relationships with and can access, or refer to, a range of Latin American specialist services. These include:

- *LAWA* (who were invited to the final Review Panel meeting): runs the only two refuges in Europe by and for Latin American women and children fleeing gender-based violence. LAWA offers holistic and intersectional services, providing everything a BME woman needs to recover from abuse and live empowered lives
- *Latin American Women's Rights Service (LAWRS)*[54]: operates across London and is commissioned by London Councils to deliver three strands of the Ascent Partnership[55]. LAWRs offers specialist advice for survivors (risk assessment, safety plan, support to report); in-house legal advice (housing, welfare, debt, and employment rights); external surgeries (from partners in family law, immigration and access to a General Practitioner (GP) for undocumented women); specialist counselling; support around urgent needs; a creche; and a range of group sessions (including support groups for survivors, informative sessions on rights, etc).

6.67 Additionally, Review Panel members were able to identify local training in relation to these issues, in particular as provided by the Women's Resource Centre[56] which offers free training, including on immigration issues.

[54] LAWRS is a user-led, feminist and human rights organisation focused on addressing the practical and strategic needs of Latin American migrant women displaced by poverty and violence. For more information, go to: http://www.lawrs.org.uk.

[55] Ascent delivers a range of services across under six themes: prevention, advice and counselling, domestic and sexual violence helplines, specialist refuges, women against harmful practises, and support services to organisation. For more information, go to: https://thelondonvawgconsortium.org.uk.

[56] The Women's Resource Centre is a national support organisation for the women's sector in the UK, working towards linking all aspects of the inequality women and girls experience. For more information, go to: https://www.wrc.org.uk.

6.68 Based on the country of birth dataset from the Office of National Statistics (ONS), LBHF has a relatively small number of residents from Mexico (247 people, or 0.1% of the borough's population) and this is also the case when considering Latin American (including Central and Southern American, and the Caribbean) countries more broadly (6749 people, or 3.7% of the borough's population)[57]. However, in the context of the borough's population as a whole,[58] other information shared with the Review Panel noted that LBHF has a relatively high number of short-term migrants (9% of the local population).

6.69 This suggests that the issues discussed above may be relevant to a significant number of residents. It is therefore positive that the local Shared Services VAWG Strategy 2015-2018[59] includes a specific acknowledgement of the importance of responding to survivors in the context of immigration status, but this may need to be considered specifically in relation to short term migrants.

Jimena's circumstances illustrate potential barriers to victim / survivors of domestic violence and abuse who are short term migrants.

Recommendation 14: The CSP to work with partners to consider actions in relation to engagement with, and support to, short term migrants as part the review of the local strategy.

6.70 Since the DHR was completed (but prior to its publication), the UK Government has progressed work on its draft Domestic Abuse Bill. The Government response to the report from the Joint Committee on the draft Domestic Abuse Bill[60] addressed concerns raised by the Joint Committee (and others) about provision for migrant women. Among a number of commitments, the UK

[57] Office for National Statistics (2012) *Detailed Country of birth (2011 Census), Borough,* Available at: *https://data.london.gov.uk/dataset/detailed-country-birth-2011-census-borough* (Accessed: 7th December 2018).
[58] Insight and Analytics Team (2018) *Hammersmith and Fulham Borough Profile 2018*, London: London Borough of Hammersmith & Fulham. Available at: https://www.lbhf.gov.uk/sites/default/files/section_attachments/borough-profile-2018.pdf (Accessed 20th October 2018).
[59] Hammersmith & Fulham, The Royal Borough of Kensington & Chelsea and The City of Westminster. (2015) *Shared Services Violence Against Women and Girls (VAWG) Strategy 2015-2018*, London: The Royal Borough of Kensington & Chelsea. Available at: https://www.rbkc.gov.uk/pdf/VAWG_Strategy2015.pdf (Accessed 20th October 2018).
[60] HM Government (2019) *Government response to the report from the Joint Committee on the draft Domestic Abuse Bill session 2017 to 2019 paper 378/HC2075: Domestic Abuse Bill*, Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/817556/CCS0619467038-001_Domestic_Abuse_Bill_Print_WEb_Accessible.pdf (Accessed: 24th July 2019).

