Domestic Homicide Review

Executive Summary

Review into the murder of Jimena in March 2015

Chair and Report Author: James Rowlands

Date completed: December 2018

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"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. Overview

1.1 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).

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

1.2 Jimena was a trans woman. She was a Mexican national, and was normally resident in Mexico, living with her husband Mario[3] in a flat owned by her father.

1.3 Jimena was a sex worker. Based on information obtained from the Metropolitan Police Service (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.

1.4 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.

[1] For more information on the chairing arrangements for this DHR, see 2.33 - 2.38 below.
[2] Not her real name.
[3] Not his real name.

1.5 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.

1.6 As recommended by the statutory guidance, pseudonyms have been used and precise dates obscured to protect the identities of those involved. The process for selecting these pseudonyms is described in the Overview Report:

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. The Review Process

2.1 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.

2.2 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 2.33 - 2.38 below.

2.3 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. The Home Office Quality Assurance Panel considered the Overview Report and Executive Summary in July 2019 and provided approval for publication in September 2019.

2.4 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.

2.5 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. The issues relating to this are described in the Overview Report.

2.6 The Review Panel would also 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. A recommendation has been made to address this issue.

2.7 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 felt that currently the DHR process is not as transparent as it could be. A recommendation has been made to address this issue.

Parallel processes

2.8 *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.

2.9 *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.

Contributors to the review

2.10 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. 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 suggestion of a Review Panel member who was aware that the clinic was often used by trans people from the Latin American communities. The clinic reported that it had not had any contact with either Jimena or Mario.

2.11 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

2.12 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
Hammersmith & Fulham Council Public Health	Background report on sexual health and substance misuse services

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

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

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

2.16 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.

Engagement of family and friends

2.17 Early in the DHR, the first Independent Chair successfully contacted and conducted interviews with Jimena's brother (Luis) and niece (Marta)[4]. Family members were provided with both the Home Office leaflet for families, as well as information on Advocacy After Fatal Domestic Abuse (AAFDA)[5]. 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.

2.18 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 (with

[4] Not their real names.
[5] For more information, go to: https://aafda.org.uk.

an interpreter) in speaking to Jimena's family outside core office hours and across time zones.

2.19 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.

2.20 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. A recommendation has been made to address this issue.

2.21 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.

2.22 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.

2.23 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.

2.24 Contact was also made with a number of friends who shared information about Jimena and Mario, describing their relationship.

2.25 For the most part, family and friends described the relationship as positive. However, there was also some evidence of conflict, including reported assaults, as well as jealousy from Mario and his disapproval of Jimena being a sex worker. This is described in the Overview Report.

2.26 Attempts were made to involve the perpetrator and their family but these were not successful. This is described in the Overview Report.

The Review Panel members

2.27 In addition to the Independent Chair(s), the Review Panel members were:

Name	Job Title	Agency
Caroline Birkett	Head of London Services	Victim Support
Catherine Bewley	Head of Sexual Violence Support Services	Galop[6] / Angelou Partnership[7]
Felicity Charles[8]	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)[9]
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)

[6] 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.
[7] 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.
[8] Came into post in 2017, previously the LBHF CSU was represented by Kate Delaney.
[9] 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/.

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

2.29 As evidenced from above, there was representation on the Review Panel from a specialist 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

2.30 At the first five Review Panel meetings, there was no representation from a service that worked with Mexican or Latin American communities. The second Independent Chair discussed this with the CSP. 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 Latin American Women's Aid (LAWA)[10], who attended the final Review Panel meeting in November 2018:

Name	Job Title	Agency
Yenny Tovar-Aude	Director	LAWA

2.31 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.

2.32 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

[10] 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/.

Overview Report and Executive Summary. After the meeting, further information was shared, and then sign off secured, via email.

Author of the Overview Report

2.33 The first Independent Chair was originally appointed to lead the DHR 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.

2.34 Given the timeframe for the review at that point, 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.

2.35 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.

2.36 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[11]. James declared this as a potential conflict of interest when approached by the CSP. The CSP agreed mitigations in relation to both independence and any potential conflicts of interests and felt that the appointment was proportionate in the interests of concluding the DHR. Additionally, 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.

