DOMESTIC HOMICIDE REVIEW - OVERVIEW REPORT

Newham Community Safer Partnership

REPORT INTO THE DEATH OF IBUKUN

October 2020

Report produced by Simon Steel – Perse Perspective Consultancy Ltd

Report Completed on

9TH June 2023

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The following tribute has been prepared by the family of Ibukun

"Alhamdulillahi (All praise to Allah) that I had the opportunity to be a parent to someone with a beautiful heart like yours Blessing"

FOREWORD

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

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

Following this death, there is emerging evidence of positive change at a local level, particular mention to the University of East London (UEL) who had already conducted an independent review and implemented significant enhanced practices. We all must do our utmost to take immediate action to protect the victim and to deal effectively with the perpetrators of domestic abuse and the chair would urge everyone to take note and act on the findings of this review. Together we must take the threat and harm posed by domestic abuse seriously at a leadership, frontline, and community level to help bring these types of incidents to an end.

1. INTRODUCTION

1.1 This Domestic Homicide Review (hereafter "the review") was established under Sec 9(3) of the Domestic Violence Crime and Victims Acts 2004. It examines agency responses and support given to Ibukun who was a resident of Newham prior to her death in October 2020.

1.2 In October 2020 Brian called police to report his concerns for his ex-girlfriend, Ibukun, who had told him she intended to kill herself. Ibukun's disappearance was assessed as high risk and extensive searches were conducted within the borough of Newham, mainly focusing on wooded and park areas. In the early hours of the morning telephone intelligence placed her phone in the area of Stratford Park, London. A search was commenced of that area and Ibukun's body was found by police. The London Ambulance Service (LAS) and the Helicopter Emergency Medical Service (HEMS) attended the scene however Ibukun's life was pronounced extinct at the scene. The subsequent investigation led to the case being passed to HM Coroner.

1.3 The review will consider the agency contact and involvement with Ibukun for 3 years prior to her death. At the initial panel meeting agency members shared a summary of their engagement with Ibukun. This period was chosen to allow for an in-depth review of current methods and processes to be carried out and to ensure that recommendations and learning

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

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

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

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

2. TIMESCALES

2.1 The Metropolitan police (MPS) referred this matter to the Community Safety Partnership (CSP) on the 27th of October 2020 by email. The email recommended that the case be considered for a Domestic Homicide Review (DHR). Due to the impact of Covid 19 and changes in the CSP leadership team there was a significant delay in their decision making to carry out a DHR. It was not until the 8th of April 2022 that the Home Office were informed by the Partnership of their intention to carry out a Domestic Homicide Review into this matter.

2.2 Simon Steel was commissioned to provide an Independent Chair (hereafter 'the chair') for this review on 11h of May 2022. The completed report was passed to the Community Safety Partnership (CSP) on XXXXX. It was submitted by the CSP to the Home Office Quality Assurance Panel on XXXXXX.

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

- Since May 2022 there have been multiple meetings between the chair, panel members and authors to discuss the content of the IMR's. At the start very little was known about this case unlike cases that are commissioned at the point of a homicide (when there is a significant timely criminal investigation being undertaken).

- To support engagement with the family. Remembering that the coroner's case had been heard in March 2021 over a year before this DHR was commissioned and as far as the family where aware prior to our approach there was no further reviews. Recognising how traumatic this process can be for families contact with the family was managed sensitively. We wished to give them the appropriate time to consider their participation whilst at that time developing trusting relationships.

- Enquiries were made to ensure that Ibukun's mother had the appropriate support in place. The author asks anyone reading to consider the distress that contact could have potentially caused to her mother given the delay with this review. In an attempt to mitigate distress as much as possible, accepting that of course complete mitigation would never have been possible, extensive research was done prior to contact. However, given the ongoing engagement by her mother the author suggests that the approach worked.

3.CONFIDENTIALITY

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

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

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

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

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

Pseudonym	Relationship	Age at the time of the incident	Ethnicity
Ibukun	Deceased	24	Black-African
Brian	Ex-Partner		
Mum	Mother		Black-African
Sibling 1	Brother		
Sibling 2	Brother		

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

4. Terms of Reference

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

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

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

- Visa status how insecure immigration status impacts on DA/SV- is this a barrier for accessing support?

- How the impact of trauma from domestic abuse contributes to suicidal ideation / suicide.

- The sharing of information. Ibukun had accessed MH services across different London Borough's, is there a linked-up system for information sharing in London?

- Impact of trauma from previous SSA allegations and how this is viewed.

- Dynamics of gender within relationships.

- Was identity, faith and/or culture a barrier.

- How accessible is anonymous reporting/ advice services for DA and SV-do we have this in place/ is it publicised enough?

5. METHODOLOGY

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

- The Behaviour of a person (A) towards another person (B) if.

    I. A and B are each aged 16 or over and are personally connected to each other and.

    II. The behaviour is abusive

- Behaviour is abusive if it consists of any of the following -

    1. physical or sexual abuse.
    2. violent or threatening behaviour.
    3. controlling or coercive behaviour.
    4. economic abuse (see subsection (4)).

5. psychological, emotional, or other abuse.

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

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

1. They are, or have been, married to each other.
2. They are, or have been, civil partners of each other.
3. They have agreed to marry one another (whether or not the agreement has been terminated).
4. They have entered into a civil partnership agreement (whether or not the agreement has been terminated).
5. They are, or have been, in an intimate personal relationship with each other.
6. They each have, or there has been a time when they each have had, a parental relationship in relation to the same child (see subsection (2).
7. They are relatives.

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

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

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

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

5.5 This review has followed the statutory guidance. On notification of the death agencies were asked to check for their involvement with any of the parties concerned and secure their records. It was during this scoping process that chronologies were collated and combined.

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

This document was reviewed by the chair and Individual Management Reviews (IMRs) for all the organisations and agencies that had contact with Ibukun were requested. IMR's were prepared by 6 agencies i.e., Metropolitan police (MPS), General practice, BARTs Health NHS Trust (Newham Hospital), East London Health Foundation trust, Victim support and the University of East London (UEL). West Midlands Police (WMP) produced a scoping report.

5.6 Document Reviewed

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

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

5.7 Panel Meetings

Review Panel meetings took place on 12th of July 2022, 27th of September 2022, 22nd of November 2022, 17th of January 2023, 1st of March 2023 and the 3rd of May 2023. The chair held several individual agency discussions with panel representatives, and authors to seek clarification on points within agency IMR's and review Key Lines of Enquiry.

5.8 Interviews Undertaken

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

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

6.1 Following the decision to conduct this DHR the partnership then did extensive enquiries with support agencies to seek to understand if anyone was supporting the family. Once it was established that no other support network was in place the partnership spoke directly with the mother of Ibukun. In line with her wishes she was contacted again within the coming weeks,

and she then allowed her information to be passed to the chair with email as the preferred initial method of contact. Contact was then continued via the chair who wrote to her mother (via email) and then had significant email contact and telephone calls. Ibukun's Mother wanted time to consider AAFDA and then decided to allow the chair to refer her to AAFDA. The chair had contact with AAFDA and then in line with mum's wishes, arranged a visit to speak in person with mum along with AAFDA. Dialogue continued via AAFDA, and meetings then turned to virtual at the request of mum.