Government stated that: "*The Government will, therefore, review the overall response to migrant victims of domestic abuse, taking careful account of evidence provided by stakeholders on this issue"* (p.44).

6.71 Given the issues identified in this report, the Review Panel felt it was appropriate to include a national recommendation alongside the local recommendation to the CSP. In particular, the Review Panel felt HM Government should consider how to provide information to those travelling to the UK prior to, or at the point of their entry into, the country.

Jimena's circumstances illustrate the difficulty in providing information about domestic violence and abuse to short term migrants, particularly if they do not (or cannot) use local services. It is therefore important to identify opportunities to provide information about domestic violence and abuse and the help and support that is available. One way to do this may be by providing information at ports of entry or through other points of contact (e.g. Visa applications).

Recommendation 15: The Home Office to consider identify ways to provide information to those entering the UK with information about domestic violence and abuse and the help and support that is available.

Other Issues

6.72 The Review Panel identified one further issue of note: there is reference to both substance use and alcohol (in particular by Mario and friends prior to and after the homicide). More specifically, a friend identified Mario's alcohol use when describing the relationship, suggesting that this was the cause of his violence. The Review Panel felt it did not have sufficient information to make any further observations or recommendations about this issue. However, it was agreed that it was important to note the following: while a number of studies have found that the perpetrator's use of alcohol, particularly heavy drinking, can result in more serious injury to their partners than if they had been sober[61], alcohol and drugs do not cause domestic violence and abuse.

[61] Stella Project (2007) *Stella Project toolkit: domestic abuse and substance use*, London: Against Violence and Abuse (AVA), Available at: https://avaproject.org.uk/resources/stella-project-toolkit-domestic-abuse-substance-use-2007/ (Accessed 21st November 2018).

Equality and diversity

6.73 The statutory guidance requires the consideration of the nine Protected Characteristics under the Equality Act 2010 (age; disability, gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation), as well as the examination of barriers to accessing services and whether delivery was impacted.

6.74 However, the draft Overview Report handed to the second Independent Chair stated the following: *"all nine protected characteristics were considered by the panel. None were of concern or relevance to the circumstances of the deaths"*. Such a declaration is troubling. Sadly, it is not unique: there is a worrying trend in published DHRs, whereby equality and diversity are considered in narrow terms and/or the relevance of the Protected Characteristics are simply ruled out.

6.75 Consequently, the second Independent Chair asked the Review Panel to reconsider the Protected Characteristics. Several were found to have relevance to this DHR. These were:

6.76 **Age** – Jimena was 33 and Mario was 24 at the time of the murder. Their relationship is believed to have begun two years earlier. A significant age gap where the perpetrator is older than the victim is a risk factor for abuse. Clearly the opposite was the case here, with Jimena being over ten years older.

6.77 **Disability** – No information available to the Review Panel to indicate this was an issue.

6.78 **Gender reassignment –** the Equality and Human Rights Commission (EHRC) note that while the Equality Act 2010 refers to 'gender re-assignment', the use of the terms 'gender reassignment' and 'transsexual' in the Act is outdated and misleading, with the preferred umbrella term being 'trans'[62]. As Jimena was a trans women, the Review Panel has considered the experience of trans victims of domestic violence and abuse. This includes for example wider experience of, and fears about, transphobia, which might mean that trans women are mis-

[62] Equality and Human Rights Commission (2018) *Gender reassignment discrimination,* Available at: https://www.equalityhumanrights.com/en/advice-and-guidance/gender-reassignment-discrimination (Accessed: 1 October 2018).

understood, excluded, or inappropriately questioned at a time when they are most vulnerable. This is discussed in the analysis above.

6.79 **Marriage and civil partnership –** Jimena and Mario were married within seven months of meeting each other and had been married for less than two years prior to the homicide. Marriage as an institution has often been associated with specific gendered norms and roles in relationships. Jimena and Mario's relationship is considered in the analysis above. Additionally, separation is highlighted as an issue as Jimena may have been intending to travel to Paris without Mario at the time of the murder.

6.80 **Pregnancy and maternity** – No information available to the Review Panel to indicate this was an issue.