2.37 James received a partial handover from the first Independent Chair. He sought further information in relation to a number of areas as described 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

[11] 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.

not been possible to resolve some issues due to a lack of information. Additionally, a draft Overview Report was also handed over by the first Independent Chair. 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. For the sake of readability, these issues are not recorded in the Executive Summary. However, they are described in the Overview Report. A recommendation has been made to address this issue.

2.38 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 and an explanation of the circumstances around chairing, including the role and issues associated with the first Independent Chair, would be included. For the sake of readability, these issues are not recorded in the Executive Summary but are described in the Overview Report. The first Independent Chair was offered the opportunity to comment 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.

3. Terms of Reference

3.1 Within the Terms of Reference developed by the first Independent Chair, 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.

4. Summary Chronology

4.1 On the night before the homicide, Jimena and Mario and some friends (Carlos, Julia, and Pilar[12]) 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.

4.2 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.

4.3 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 the client went alone to the bedroom with Jimena.

4.4 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.

4.5 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.

4.6 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.

4.7 Shortly thereafter, Carlos, Julia, and Pilar went to Julia's flat.

[12] Not their real names.

4.8 Mario made three trips to a local supermarket during the morning.

4.9 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. 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 this, Mario was asked to leave. He did so and went back to the flat he shared with Jimena.

4.10 Mario then left the flat just before 3pm. He made his fourth visit of the day to the supermarket. He then travelled by cab to a shopping centre nearby and purchased a new mobile phone. Shortly before 5pm, he made a cab journey and went to a sex work establishment. Whilst there he had sex with the two sex workers. He left shortly before 7pm.

4.11 Shortly after 7.30pm he went back to Julia's flat. He asked them about the whereabouts of Jimena, saying that she was not answering the door. Carlos tried to contact Jimena unsuccessfully. 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.

4.12 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.

4.13 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.

5. Key issues arising

5.1 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.

5.2 Tragically, it is not possible to know Jimena's perspective about 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.

5.3 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 were 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*".

5.4 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.

5.5 One friend (Julia) said 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.

5.6 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).

5.7 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 of domestic violence and abuse. 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.

5.8 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, having confided his fears to his sister, Mario appears to have been aware of this.

5.9 It is of note that all of these behaviours are correlated with domestic violence and abuse. In particular, extreme jealousy[13] and the period shortly before or after separation are often associated with domestic homicide[14].

5.10 The Review Panel also considered how Jimena's sex work, noting a number of issues that might be relevant:

[13] 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.
[14] 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].

- 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[15]. Additionally, sex workers may also face a range of criminal justice sanctions depending on the legal jurisdiction in which they operate
- 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 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).

5.11 There were also reports that Jimena was "*in control*" in the relationship. These reports are based on very limited information. The Review Panel felt it was impossible to test these because the Review Panel cannot speak with Jimena to seek her views, while Mario declined to participate in the DHR. 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. Instead, the Review Panel concluded that 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.

5.12 The Review Panel also considered areas relating to:

- Trans people's experience of domestic violence abuse
- Help and support for sex workers locally, specifically sex workers at risk of domestic abuse
- Potential barriers to help and support for Mexican (and more generally Latin American) victims and survivors, particularly those who – like Jimena – are short term migrants.

5.13 In approaching each of these areas, the Review Panel considered evidence of local need, provision of support and the wider strategic context. While there is evidence of good practice locally, recommendations have been made in

[15] 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

relation to the local areas picture of need, local practice, pathways and provision, as well as training.

6. Conclusions

6.1 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.

6.2 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.

7. Lessons to be learnt

7.1 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.

7.2 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.

7.3 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 need to be taken to ensure that information is available about domestic violence and abuse, as well as the help and support that is available.

7.4 In order to protect or support someone in Jimena's position, professionals and agencies need to be able 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.

7.5 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 also committed to ensuring that this DHR has been concluded, not least because of the transparency that this affords.

7.6 Lastly, this DHR has 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 or broader structural conditions, 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.

7.7 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.

8. Recommendations

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

8.2 The Review Panel has made the following recommendations. 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.

8.3 **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.

8.4 **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).

8.5 **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.

8.6 **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.

8.7 **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.

8.8 **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.

8.9 **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.

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

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

8.12 **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.

8.13 **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.

8.14 **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.

8.15 **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.

8.16 **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.

8.17 **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.