6.2 The 2 siblings were not spoken to as part of this process. An offer was extended to them via AAFDA and mum however after a number of discussions via their mother they were not able to take part. Contact with the family is contained in Appendix 3. The panel were unable to identify anyone else that would be able to contribute to this review.

6.3 Despite proportionate enquiries Brian was unable to be located to offer him the opportunity to contribute. None of the statutory partners that formed the panel where aware of his current whereabouts. This was not a complete surprise as many young people in London are transient and this review was some time in its forming.

7. CONTRIBUTORS TO THE REVIEW

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

Agency	**Contribution**
Metropolitan Police	Chronology and IMR
GP	Chronology and IMR
Education University of East London (UEL)	Chronology and IMR
Barts Health NHS Trust (Newham Hospital)	Chronology and IMR
Victim Support	Chronology and IMR
East London Foundation Trust (ELFT)	Chronology and IMR
West Midlands Police	Scoping report

7.2 Quality and Independence of the IMR authors. The IMR's were prepared by authors who were independent of any service delivery or case management regarding Ibukun and Brian. The IMR's were comprehensive and allowed the panel to analyse the contact with Ibukun & Brian. The detail ensured that the panel were able to identify learning and recommendations for this

review and where necessary, follow-up meetings were held, and questions sent to agencies. Responses were received, prior to, or at, subsequent panel meetings.

8 Review Panel Members

Name	Role/Job Title	Agency
Simon Steel	Independent Chair and Author	Perse Perspective Consultancy Ltd
Sharmeen Narayan	Domestic Abuse and Sexual Violence Commissioner	Public Health Commissioning
Emma Tukmachi	Named GP Safeguarding lead	NHS North East London (NEL) Integrated Care Board (ICB)
Janice Cawley	Detective Sgt Specialist Crime Review Group	Metropolitan Police Service
Rachel Nicholas	Head of Domestic Abuse Services	Victim Support
Emma Crivellari	Named Safeguarding lead	East London NHS Foundation Trust (ELFT)
Ed Lander	Service Manager ELFT representing Mental Health Services	East London NHS Foundation Trust (ELFT)
Farida Butt	Service Manager Hestia	Hestia DA services Newham
Clare Hughes	Associate Director of Safeguarding BARTS Health NHS Trust (representing Newham Hospital)	BARTS Health NHS Trust
Daniel Wilson	Designated Professional Safeguarding Adults, Newham (CCG)	NHS North East London (NEL) Integrated Care Board (ICB)

Dawn Henry	Specialist Pathways Team Leader Newham (housing)	Newham CSP
Wendi Hatt	Adult Social Care Safeguarding	Newham CSP
Katie Burgess	Adult Social Care Safeguarding	Newham CSP
Jenni Bonner	Counselling Manager Black Women's project	London Black Women's project
Seb Florent	Detective Chief Inspector	Protecting Vulnerable People Metropolitan Police
Lydia Pell	Interim Dep Director of Student Services UEL	University of East London (UEL)
Nicole Redman	Director of Student Services and Safeguarding lead UEL	University of East London (UEL)
Adam Cockerton	Det Sgt – Force review Team	West Midlands Police

9 AUTHOR OF THE OVERVIEW REPORT

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

9.2 Since retirement, Simon has established his own consultancy business and has now chaired 4 Domestic Homicide Reviews. Simon has also lectured at 2 separate Universities on Domestic Homicides. Simon has been subcontracted by Foundry Risk Management who have a long history of chairing reviews.

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

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

9.5 Simon has no connection with Newham Community Safety Partnership.

10 Parallel Reviews

10.1 Inquest: The coronial hearing in this case was heard on the 3rd of March 2021 where HM Coroner ruled an Accidental Death.

11 Equality and Diversity

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

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

11.2 The panel reflected upon each of these in evaluating the various services provided to Ibukun. It is incumbent on this review to consider the duty on public authorities to; remove or reduce disadvantages suffered by people because of a protected characteristic, meet the needs of

people with protected characteristics, encourage people with protected characteristics to participate in public life and other activities[1].

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

11.4 The panel identifies that women and girls are disproportionally impacted by domestic abuse and forms of gender-based abuse, whilst also recognising that other genders also suffer similar issues of violence and abuse. Analysis reveals gendered victimization across both intimate partner and familial homicides with females representing most victims and males representing most perpetrators[2].

11.5 Ibukun was born in Nigeria in 1996. She was born into the Muslim faith and her religion formed a key part of her lifestyle. The panel also considered the immigration status of Ibukun. Whilst there was not a legal issue with her status, the very fact she had mentioned this as a barrier to disclosure is highly relevant.

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

11.7 DISABILITY: Ibukun had a diagnosis of Dyspraxia, Dyslexia and showed traits of ADHD. There is national commentary that shows disabled persons experience disproportionately higher levels of domestic abuse such as in 2015, a report by Public Health England 'Disability and Domestic Abuse' that summarised: '*Disabled people experience disproportionately higher rates of domestic abuse. They also experience domestic abuse for longer periods of time, and more severe and frequent abuse than non-disabled people. They may also experience domestic abuse in wider contexts and by greater numbers of significant others, including intimate partners, family members, personal care assistants and health care professionals. Disabled people also encounter differing dynamics of domestic abuse, which may include more severe coercion, control or abuse from carers.* [3] This same report continues, "*when domestic abuse does happen disabled people may be less likely to understand boundaries, recognise abuse, know their rights and how to report it".*

11.8 SEX & Gender: Ibukun was female, and Brian and her father were male. The gendered nature of domestic abuse is reflected in a number of reports and also by specialist organisations. An analysis of DHRs reveals gendered victimisation across both intimate partner and familial

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

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

[3] Microsoft Word - Disability and domestic abuse topic overview FINAL.docx (publishing.service.gov.uk)

homicides with females representing the majority of victims and males representing the majority of perpetrators. Women's aid reports, "There are important differences between male violence against women and female violence against men, namely the amount, severity and impact. Women experience higher rates of repeated victimisation and are much more likely to be seriously hurt (Walby & Towers, 2017; Walby & Allen, 2004)[1] or killed than male victims of domestic abuse (ONS, 2020A; ONS, 2020B)[2]."

11.9 RACE: In relation to prevalence of domestic abuse, Safelives in responding to the Race Report concluded, "there is clear evidence that Black and Asian women are disproportionately at risk of being killed by a domestic abuser[3]. This is supported in recent research "Identifying predictors of harm within Black, Asian, and other racially minoritised communities" that '*The proportions of Black, Asian and racially minoritised communities within the population is a statistically significant predictor of the domestic count and rate at the LSOA level along with other structural and community cohesion variables, suggesting that ethnicity matters*[4]'.