6.81 **Race** – Both Jimena and Mario were Mexican Nationals. There is limited information available to the Review Panel on this specific issue and its impact, however consideration has been given to some of barriers that can arise in these circumstances which may increase risk or affect or limit options in terms of help seeking. This includes both the impact of cultural norms, but also the experience of migrants to the UK.

6.82 **Religion or belief** – The only reference to religion or belief was the fact that Jimena had Mario had a religious ceremony after a civil service when they were married. The Review Panel is therefore unable to say whether religion or belief were an issue in this case.

6.83 **Sex** – Jimena was murdered by Mario, who is male. The sex of the perpetrator is of note in any DHR. The latest published data from the Office of National Statistics (ONS) show that the majority of victims of domestic homicides aged 16 or over were killed by a male suspect[63].

6.84 **Sexual orientation** – No information available to the Review Panel to indicate this was an issue.

6.85 The Review Panel has also considered Jimena's experience as a sex worker, as well as the attitudes and beliefs of Mario. These issues are discussed further in the analysis above.

[63] Office for National Statistics (2017) *Domestic abuse in England and Wales: year ending March 2017*, London: Office for National Statistics, Available at https://www.ons.gov.uk/releases/domesticabuseinenglandandwalesyearendingmarch2017 (Accessed: 1 October 2018).

6.86 Several reports published by Imkaan[64] provide a way to bring together these different aspects of someone's experiences and/or identities using an intersectional approach, which considers

"... *the different ways that violence is perpetrated and experienced, with recognition that Black and Minority Ethnic (BME) girls and women's experience of gender inequality inevitably intersect with 'race' inequality and may also intersect with other sites of oppression which include class, sexuality, age, disability, caste, belief and religion[65].*

6.87 As Imkaan note, developing better access to appropriate help for BME women who experience domestic abuse requires a holistic and multi-layered approach, which understands their intersectional experiences.

6.88 It seems likely that Jimena would have had to navigate the intersection of her status as a Mexican national visiting the UK, a trans woman and as a sex worker. As an example, if Jimena had experienced domestic abuse, some of the barriers she may have faced to a greater or less extent may have included her fears as a trans woman (being 'outed' to agencies or fears that contact with professionals would be unsympathetic), with these potentially compounded by the risk of criminalisation as a result of her sex work. Singly or together both may have hindered her access to help and support or made her situation worse. As a result, if Jimena had sought help from local services, they would have needed to have the confidence and skills to be able to take a holistic and multi-layered approach to her needs.

6.89 It is also of value to consider Mario. He too would have had to navigate the intersection of his status as a Mexican national visiting the UK, and was also relatively isolated (in particular, he spoke limited English and was young). However, as the Review Panel has not been able to speak with Mario and / or his family, there insufficient information available to consider this further. As in other DHRs, this is a reminder of the challenge in intervening with domestic

[64] Imkaan is a UK based, national second tier women's organisation dedicated to addressing violence against Black and 'minority ethnic' (BME) women and girls. For more information go to http://imkaan.org.uk.
[65] Larasi, M. with Jones, D. (2017) *Tallawah: a briefing paper on black and 'minority ethnic' women and girls organising to end violence against us*, London: Imkaan, Available at https://www.imkaan.org.uk/resources (Accessed: 1 October 2018).

abuse perpetrators at an early opportunity. In Mario's case, there was no opportunity to do so while he and Jimena were resident in the UK.

Good Practice

6.90 Given that there was no contact with either Jimena or Mario by any agency before the homicide, there has not been an opportunity to identify or consider any good practice.

6.91 However, the Review Panel noted more general features of the local partnership, in particular the expertise that Galop (and through it, access to the wider Angelou Partnership), and other providers like LAWA and LAWRS, bring in relation domestic violence and abuse as well as other forms of VAWG. The involvement of health providers in this DHR, in particular from sexual health services, is also positive.

7. Conclusions

7.1 Because of the short period of time during which Jimena was in the UK, and the fact that neither she nor Mario had contact with services prior to the homicide, this DHR has been not been able to look at the specific issue of how local professionals and organisations worked individually and together to safeguard the victim. As a result, no conclusions can be drawn in relation to agency practice per se. However, consideration of a range of issues has illuminated many of the challenges that trans victims of domestic violence and abuse, those engaged in sex work, and people from other countries resident in the UK for short periods of time, may face in accessing help and support.

