

MR GRAEME IRVINE
HIS MAJESTY'S CORONER
EAST LONDON
124 Queens Road Walthamstow, E17 8QP
[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

[redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The [redacted] Secretary of State for the Home Department** **Sent via email: [redacted]** **[redacted] Mayor of London** **Sent via email: [redacted]** **[redacted] Commissioner of Police for the Metropolis** **Sent via email: [redacted]**
1	**CORONER** I am Mr Graeme Irvine, Senior Coroner for the coroner area of East London
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 24th October 2022 this Court commenced an investigation into the death of Yolanda Saldana Feliz, aged 53 years. The investigation concluded at the end of a two-week inquest before a jury on 28th April 2026 when the Court returned a short-form conclusion with an associated narrative. The narrative cited failures on the part of the police as part of a domestic abuse investigation that were more than minimally causative of Yolanda's death, these included: • Failures in risk assessment, including, the initial grading assessment, ignorance

	of the need to utilise proscribed risk-assessment tools, and failure to reassess risk when behaviour escalated. • Unsafe case allocation to a trainee officer. • A series of cumulative failures to adequately investigate a report of crime. • Failure of senior officers to adequately supervise an investigation, • Delay in the location and arrest of a suspect, • Failures of the police force to ensure that local policy guidance on case numbers and capacity were followed, • A failure to ensure that a victim of crime was provided with the resources of victim support, • A failure to refer the case to ("MARAC") the Multi-Agency Risk Assessment Conference • A failure to acknowledge or respond to communications from the victim of a crime Mrs Saldana Feliz's medical cause of death was determined as; 1a Multiple Sharp Force Stab and Incised Wounds
4	**CIRCUMSTANCES OF THE DEATH** Yolanda Saldana Feliz was a 53-year-old nurse and mother of three who was born in the Dominican Republic. Yolanda moved to the UK in the summer of 2021 with her daughter to stay with her daughter's husband in London. Both women were native Spanish-speakers with a limited understanding of English. The relationship between Yolanda's daughter and son in law deteriorated. Yolanda and her daughter moved to separate premises, a house of multiple occupation in Stratford. The two shared a bedroom. The premises were insecure, the kitchen door, leading to a garden could not be locked. Yolanda's daughter made a complaint to the police on the 18th of June 2022 alleging harassment on the part of her ex-partner. The complaint incorporated, threats of violence, controlling behaviour, stalking, sexual insults and allegations. Yolanda's daughter asked for protection and help to acquire a restraining order against her ex-partner. The complaint set out a further offence of making a threat to kill. The facts of the allegation were that Yolanda's son-in-law, threatened his wife that he would kill Yolanda. He believed that Yolanda was responsible for sustaining the couple's separation. Yolanda was never contacted by the police. The threat to kill offence was never investigated, thus neither the credibility of threat nor a meaningful risk assessment of likely harm was ever undertaken. The harassment allegations were assessed to present a medium level risk of harm by a civilian member of police staff who had 3 months experience in the job. Officers at inquest accepted that the risk ought to have been assessed as high. The risk assessment failed to consider a Merlin intelligence report that set out that in March 2022 Yolanda's son-in-law had been arrested for Affray, in which he had threatened roommates with a machete. The arrest necessitated the production of a taser and resulted in his detention under the Mental Health Act 1983. The categorisation of risk as being medium, did not cross the threshold for a referral to MARAC. Such a referral can result in actions being undertaken which include:

- The appointment of an advocate, an Independent Domestic Violence Advisor (IDVA),
- “Target Hardening” including the introduction of security for the home, such as locks, reinforced doors, or panic alarms.
- “Flagging” the police and NHS "flag" the victim’s file. Allowing emergency services to prioritise a high-risk MARAC case.
- Civil Injunctions: Non-Molestation Orders or Domestic Abuse Protection Orders (DAPOs).

The crime was allocated to a trainee police officer with no experience of domestic abuse investigation. The allocating sergeant in the Community Safety Team (“CSU”) did not know the chosen officer, their level of experience, or their caseload capacity at that time. The allocated constable was, at that time, not part of the CSU, they were not due to arrive for a further 5 days.

The allocating sergeant recognised the risk of such a decision in a contemporaneous note. The same officer had escalated concerns, in writing, to his line of command regarding the lack of resources available to the CSU in the preceding weeks. He argued that his team ought to have 10 constables and 2 sergeants instead, it consisted of 4 constables and 1 sergeant.

The allocated investigating officer did not consider the allegations until their 9th day on the CSU, some 16 days after the complaint was made by Yolanda’s daughter. The officer had a caseload of 20-27 cases when contemporary guidance indicated that anything over 13 cases could result in exhaustion.

The investigation ought to have been supervised weekly by a sergeant, this task was not undertaken.

The investigating officer was asked to direct Yolanda’s daughter to the charity Victim Support, this task was not undertaken. Victim Support provide a gateway to access,

- Referral to an Independent Domestic Violence Advisor
- Safety Planning
- Legal Guidance: rights and civil injunctions
- Police Liaison
- Practical Help inc Home Security and emergency accommodation or refuge.
- Financial & Housing Advice
- Emotional Support
- Cultural-specific support

Yolanda’s son in law was not arrested until 51 days after the allegations were made. Following arrest, his custody for the purpose of interview was not authorised by the custody officer. The decision was justified in part because arresting officers could not rationalise the delay in locating and arresting the suspect.

Following the arrest, the abusive behaviour of Yolanda’s son in law escalated, despite that fact being explained to the investigating officer no reassessment of risk was undertaken by the police.

Repeated communications to the police from Yolanda’s daughter went unacknowledged and unassessed.

In the early hour of 23rd October 2023 Yolanda’s son-in-law entered her home [redacted]. Yolanda and her daughter were made subject to a sustained knife attack. Yolanda sustained 40 incised wounds, her injuries proved fatal, she was declared dead at the scene. Yolanda’s daughter survived the attack, but sustained many knife wounds to her face, neck, chest and abdomen resulting in emergency surgery and 2 months of post-operative inpatient treatment.

	Yolanda's son-in law took his own life on 23rd October 2023 by immersion in water.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – 1. The failure of the police to professionally investigate a complaint of domestic abuse to secure relevant information necessary to adequately assess and mitigate risk of fatal harm. 2. The adoption of investigatory standards, policies and procedures by a wider criminal justice system without any realistic prosect of compliance given lack of deployable resources. 3. The police service's systemic failure to monitor, detect and remediate departures from required practice, even when officers escalated prophetic warnings about such failure. 4. The allocation of policing duties to civilian staff and trainee officers whose experience, training and caseload capacity were incongruent with the gravity of those tasks. 5. Yolanda's sex, language skills and wealth impacted upon her ability to access public services, legal support and home improvements to maintain her security.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by **7th July 2026**. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise, you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons the family of the family Ms Feliz. I have also sent it to the local Director of Public Health who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response.

9	**[DATE] 08/05/2026 [SIGNED BY CORONER]** [redacted]