11.10 Women's Aid note, "Whatever their experiences, women from Black, Asian or minority ethnic communities are likely to face additional barriers to receiving the help that they need [5]." The same internet article directed at survivors suggests "It may be particularly hard for you to admit to having problems with your marriage, and you may experience additional pressure from your extended family to stay with your partner. You may even have been forced or persuaded into marrying him in the first place. If your marriage fails, it may be seen as your fault, and you may be blamed for damaging the family honour; and you may be afraid that, if you leave your husband, you will be treated as an outcast within your community." Two organisations that have websites with much learning and information are Imkaan and https://southallblacksisters.org.uk/ and the author encourages anyone who works in this field to consider further research.

11.11 RELIGION: Whilst race and religion are often together, there are areas of work that consider the implications of faith on survivors, such as the Faith & Communities Programme by Standing Together in London, that summarises some of the challenges confronting victims,

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

2 Domestic abuse is a gendered crime - Womens Aid

3 SafeLives' detailed response to the Race Report | Safelives

4 FINAL Predictors of Harm UOS report.pdf

5 Women from BME communities - Womens Aid

"Many survivors with a faith feel that some specialist services and society, in general, are unable to understand their experiences of abuse, and their barriers to accessing support due to their religious identity, their faith community and any spiritual abuse that they may experience at the hands of their perpetrator" [1].

11.12 This is supported by various studies, including 'A Qualitative Systematic Review of Published Work on Disclosure and Help seeking for Domestic Violence and Abuse among Women from Ethnic Minority Populations in the UK' that drew a number of relevant conclusions including: - community influences are significant barriers to disclosure; - the cultural community influenced the disclosure and help-seeking practices of women with lived experience of domestic violence and abuse. The implication of this is that, many women will seek help from within their immediate community, either through faith-based organisations or social groups[2].

11.13 One important part of research is the Super Complaint made by Liberty & the Southall Black sisters [3] in relation to immigration status pertaining to victims of modern slavery and domestic abuse. The Super-complaints provide a voice for designated bodies to raise concerns on behalf of the public about patterns or trends in policing that are, or appear to be, significantly harming the interests of the public. Liberty and Southall Black Sisters put forward this super complaint about the treatment of victims of crime and witnesses with insecure immigration status. It focuses on how information about them is passed to the Home Office for immigration enforcement. Of course, the very title "safe to share" is hugely significant and the author for this review considers that wording and says "did Ibukun feel it was safe to share"?

As set out in the legislation, super-complaints identify practices that are alleged to cause significant harm to the interests of the public. The specific harms they identify include:

- the 'weaponisation' of immigration status by perpetrators;
- victims/witnesses are too afraid to report crimes to the police;
- discrimination against Black, Asian and Minority Ethnic (BAME) migrants leading police to:
    - conduct immigration checks on BAME victims/witnesses; and
    - prioritise immigration enforcement when dealing with BAME victims/witnesses;

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[1] Faith & Communities Programme — Standing Together

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

[3] Safe to share? Liberty and Southall Black Sisters' super-complaint on policing and immigration status - HMICFRS (justiceinspectorates.gov.uk)

• the criminalisation of victims/witnesses;

• an adverse effect on other proceedings or potential avenues of recourse being contemplated by victims, caused by police failures to deal appropriately with domestic abuse;

• police participation in formal and informal multi-agency discussions leading to a prioritisation of immigration enforcement across state agencies;

• members of the general public are exposed to the risk of becoming future victims of perpetrators who have not been dealt with by police; and

• the prioritisation of immigration enforcement generates a culture of impunity for perpetrators who are not brought to justice.

11.14 It is against the background of concerns raised in such reports, that the review will consider the circumstances of Ibukun's death.

12. DISSEMINATION

12.1 Once finalised by the Review panel the Executive Summary and Overview Report will be presented to the following CSP panel members for approval. Upon approval they will be sent to the Home Office for Quality Assurance.

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

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

Agency
Newham CSP
Newham Safeguarding Adults board
Newham Health and Well being board
Newham CSP DHR Recommendations Working Group
Newham Children's Safeguarding Board
The Office of the Mayor of London

The Domestic Abuse Commissioner
The Family
All Panel Members

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

13 Background Information (The Facts)

13.1 At the time of her death Ibukun was a 24-year-old woman who had multiple health challenges. She was born in Nigeria and came to England at the age of 9.

The Death

13.2 On a morning in October 2020 Ibukun was found by Metropolitan Police officers during a search for her as a high-risk missing person in Stratford Park, London. The London Ambulance Service (LAS) and the Helicopter Emergency Medical Service (HEMS) attended the scene and attempted to administer first aid. Ibukun's life was pronounced extinct at the scene.

13.3 The investigation was very quickly concluded, and the Police passed the case to HM Coroner. The coroners hearing into her death has already concluded on 3 March 2021 where accidental death was recorded with a cause of death as suspension.

14 Combined Narrative Chronology

14.1 The following section summarises contact between Ibukun and various agencies. To assist the reader, the table below summarises the names of the organisations and their role in this case. The paragraphs within the narrative chronology are pre-faced with the lead agency to identify the primary source of information and assist the reader.

Organisation	Role	Pre-Face
Metropolitan Police	Police	MPS

Victim Support	Victim Service	VS
GP	Primary Care GP	GP
Barts	Hospital	BARTS
ELFT	Hospital	ELFT
London Ambulance Service	Ambulance	LAS
University of East London	Education	UEL
West Midlands Police	Police	WMP

14.2 JANUARY 2017

14.2.1 **GP.** On the 13th Ibukun had a hospital appointment.

14.3 APRIL 2017

14.3.1 **MPS.** On the 2nd Ibukun attended Hounslow Police Station to report she had been raped twice by the same suspect at an address in Enfield. She was supported by a SOIT officer, and an appointment was made for her to attend the Haven (specialist sexual assault referral centre).

14.4 JUNE 2017

14.4.1 **GP.** On the 12th Letter from the independent sexual violence advisor. Accessing support following serious sexual assault.

14.4.2 **GP.** On the 15th Ibukun was seen and treated for a viral infection.

14.5 JULY 2017 – SEPTEMBER 2017

14.5.1 **GP.** 5 encounters for regarding vaginal / abdominal symptoms

14.6 OCTOBER 2017 – APRIL 2018

14.6.1 **GP.** Between this time Ibukun had contact with her GP on 13 separate occasions for routine matters, low mood and matters relating to ovarian pain and vaginal matters.

14.7 MAY 2018

14.7.1 **GP.** On the 14th Ibukun seen by GP and A&E for serious mental health concerns.

14.7.2 **GP.** On the 16th Ibukun seen in A&E with syncope.

14.7.3 **GP.** On the 21st Ibukun see's her GP about medication side effects.

14.8 JUNE 2018

14.8.1 **GP.** On the 4th Ibukun was seen Face-to-face by GP for a review of her mental health.