7.2 In concluding this DHR, the Review Panel wishes to reiterate their sympathy to the family and friends of Jimena and thank them again for their contribution. The Review Panel would also like to acknowledge the impact that the lack of timely updates has had on Jimena's family, as well as recognise how opportunities to identify lessons and take actions to address these in a timely manner have also been delayed.

8. Lessons to be learnt

8.1 Jimena was in the UK for a relatively short time before her murder, and neither she nor Mario had contact with services prior to this. As a result, the Review Panel has sought to place Jimena's case in context, seeking to identify the lessons to be learnt from a broader operational or strategic perspective.

8.2 People who experience domestic violence and abuse should be able to access timely help and support, so they can be assisted in managing risks, needs and ultimately recovering. In considering the learning from the homicide of Jimena, this DHR has identified issues in how the local area understands and responds to the needs of trans victims of domestic violence and abuse. In a similar vein, this DHR has also identified issues in relation to the local sex industry, in particular how the local area understands and responds to the needs of those engaged in sex work. Recommendations have been made to address both these areas.

8.3 This DHR has also highlighted the specific issues that a victim or survivor with Mexican (or more broadly Latin American) heritage may face. The Review Panel has recognised the importance of having access to specialist services like LAWA and LAWRs and has made specific recommendations in relation to victim/survivors who are short term migrants. These recommendations concern the steps that needed to be taken to ensure that information is available on domestic violence and abuse, as well as the help and support that is available.

8.4 In order to protect or support someone in Jimena's position, professionals and agencies would have needed to adopt an intersectional approach and consider a range of issues and how these might affect someone's experiences and/or help and hinder support. The challenge for all agencies is to ensure that their staff have adequate training and resources, supported by robust policy and procedures, as well as commissioning and strategic frameworks, to respond appropriately.

8.5 This DHR has also identified learning relating to the DHR process itself. This has included learning for the local CSP around the management of the DHR process and family involvement. The CSP has acknowledged the seriousness of issues that have been identified in finalising this DHR. The Review Panel is pleased that the CSP has done so and has committed to ensuring that the DHR process is concluded, not least because of the transparency that this affords.

8.6 Lastly, this DHR has also highlighted important learning around how equality and diversity issues are considered. It is too easy for a DHR to see a victim in isolation, whereby someone's personal circumstances, including the relevance of any Protected Characteristics, are not considered. A key revision to the statutory guidance was that the narrative of each DHR should articulate the life through the eyes of the victim: understanding someone's lived experience as best as possible is critical to that endeavour.

8.7 Taken together, the learning around process and equality and diversity issues, have been reminders of the challenge and opportunity of doing a DHR well. The Review Panel hopes that the lessons learnt from this tragedy can further develop local services and reduce the likelihood of future homicides.

9. Recommendations

9.1 No single agency recommendations were made in IMRs or reports providing background information.

9.2 The Review Panel has made the following recommendations, which are also described in the analysis and are also presented as an Action Plan template in Appendix C.

9.3 These recommendations should be acted on through the development of the Action Plan template, with progress reported on to the CSP within six months of the review being approved.

9.4 **Recommendation 1**: The CSP to develop a local procedure for the conduct of DHRs. This to include a clear process around the monitoring of progress and, where there are delays, the escalation and agreement of mitigating actions to ensure that DHRs are conducted in a timely manner.

9.5 **Recommendation 2**: The Home Office to amend the statutory guidance in order to improve the transparency of the DHR process by requiring CSPs to routinely report on key milestones (e.g. notification received, commissioned, commenced, submitted to the Home Office for quality assurance, approved for publication).

9.6 **Recommendation 3:** The CSP to ensure that the expectations around timely and regular family contact are reflected in the local procedure for the conduct of DHRs.

9.7 **Recommendation 4:** The CSP to ensure that the expectations in relation to Independent Chairs (in particular around the role of the chair in relation to family contact and issues such as record keeping and data retention) are explicit in the terms of their engagement and reflected in the local procedure for the conduct of DHRs.