14.8.2 **GP.** On the 5th Ibukun's form for student disability completed and handed to reception.

14.9 JULY2018

14.9.1 **GP.** On the 1st Ibukun seen for a hospital appointment.

14.9.2 **GP.** On the 5th Telephone encounter for a review of her mental health.

14.10 SEPTEMBER 2018

14.10.1 **GP.** On the 19th Ibukun registered as a new patient at Hanley primary care centre.

14.11 OCTOBER 2018

14.11.1 **GP.** On the 10th Ibukun would like a referral to secondary acre and was treated for a chest infection.

14.11.2 **GP.** On the 26th Ibukun reports concerns with her mental health. Requesting a mental health assessment.

14.12 NOVEMBER 2018-DECEMBER 2018

14.12.1 **GP.** In this time 5 routine encounters.

14.13 JANUARY 2019

14.13.1 **GP.** On the 31ST Ibukun was assessed by a psychological wellbeing practitioner at iCope. Due to the service policy they are unable to offer her psychological support as she is heavily engaging with alcohol.

14.14 FEBRUARY 2019

14.14.1 **GP.** On the 14th Ibukun has an infection and is given antibiotics

14.14.2 **GP.** On the 26th was seen for a review of her mental health, the GP contacted the hospital for advice,

14.15 MARCH 2019

14.15.1 **GP.** On the 4th Correspondence from iCope. The impression is the central current concern is the alcohol use. This will be adversely affecting her psychologically and physically.

14.15.2 **GP.** On the 14th Ibukun has suspected infection and was prescribed antibiotics

14.16 APRIL 2019

14.16.1 **GP.** 2 encounters regarding gynaecological matters.

14.17 JUNE 2019

14.17.1 **UEL.** On the 29th Ibukun applied to UEL to attend Undergraduate course. In application discloses disability and MH conditions, range of medical evidence is provided.

14.18 JULY 2019

14.18.1 **MPS.** On the 13th Ibukun reports theft of her mobile phone from her bag whilst in a club in Hackney. Crime recorded but no suspects identified.

14.18.2 **GP.** On the 22nd Ibukun attends regarding vaginal / abdominal symptoms

14.18.3 **GP.** On the 26th Ibukun would like a letter for university from when she attended the surgery with regards to her sexual assault. Charged a £30 fee for the letter.

14.19 AUGUST 2019

14.19.1 **WMP.** On the 19TH Ibukun reported to WMP that she had been sexually assaulted the night before.

14.20 SEPTEMBER 2019

14.20.1 **GP.** On the 11th Ibukun reports symptoms which she was reassured for.

14.21 NOVEMBER 2019

14.21.1 **GP.** On the 19th Ibukun seen with a skin infection which was treated.

14.21.2 **UEL.** On the 21st Ibukun emailed and phoned by disability team to offer support. To put in place reasonable adjustments.

14.22 DECEMBER 2019

14.22.1 **GP.** On the 6th Ibukun is seen in the surgery for a review of her mental health.

14.22.2 **UEL.** On the 9th Ibukun had a disability team appointment. All adjustments put in place, Emailed confirming summary of agreed support, and signposting to additional support such as wellbeing team.

14.22.3 **GP.** On the 9th Ibukun has a headache and received appropriate advice.

14.23 JANUARY 2020

14.23.1 **MPS.** On the 5th Ibukun contacted MPS to report she was being harassed by a male she met on Tinder in November 2019. She said she went to his address where she stayed the night then left his address in the morning.

14.24 FEBRUARY 2020

14.24.1 **GP.** On the 3rd Ibukun reports gynaecological symptoms. Booked for face-to-face appointment the next day. Does not attend this appointment.

14.24.2 **UEL.** On the 12th Ibukun emailed advising on changes to her needs assessment, including additional support (mentoring and study skills).

14.25 MARCH 2020

14.25.1 **GP.** On the 11th there was a falied encounter. A message left on answer machine. Invitation to online consultation doctor IQ.

14.26 MAY 2020

14.26.1 **GP.** On the 2nd Ibukun had an online consultation about gynaecological symptoms.

14.26.2 **GP.** On the 4th Ibukun reported an improvement in her gynaecological symptoms and a review of her mental health is conducted.

14.26.3 **GP.** On the 12th Ibukun sees psychiatry privately and a diagnosis is made with suggestions on altering medication and patient literature advised.

14.26.4 **NEL.** On the 24th Ibukun contacts NEL who reports she needs assistance in contacting a specialist clinic.

14.26.5 **GP.** On the 28th GP contact her with regards to her blood tests.

14.27 JUNE 2020

14.27.1 **GP.** On the 2nd Ibukun is seen in for a mental health review following her diagnosis from the private clinic

14.27.2 **GP.** On the 15th Ibukun was seen at A&E for an allergic reaction and also for a specialist hospital appointment.

14.28 JULY 2020

14.28.1 **GP.** 3 routine encounters.

14.28.2 **GP.** On the 29th Ibukun had a telephone encounter for a mental health review after being distressed after receiving a letter regarding her assault in 2017.

14.29 AUGUST 2020

14.29.1 **GP.** 4 routine encounters.

14.29.2 **GP.** On the 26th Ibukun has ttelephone consultation for foot pain and requesting further assessment for ADHD

14.29.3 **GP.** On the 27th Ibukun is referred for an ADHD assessment, an email from the service stating that a face-to-face review and continuity of care should be the next steps. She has been referred to another programme after her recent diagnosis and would be best to engage with this first.

14.29.4 **NEL.** On the 31st Ibukun contacts NEL (non-emergency line) reported having whooshing sounds in her ear. Following the telephone assessment Ibukun was advised to contact a primary care service within 12 hours.

14.30 SEPTEMBER 2020

14.30.1 **GP.** Has 5 routine encounters and gynaecological / abdominal symptoms.

14.31 OCTOBER 2020

14.31.1 **GP.** On the 2nd, Ibukun reports gynaecological symptoms and abdominal pain.

14.31.2 **MPS.** On the 12th Ibukun called MPS to report she'd had her mobile phone snatched from her as she walked along Ropery Street in Tower Hamlets. She reported chasing after the suspect but lost sight of him. She believed the phone may have been pawned as she attempted to trace it using a phone finder app. Crime was recorded by the Telephone Investigation Unit and screened in for further investigation. The investigating officer conducted a CCTV trawl but did not gain any evidence of the offence. Suspect was not identified, and the phone could not be traced.

14.31.3 **LAS.** On the 14th an ambulance was requested by an unknown person to attend Ibukun. It was reported that the caller thought Ibukun may have "attempted or committed suicide" as they had not heard from her since the previous day. A history of personality disorder was also provided. Caller also commented that Ibukun had her phone stolen the previous day so did not have a phone for a ring back. The call was triaged for a ring back to the caller for a more enhanced assessment.

14.31.4 Further information was gained; caller was Ibukun's ex-boyfriend. Ibukun had reported to him that she was going to kill herself and he could no longer contact her. He was unaware of her location but felt she might be at her home address. Ibukun was reported to be high risk and had attempted to run in front of traffic the previous day, he had stayed with her overnight and then left. The outcome of the call was that an ambulance would attend.

14.31.5 On their arrival the ambulance staff have documented that they were let in by a roommate of Ibukun's. Ibukun was upstairs alert and orientated. Ibukun had a possible dislocated finger, she reported being with her ex-partner the previous day and got into a fight which turned physical, and her partner twisted Ibukun's thumb in a dangerous manner. Ibukun wanted to get away and ran into traffic, her intent was to kill herself as she felt this was the only way to get away. A restraining order had been applied for this day and Ibukun was no longer feeling suicidal. Following the ambulance staff's assessment Ibukun was conveyed to Newham Hospital where a handover of care was provided to the hospital staff.

14.31.6 **BARTS.** On the 14th Ibukun attended ED complaining of pain in her thumbs and wrist. She alleged that her ex-partner and her had an argument in the street the night before and he pulled her thumbs back there was evidence of swelling and bruising seen. She also stated she ran into traffic as she wanted to kill herself to get away from her ex-partner, she was not hit by any vehicles at this time.

14.31.7 **ELFT.** On the 14th Ibukun attended the local Emergency Department at Newham University Hospital after a fight with her ex-boyfriend, she sustained injuries to her thumbs, bruising to her knees and pain in her nasal bones and epistaxis. She reported suicidal ideation and a suicide attempt two days previously. No fractures, but soft tissue injuries. She was referred to the Psychiatric Liaison Mental Health Team and assessed by SA, PLN. Upon assessment, Ibukun denied any present suicidal ideation, plan or intent. Reports she is future orientated and has protective factors. No psychotic symptoms evident or mood disorder. Plan made to discharge to the community and Ibukun to access the crisis line if needed, she declined any other community mental health follow up. Case and plan discussed with the duty doctor. Notification sent to Ibukun's GP.

14.31.8 **GP.** On the 14th Ibukun has 1st online consultation stating that she has been a victim of domestic abuse. The GP practice tried to contact her 3 times and again the following day. The case was added to the clinical meeting for discussion.

14.31.9 **MPS.** On the 19TH Ibukun made an allegation to MPS that Brian had assaulted her and damaged her property during an incident which took place on the 14th of October 2020.

14.31.10 **GP.** On the 20th Ibukun was spoken to by doctor at the surgery in response to her reporting domestic abuse and related injuries. She was signposted to domestic abuse services; her mental health was reviewed and she was given analgesia.

14.31.11 **UEL.** On the 20th Ibukun has an appointment with wellbeing practitioner, and email sent to Ibukun with summary of appointment.

14.31.12 **BARTS.** On the 21st Ibukun had an online consultation regarding a follow up on her injury.

14.31.13 **GP.** On the 21st there was an online consult. Ibukun contacted the surgery wondering whether she had an alternative mental health diagnosis. The surgery responded the same day signposting her to Icope.

14.31.14 **MPS.** In this month Brian called the MPS to report he had just spoken to his ex-girlfriend, Ibukun, who said she had a heavy rope and intended to kill herself. He had gone to her home address and had spoken to her landlord who said she had left the address approximately 40 minutes earlier. Brian spoke to Ibukun again and she repeated that she was going to take her own life. Ibukun's disappearance was assessed as High Risk and extensive searches were conducted within the borough of Newham. MPS then discovered Ibukun hanging from a climbing frame. She was cut down and CPR commenced. London Ambulance Service (LAS) and the Helicopter Emergency Medical Service (HEMS) attended the scene and continued administering first aid. Despite medical intervention, Ibukun's life was pronounced extinct by a HEMS doctor.

14.31.15 **LAS.** An ambulance was requested by the MPS to attend Densham Road, E15. It was reported that a female had been found hanging. We now know this female to be Ibukun On their arrival the ambulance staff have documented that Ibukun was lying under a climbing frame, there

was a pool of vomit beside her head, the MPS were performing Cardiopulmonary Resuscitation (CPR). An Electrocardiogram (ECG) indicated that Ibukun's heart rhythm was in asystole (no electrical activity present). CPR was ceased and recognition of life extinct was recorded at 01:42. It is further documented that Ibukun had been missing since 21:30 and was found hanging from the climbing frame. The MPS had cut her down and started CPR. A mostly empty bottle of wine had been found on top of the climbing frame. Ibukun was left on scene in care of the MPS.

14.31.16 **UEL.** On the 27th Ibukun did not attend booked appointment with Wellbeing team and also an Email offering a place on CBT workshop. By this stage unknown to UEL Ibukun had died.

14.32 NOVEMBER 2020

14.32.1 **VS.** On the 4th 2 attempts at phone contact following MPS referral. Email to MPS explaining they had been unsuccessful in making contact.

15. OVERVIEWS

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

15.1 METROPOLITAN POLICE (MPS)

15.1.1 Ibukun and Brian had limited contact with the MPS as individuals and only one interaction with them in relation to domestic abuse. This is in relation to the incident which was reported on 19/10/2020. Ibukun made an allegation to MPS that Brian had assaulted her and damaged her property. This incident was alleged to have taken place on 14/10/2020 at around 0300 hours. (This incident is referred to as both the incident on 13/10 and 14/10/20 due to it happening overnight of the 13th and 14th of October 2020)

15.1.2 The next contact with the MPS was on 22/10/20 when Brian called with his concerns re Ibukun and a subsequent High Risk Missing person investigation was commenced.

15.1.3 Of note is that on the 2/04/2017 Ibukun attended Hounslow Police Station. Ibukun stated she met a male at a club and agreed to go home with him. They were accompanied by two other males and a female at that time. She stated that whilst at the address she was raped by another one of those males. She told MPS she was quite drunk and could not recall exactly where the address was. The subsequent investigation resulted in no further action.

15.1.4 In regard to the incident on 05/01/2020 Ibukun contacted MPS to report she was being harassed by a male that she had met through the dating app, Tinder, in November 2019. She said she went to his address, and she stayed the night, then left his address in the morning. Ibukun reported that the male called and texted repeatedly following that meeting, but she had ignored his attempts at contact. She said that the male concerned had not threatened

her and she did not want him to be arrested. Ibukun said she did not want to support a prosecution but wished MPS to tell him not to contact her again.

15.2 VICTIM SUPPORT

15.2.1 Contact with Victim Support is limited and in effect the only referral is made on 22/10/20 in relation to the incident on the 14/10/20. The case was allocated to the multi-crime service for Standard-Medium risk cases for telephone contact. This was in line with the London Victim and Witness service contact methodology in relation to Domestic Abuse in 2020.