9.8 **Recommendation 5**: The CSP to ensure it has a picture of the size and needs of the local trans community, in order to inform local commissioning and strategy decision.

9.9 **Recommendation 6:** The Government Equalities Office to ensure that, alongside the reform of the GRA, there is guidance on how to lawfully implement the discretion held by single-sex service providers under the Equality Act.

9.10 **Recommendation 7**: The CSP to undertake an audit of local agency practice in relation to domestic abuse to identify whether this is trans inclusive, including considering the training available to staff to meet the needs of trans victims and survivors.

9.11 **Recommendation 8**: The CSP to work with domestic abuse and LGBT+ specialist services to ensure that there are appropriate referral pathways, provision and publicity material in place to meet the needs of trans victims and survivors of domestic abuse.

9.12 **Recommendation 9**: Public Health Commissioners to review the need for sex work outreach in the borough.

9.13 **Recommendation 10**: The CSP to work with partners to develop online resources with information on the help and support for sex workers locally and to develop a comprehensive dissemination strategy.

9.14 **Recommendation 11**: The CSP to work with partners (in particular Public Health) to ensure that the LBHF has a picture of the size and needs of the local sex industry, in order to inform local commissioning and strategy decisions.

9.15 **Recommendation 12**: The CSP to undertake an audit of local agency practice in relation to sex workers at risk of domestic abuse, including considering the training available to staff to meet the needs of victims and survivors.

9.16 **Recommendation 13**: The CSP to work with domestic abuse and sexual health services to ensure that there are appropriate pathways and provision in place to meet the needs of sex workers at risk of domestic abuse.

9.17 **Recommendation 14**: The CSP to work with partners to consider actions in relation to engagement with, and support to, short term migrants as part the review of the local strategy.

9.18 **Recommendation 15:** The Home Office to consider identify ways to provide information to those entering the UK with information about domestic violence and abuse and the help and support that is available.

10. Appendices

Appendix A: Glossary

AAFDA	Advocacy After Fatal Domestic Abuse
ASB	Anti-Social Behaviour
BME	Black and Minority Ethnic
CCG	Clinical Commissioning Group
CCTV	Closed Circuit Television
CSP	Community Safety Partnership
CSU	(LBHF) Community Safety Unit
DASH RIC	Domestic Abuse Stalking and Harassment Risk Identification Checklist
DHR	Domestic Homicide Review
EHRC	Equality and Human Rights Commission
GP	General Practice
GRA	Gender Recognition Act 2004
GUM	Genitourinary Medicine
10HB	10 Hammersmith Broadway
HIV	Human Immunodeficiency Virus
IMR	Individual Management Review
LAWA	Latin American Women's Aid
LAWRS	Latin American Women's Rights Service
LBHF	London Borough of Hammersmith & Fulham
LGBT+	Lesbian, Gay, Bisexual and Trans. The 'plus' indicates the inclusion of a range of LGBT identities
MARAC	Multi Agency Risk Assessment Conference
MOPAC	Mayor's Office for Policing and Crime
MPS	Metropolitan Police Service
NHS	National Health Service
NUM	National Ugly Mugs
ONS	Office for National Statistics
SASH	Support and Advice on Sexual Health
SCRG	(MPS) Specialist Crime Review Group
Sex worker	The term 'sex worker' refers to those engaged in prostitution. Sex work is a term used to describe a wide range of activities relating to the exchange of money (or its equivalent) for the provision of a sexual service
STADV	Standing Together Against Domestic Violence
STI	Sexually Transmitted Infection
The three boroughs	The three boroughs are LBHF, Westminster City Council and The Royal Borough of Kensington and Chelsea
THT	Terrence Higgins Trust
Trans	An umbrella term to describe people whose gender is not the same as, or does not sit comfortably with, the sex they were assigned at birth
Transgender woman	A term used to describe someone who is assigned male at birth but identifies and lives as a woman
UK	United Kingdom
VAWG	Violence against Women and Girls
WLMHT	West London Mental Health NHS Trust

Appendix B: DHR Terms of Refence

The general terms of the review are:

- Decide whether in all the circumstances at the time, any agency or individual intervention could have potentially prevented Jimena's death
- Review current responsibilities, policies and practices in relation to victims of domestic abuse – to build up a picture of what should have happened and review national best practice in respect of protecting adults from domestic abuse
- Examine the roles of the organisations involved in this case, the extent to which Jimena had involvement with those agencies, and the appropriateness of single agency and partnership responses to her case to draw out the strengths and weaknesses
- Establish whether there are lessons to be learnt from this case about the way in which organisations and partnerships carried out their responsibilities to safeguard Jimena's wellbeing
- Identify clearly what those lessons are
- Identify whether, as a result, there is a need for changes in organisational and/or partnership policy, procedures or practice in order to improve our work to better safeguard victims of domestic abuse.

The review in this case will also:

- Consider if this homicide raises any learning around how agencies can best work with sex workers within the transgender community
- Consider if there any learning around how we may use transgender and/or sex worker networks to highlight services available to a visiting sex worker who may be exposed to domestic abuse?
- Consider if there are any past features in this homicide that might indicate controlling or coercive behaviours from either perpetrator or victim.
- What barriers are there, if any, against a transwoman sex worker who is visiting the UK accessing relevant public services for advice or support.

Appendix C: Template DHR Recommendations and Action plan

Recommendation	Scope	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
Recommendation 1: The CSP to develop a local procedure for the conduct of DHRs. This to include a clear process around the monitoring of progress and, where there are delays, the escalation and agreement of mitigating actions to ensure that DHRs are conducted in a timely manner.	Local	Develop procedure document for DHRs	LBHF – Community Safety Unit	• Procedure taken to DHR sub-group for review • Procedure agreed at CSP Board • Procedure published on LBHF website	Apr 19	Completed May 2019 Ongoing
Recommendation 2: The Home Office to amend the statutory guidance in order to improve the transparency of the DHR process by requiring CSPs to routinely report on key milestones (e.g. notification received, commissioned, commenced, submitted to the Home Office for quality assurance, approved for publication).	National	Contact to be made with Home Office DHR lead to outline suggested amendments to statutory guidance regarding options for improved transparency	Home Office	Letter to Home Office with DHR report submission	Feb 19	Completed April 2019
Recommendation 3: The CSP to ensure that the expectations around timely and regular family contact are reflected in the local procedure for the conduct of DHRs.	Local	Develop procedure document for DHRs	LBHF – Community Safety Unit	As per recommendation 1	Apr 19	Ongoing
Recommendation 4: The CSP to ensure that the expectations in relation to Independent Chairs (in particular around the role of the chair in relation to family contact and issues such as record keeping and data retention) are explicit in the terms of their engagement and reflected in the local procedure for the conduct of DHRs.	Local	Develop procedure document for DHRs DHR contract template to reflect robust expectations of chairs	LBHF – Community Safety Unit	As per recommendation 1	Apr 19	Completed May 2019
Recommendation 5: The CSP to ensure it has a picture of the size and needs of the local trans community, in order to inform local commissioning and strategy decision.	Local	Contact to be made with internal teams (e.g. Public Health, Impact and Assessment, Community Engagement) to identify immediate actions to take forward	LBHF – Community Safety Unit	• Immediate actions identified and agreed • Appropriate service identified to complete scoping exercise • Completed needs assessment • Updated VAWG Strategy	Apr 19 Mar 20	