15.3 INTEGRATED CARE BOARD – GP SURGERY

15.3.1 There was numerous interactions with the GP Surgery. Ibukun suffered from borderline personality disorder and anxiety with depression, with a history of deliberate drug overdose, intentional self-harm, sexual assault, and domestic violence. Ibukun said that as a child she had experienced significant trauma. Her first suicide attempt was at a very young age and on discovery of this she reported that her father 'beat the shit out of her'. She was estranged from both of her parents who she reported to be abusive. (This must be put into context. There is no evidence seen by this review that her mother was abusive, and the panel are conscious at times this language can be used and encapsulate a wide range of parent/child disagreements). She had very little support and significant mental health concerns.

15.3.2 For someone of her age her primary record is extensive. She contacted her GPs on multiple occasions every month, sometimes twice in the same day. Nearer the end of her life, she made online consultations, but GPs were not able to get through to her to discuss her concerns on her phone. This painted a picture of a young woman in crisis and chaos. She died during the covid pandemic when most patients were being seen virtually. Leading up to her death she was under the care of a number of services including the local mental health team and had been offered Dialectical Behaviour Therapy (DBT) sessions for her emotionally unstable personality disorder. The vast majority of her calls (18 in total) were regarding vaginal / abdominal symptoms. She was fully investigated and seen by the sexual health team, with multiple sets of swabs.

15.4 INTEGRATED CARE BOARD – BARTS

15.4.1 Ibukun attended the Emergency Department (ED) based at Newham University Hospital (NUH) on 14th October 2020 (during the COVID pandemic) complaining of pain in her thumbs and wrist. She alleged that she'd had an argument with her ex-partner in the street the night before and he pulled her thumbs back. Evidence of swelling and bruising was seen. She also stated

she ran into traffic as she wanted to kill herself to get away from her ex-partner, she was not hit by any vehicles at this time. There was then a video outpatient appointment with the hand clinic on 21st October 2020 which was attended.

15.5 ELFT

15.5.1 On 14/10/2020 Ibukun was assessed by ELFT Psychiatric Liaison Service at Newham General Hospital. Prior contact with mental health services had happened with Camden and Islington Mental Health Trust. A clinical handover from Campden & Islington was received by the Psychiatric liaison team to inform the clinical and risk assessment that was undertaken.

15.5.2 The documentation from contact with Psychiatric Liaison Services indicates that during the assessment there was a disclosure around incidents of domestic abuse with her ex-partner the previous day. Experiences from this relationship during the last period of her life had impacted on her wellbeing to the extent that she felt suicidal and had acted upon this distress by attempting to take her own life.

15.6 UNIVERSITY OF EAST LONDON (UEL)

15.6.1 At the time of her death Ibukun was an undergraduate student studying for a degree at the University of East London (UEL). She was in year two of a three-year undergraduate degree course at the time of death. The University was informed of the death on 12 May 2021 in response to proactive enquiries on their part.

15.6.2 Ibukun was a registered disabled student. She engaged with Student Services to access Disabled Students Allowance (DSA) support in November 2019, during her first term at UEL. Her disabilities related to dyspraxia, depression, and anxiety. Reasonable adjustments were made based on these disabilities and related recommendations from the assessor.

15.6.3 On 19 October 2020 Ibukun self-referred by email to the wellbeing service again. A Wellbeing Practitioner telephoned her the same day arranging an appointment the following day, 20 October 2020. At the appointment Ibukun met with an experienced Wellbeing Practitioner. She cited a range of complex issues, including self-harm and suicidal feelings. She refers to the incident on the 14/10/20 which she had reported to the MPS. The Wellbeing Practitioner conducted a suicide risk assessment at the meeting on 20 October 2020. The Wellbeing Practitioner specifically noted that the Ibukun was future oriented. A further appointment was booked for the 27/10/22.

15.7 WEST MIDLANDS MPS (WMP)

15.7.1 Ibukun contacted WMP on the 19/08/19 via webchat to report she was sexually assaulted the day before. She stated that she had been to a house party and met a male with whom she left the party, going with him to the address he was staying at. When she woke up, she could not wake the male, who was supposed to give her a lift home.

15.7.2 She then went into the offender's bedroom and asked if he would arrange a lift for her. The offender spoke to another male when she walked in, stating that he would have her. The other male left the room, and the offender then sexually assaulted her.

16. ANALYSIS

HINDSIGHT BIAS

16.1 As the report author, the chair has attempted to view this case, and its circumstances as it would have been seen by the individuals at the time. It would be foolhardy not to recognise that a review of this type will undoubtedly lend itself to the application of hindsight. Hindsight always highlights what might have been done differently and this potential bias or 'counsel of perfection' must be guarded against. There is a further danger of 'outcome bias' and evaluating the quality of a decision when its outcome is already known. However, I have made every effort to avoid such an approach wherever possible.

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

16.3 DOMESTIC ABUSE

Pattern of Abuse

16.3.1 Considering the government definition of domestic violence and abuse, which describes a pattern of incidents of controlling, coercive or threatening behaviour, the Review Panel was able to determine there was a history of reported Domestic Abuse. This conclusion is based on all the information provided however in particular the information provided by the Metropolitan MPS and the GP. The review panel notes the abuse that started at a very young age, the disclosure made in relation to attempting to take her own life at a very young age shows the trauma that Ibukun must have been feeling.

AGENCY INVOLVEMENT

In the period October 2017 to October 2020 there were numerous agencies involved with Ibukun. The most regular contact was with the GP practice.

16.4 METROPOLITAN MPS

16.4.1 The one interaction that Ibukun and Brian had with the MPS in relation to Domestic Abuse is the incident which was reported on 19/10/2020. Ibukun made an allegation to MPS that Brian had assaulted her and damaged her property. This incident was alleged to have taken

place on 14/10/2020 at around 0300 hours. (This incident is referred to as both the incident on 13/10 and 14/10/20 due to it happening overnight of the 13th and 14th of October 2020)

16.4.2 Ibukun said she returned home alone after a night out with her friends. Shortly after entering she heard a knock at her bedroom door and when she opened it, she saw Brian who had turned up uninvited. She was surprised to see him as they had split up and she had blocked his number. She allowed Brian to come into her room so they could talk and to see if they could settle their differences. She said she did not believe Brian had been honest in the relationship and so asked to see his phone as she believed he had been speaking to other women. He allowed her to do this, and this confirmed her suspicions.

16.4.3 Ibukun stated this resulted in a "heated verbal argument" so she asked Brian to leave but he refused. She said that she grabbed his bag and threw it out of the window. She stated he grabbed her laptop in retaliation and threw it out of the window. She told the officers that the argument escalated, stating that she tried to push and kick Brian out of the property. Ibukun said that Brian threw her onto the bed and tried to choke her. She said she feared for her life so tried to punch and kick her way out of his grasp, and that in the disturbance she pulled out a number of his "*dreadlocks*". She said he got off the bed, apologised and left her address.

16.4.4 A DASH risk assessment was completed with Ibukun. Of note in her responses, she said Brian was controlling, jealous and she was afraid of what he might do to her. The risk was assessed as Medium. *Comment: It's the view of the panel this was the correct risk assessment.*

16.4.5 MPS arrested Brian on 20/10/2020 and interviewed him regarding the allegation. The investigating officer (IO) contacted Ibukun prior to the interview to confirm the information she had provided to the reporting officer. Ibukun stated they had been in an on/off relationship for around a year. She told the IO that after the incident an ambulance had been called by a "*concerned party*" suggesting that she may be suicidal, and she believed this was Brian. She said she had gone to the hospital but would not elaborate on the outcome. She also said that Brian had footage on his phone and that they had threatened each other with restraining orders. She declined any further assistance from support agencies but said she had self-referred to the National Centre for Domestic Violence (NCDV) in order to seek a Non-Molestation Order (NMO).

16.4.6 In interview, Brian stated that he and Ibukun had gone to stay at an Airbnb rental over the period of 12-13/10/2020. He said Ibukun left the premises when they were having a conversation about their relationship. Brian followed her and stopped her when she tried to walk into oncoming traffic. He decided to take her home as he was aware she suffered with mental health issues. He said he watched over her until they fell asleep. He knew she had planned to meet with a friend on the evening of 13/10/2020 so he left his bag containing his clothes in her room and went home.

16.4.7 Brian said he returned to her address at approximately 23.30 hours, called her and she let him in. He said the atmosphere between them wasn't good as she had his phone earlier and seen that he had received messages from other girls and had responded to them. He said Ibukun demanded to look at his phone again and said that as he lay on the bed she kicked and punched him to "*vent her anger*". He claimed he did not retaliate as he felt he deserved it. He said she became increasingly angry and pulled at his hair ripping some braids out. When he told her he was leaving he said she became increasingly angry. He described that she went to pick up his bag and tried to throw it out of the window. He said he tried to grab the bag but as Ibukun went to throw it, the bag caught the laptop which was on the windowsill and Ibukun's items fell out of the window into the garden below.

16.4.8 Brian denied putting any hands on her other than grabbing at her hands to stop her ripping his braids out. He also denied deliberately throwing her laptop out of the window. He said he left and later tried to recover the bag and laptop but could not gain access to the garden. Ibukun told him it would be £1,000 to replace the laptop. Brian said that he transferred £1200 to her later in the day.

16.4.9 Brian said that they met up a few days later and spent 17-19/10/2020 in a hotel. He said that they again discussed their relationship and Ibukun stated that she felt that he kept "*seducing*" her into the relationship only to end it again and so to stop this she was going to get a restraining order against him. He told her he couldn't understand why, and she said he had to be charged by MPS for an offence in order for her to get this. Brian said in response that he had the phone footage and would use this. Ibukun asked him not to tell anyone they had met up and he felt they parted on good terms.

16.4.10 The evidence was reviewed by an Evidential Review Officer (ERO) and it was noted there were no independent witness accounts and undermining video footage of Ibukun assaulting Brian on that occasion. Brian was released from custody and the matter was closed with no further action taken because it was unlikely there was a realistic prospect of conviction. The IO contacted Ibukun and explained the outcome and that due to evidential difficulties this would not have met the Crown Prosecution Service (CPS) threshold for charge. The IO advised Ibukun to pursue an NCDV supported application for an NMO and asked if she wished to change her mind about a referral to domestic abuse support services. The IO told her that should she change her mind that she could contact them and stressed that she should report any further concerns or incidents. *Comment: although Ibukun stated she did not wish to be referred to victim support a mistake was made and the referral was made the next day on 21/10/20.*

16.4.11 Comment: *Brian made reference to Ibukun expressing suicidal thoughts and having mental health issues in his interview. The IO offered Ibukun referrals to support services but did not record if they discussed if she required any support with her mental health. It is acknowledged that on 19/10/2020 a supervisor attempted to discuss Ibukun's self-reported*

attendance at hospital following the incident on 13/10/2020 but she declined to provide any further information.

16.4.12 Ibukun made contact with the IO on 21/10/2020 by text to ask advice, stating that Brian had contacted her asking for compensation for damage caused to his Nintendo Switch games console. Ibukun wanted to know if she should pay and also wanted to know if injuries she sustained were taken into account when making the decision to close the case. The IO reported that they could not advise her regarding seeking proof of damage to his property and any compensation but stated that all evidence was considered when making the decision to close the case. Ibukun replied to thank the officer for their response and the investigation was closed. It is noted that consideration was given to whether the case met the threshold for referral to the Multi Agency Risk Assessment Conference (MARAC) but it was decided it did not.

16.4.13 **Comment:** *There was no reference to any other household residents being spoken to during the investigation of this offence despite Ibukun stating that she shared the premises with two other people. Ibukun also made reference to Brian exhibiting controlling behaviour in answer to the DASH RIC questions. How this behaviour manifested was not explored in the statement she provided. The IO noted that there was no previous history of domestic abuse however does not appear to have explored whether additional information could be gathered to consider if there was evidence of coercive and controlling behaviour in the relationship.*

16.4.14 The next contact with the MPS was on 22/10/20 when Brian called with his concerns re Ibukun. It is the view of the panel that MPS response to the concerns re Ibukun and subsequent search was proportionate and effective. However, as a result of the subsequent investigation into Ibukun's death additional information was received from the landlord in relation to the incident on 13/10/22.

16.4.15 The landlord reported that he recalled a disturbance on 13/10/2020 when he was making his way to the bathroom and saw Brian trying to get into Ibukun's room. As he left the bathroom Brian apologised to him and he saw Ibukun pulling Brian's hair and trying to slap him. He asked what was going on and told them that their behaviour would not help sort out their issue. He recalled watching Brian walk out of the address and then recalled Ibukun walking around for a short time before leaving the house. He looked out of the window and saw Brian and Ibukun run out into the road arguing in the street. He said they were not being physical with one another at that point.

16.4.16 *Comment: The information provided by the landlord is concerning. This is evidence that should have been collected in relation to the DA incident on 13/10/22. Whilst the information in this case potentially contradicts Ibukun's account it was an enquiry (other people that live at an address) that should have been carried out at the time and the panel have sought reassurance from the Metropolitan MPS that this was indeed an individual error as opposed to organisational culture. The panel sought reassurance from the MPS regarding*

standards of investigation and were assured that house to house enquiries, other residents in properties, formed part of their routine enquiries.

16.4.17 On 02/04/2017 Ibukun attended Hounslow MPS Station. She alleged she had been raped twice by the same suspect. Ibukun stated she met a male at a club and agreed to go home with him. They were accompanied by two other males and a female at that time. She told MPS she was quite drunk and could not recall exactly where the address was. During that evening Ibukun stated that she was raped at that address.

16.4.18 Ibukun was supported by a Sexual Offences Investigation Team (SOIT) officer and an appointment was made for her to attend the Haven (a specialist sexual assault referral centre). The investigation resulted in no further action following scene identification, suspects being arrested and interviewed. She confirmed she was being supported by an Independent Sexual Violence Advisor (ISVA) and no further action was taken. Ibukun was not resident in London at that time and provided a home address in Sheffield.