Recommendation	Scope	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
		Community Safety to undertake scoping and needs assessment as part of wider VAWG needs assessment Incorporate findings from scoping/needs assessment into 20/21 VAWG strategy		• Consideration of how to use 2021 census data on Gender Identity		
Recommendation 6: The Government Equalities Office to ensure that, alongside the reform of the GRA, there is guidance on how to lawfully implement the discretion held by single-sex service providers under the Equality Act	National	Contact to be made with GEO through the Home Office	Government Equalities Office	Letter to Home Office with DHR report submission	Feb 19	Completed Apr 2019
Recommendation 7: The CSP to undertake an audit of local agency practice in relation to domestic abuse to identify whether this is trans inclusive, including considering the training available to staff to meet the needs of trans victims and survivors.	Local	Training around LGBT/DA to be addressed through VAWG training subgroup VAWG Strategic Coordinator to take Recommendation 7 to Specialist Services Group Service Specification for recommissioning VAWG provision to explicitly address this.	LBHF – Community Safety / VAWG Strategic Lead Galop	• Recommendation taken to both DHR and training subgroup • Inclusion on 19/20 training programme • Training delivered to relevant agencies including health and DA services • Action taken on the findings of audit Presentation at VAWG Strategic Board	Mar 19 Sept 19 Mar 20	Commenced and ongoing
Recommendation 8: The CSP to work with domestic abuse and LGBT+ specialist services to ensure that there are appropriate referral pathways, provision and publicity material in place to meet the needs of trans victims and survivors of domestic abuse	Local	Revision of current pathways and publicity with Angelou and Ascent Partners Pathways and publicity for trans DA survivors to be considered as part of recommissioning VAWG services	LBHF – Community Safety	• Updated service and local authority websites • Dissemination around referral pathways • Service Spec for recommissioning addresses pathways for LGBT/DA survivors	Apr 19 Sept 19	Commenced and ongoing

Recommendation	Scope	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
Recommendation 9: Public Health Commissioners to review the need for sex work outreach in the borough	Local	Review of current outreach provision Work with local providers to identify any barriers to outreach locally and action plan to address these	LBHF – Public Health	• Recommendation taken to DHR subgroup • Recommendation taken to MSE operational group	Apr 19 Jul 19	
Recommendation 10: The CSP to work with partners to develop online resources with information on the help and support for sex workers locally and to develop a comprehensive dissemination strategy	Local	Review existing resources with local partners (including drug and alcohol services, sexual health and third sector orgs – Rahab) Identify additional resources based on local need	LBHF – Public Health	• Recommendation taken to DHR subgroup Communications plan developed for dissemination	Apr 19 Aug 19	
Recommendation 11: The CSP to work with partners (in particular Public Health) to ensure that the LBHF has a picture of the size and needs of the local sex industry, in order to inform local commissioning and strategy decisions.	Local	Public Health Commissioners to examine existing local data on women affected by prostitution Consideration about whether a separate needs assessment needs to be undertaken VAWG service specification to reflect local need for women affected by prostitution	LBHF – Public Health	Data sets identified Recommendation taken to DHR subgroup Findings shared at VAWG strategic board	Apr 19	
Recommendation 12: The CSP to undertake an audit of local agency practice in relation to sex workers at risk of domestic abuse, including considering the training available to staff to meet the needs of victims and survivors.	Local	Training around DA / women affected by prostitution to be address at VAWG training subgroup	LBHF – Community Safety	• Recommendation taken to both DHR and training subgroup • Specialist training available	Apr 19	Commenced through WABP subgroup

Recommendation	Scope	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
		Links made with specialist service, Rahab		Training delivered to relevant agencies including health, drug and alcohol and DA services	Sept 19	Commenced & ongoing
Recommendation 13: The CSP to work with domestic abuse and sexual health services to ensure that there are appropriate pathways and provision in place to meet the needs of sex workers at risk of domestic abuse	Local	Revision of current pathways and publicity with DA, sexual health, drug and alcohol and specialist services (e.g. Rahab) Pathways and publicity for DA survivors affected by prostitution to be considered as part of recommissioning VAWG services	LBHF – Community Safety	• Updated service and local authority websites • Dissemination around referral pathways • Service Spec for recommissioning addresses pathways for DA survivors affected by prostitution	Apr 19 Sep 19	Commenced & ongoing
Recommendation 14: The CSP to work with partners to consider actions in relation to engagement with, and support to, short term migrants as part the review of the local strategy	Local	Recommendation to be taken to DHR subgroup	LBHF – Community Safety		Apr 19	Completed Jun 2019
Recommendation 15: The Home Office to consider identify ways to provide information to those entering the UK with information about domestic violence and abuse and the help and support that is available	National	Contact to be made with Home Office DHR lead to outline suggested recommendation.	LBHF – Community Safety	Contact made with Home Office DHR Lead & recommendation shared.	Aug 19	

Appendix D: Home Office letter