16.4.19 On 05/01/2020 Ibukun contacted MPS to report she was being harassed by a male that she had met through the dating app, Tinder, in November 2019. She had met up with him and stayed with him on one occasion. Ibukun reported that the male called and texted repeatedly following that meeting, but she had ignored his attempts at contact. She said that the male concerned had not threatened her and she did not want him to be arrested. Ibukun said she did not want to support a prosecution but wished MPS to tell him not to contact her again. The crime report noted that Ibukun gave officers the contact details and address for the male. A DASH RIC was completed with Ibukun, and the risk graded as Standard. This report was subsequently filed no further action after attempts to identify the male had not succeeded and discussions with Ibukun.

16.4.20 It does not appear that officers had cause to make enquiries into Ibukun's immigration status. A referral to support services was offered to her twice during the investigation into allegations she made of domestic abuse however she declined. *Comment: The author cannot comment on whether Ibukun's immigration status impacted on her decision but there is no evidence the MPS treated her differently or indeed were aware of her status.*

16.4.21 *Comment: The panel find that on analysis, the interactions with the Metropolitan MPS were thorough and proportionate. Whilst it's acknowledged that the landlord should have been spoken to in this case at the point of the DA disclosure, that would have undermined Ibukun's account, and the panel are satisfied this was an individual error as oppose to organisational. It is acknowledged that Ibukun was referred to victim support incorrectly and the panel acknowledge again this was an individual error made on an electronic system.*

16.4.22 The Metropolitan MPS have a very clear Domestic Abuse policy. It also the only agency who reference immigration status as a barrier pages 40 & 41 of the policy dated Nov 2022. Whilst it is very clear there is no evidence to suggest any officer dealing with Ibukun checked her status or treated her differently the panel feels the policy needs to be clearer. Whilst

acknowledging the complexity of policies and the information they need to contain the panel believe it could be clearer.

Recommendation (LR1) – MPS need to update their DA policy to make it absolutely clear that DA offences are a priority over any potential immigration offences.

Recommendation (LR2) – MPS need to ensure officers understand the importance of mistakes made when referring to support services and potential consequences.

16.5 VICTIM SUPPORT

16.5.1 The only contact that Victim Support had, was in relation to the MPS referral on the 22/10/20 timed (00.31). (Noting the previous commentary that the referral was a mistake by the MPS, however analysing in any event is important). It took until 4/11/20 before any attempt was made to contact Ibukun. On that day 2 attempts at phone contact were made. MPS were then made aware that they had been unsuccessful in contacting Ibukun. A delay of 13 days was identified in attempting to contact Ibukun. *Comment: Given that Victim Support received the referral automatically by the MPS on 22/10/2020 and Ibukun died the following day on 23/10/2020 it is unlikely (though very much not impossible) in this case that they would not have been able to contact her as she had already sadly died. However, no one can say had the contact been almost immediate whether that interaction could have had a positive impact that could have assisted Ibukun.*

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

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

Exclusions of the LVWS are non-crime Anti-social behaviour, Sexual Violence outside of a Domestic Abuse setting, due to other services being commissioned to provide these in London The LVWS operates in a pan London way to flex to the varying demand from across the whole of London. This is in place to help mitigate the reasons for the delay in contact. from referral,

the contract requires the service to make contact within 72 hours of referral receipt with financial penalties in place should they fail to do this.

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

- Crime Type: Inflicting GBH, domestic Rape, Attempted Murder, Threats to kill, Stalking, Endangering Life, Arson endangering life, Wounding or carrying out an act to endanger life, malicious wounding: wounding or inflicting GBH, Assault with intent to cause serious harm will be assigned to the Independent Domestic Violence Advocate (IDVA) section of the LVWS by the case management system.
- All other crime types will be assigned by the case management system into the Independent Victim Advocate (IVA) section that triages all cases and conducts the risk and needs assessment.

16.5.3 This case was allocated by a manger on the 23/10/20 (08:12) in the multi-crime section of the LVWS and was to an Independent Victims Advocate for initial contact and risk and needs assessment. For context it is helpful to understand the demands on the service. The LVWS received 491 crime referrals on 22/10/20 of which 103 were DA referrals and a further 462 crime referrals on 23/10/20, 87 of those referrals were flagged DA. Due to the specific contact methodology in relation to DA flagged referrals in 2020, DA flagged cases are prioritised for telephone contact over all other crime types. The mangers within the IVA section of the LVWS check the current availability and case load of all IVAs before allocation. The allocation of this case was in line with London Victim & Witness Service contract requirements.

16.5.4 On the 04/11/202 the IVA makes 2 attempts at phone contact on the number provided on the MPS referral. As per policy, following unsuccessful contact an email is sent that same day to the MPS explaining Victim Support had been unsuccessful in making contact. *Comment It is evident that this contact was not in line with VS operating procedures or the LVWS contractual obligations for the timeframes of initial contact with victims of domestic abuse, as the initial call was recorded as being attempted 11 working days after the referral was received via the ADT process.*

16.5.5 The timeframe between the referral entering Victim Support and the case being allocated, effectively within 24 hours (given the referral came in overnight), would remain the same today given the contractual requirements to allocate within 24 hours. Once allocated to the IVA however the delay in making the first attempts at contact with Ibukun 13 days after the referral into Victim Support, highlights procedures not being followed.

16.5.6 As previously noted, the LVWS is a high-volume service seeing many thousands of referrals per month, and operating during, and managing the issues around the pandemic lockdowns

had meant that there have been real challenges for the service to surmount. The IVA side of the LVWS has been significantly impacted by staffing attrition over the past 18 months. Which in turn would have an impact on caseloads and capacity of individual IVAs. Since the end of covid restrictions, Victim Support has implemented a hybrid way of working, has revised, and improved the IVA salary which has improved staff retention.

16.5.7 The LVWS changed its DA contact methodology for non-high risk DA cases in October 2021, so that initial contact was pre-empted by a text message (where mobile telephone was indicated) that was automated by the case management system. Had this been the case in October 2020, Ibukun would have received this text message on 22/10/2020, however the first telephone contact attempt would in all likelihood have not taken place until after the 23/10/2020.

16.5.8 Partners are made aware when IDVA's reach capacity and/or when Victim Support is operating a waiting list for the advocacy casework within the IVA section of the service. There is no way to prevent referrals via ADT from the MPS, so they are always accepted even if the service is working at capacity and beyond. This means there can be a delay in initiating that first telephone contact.

16.5.9 Whilst it may not be possible to prevent delays from happening going forward, VS has taken the following steps to mitigate something like this happening again.

- All new staff undertake a thorough induction programme and relevant training to support them to provide high service standards.
- As referenced above, the LVWS has a system in place where non-high-risk DA clients are sent an SMS prior to the initial call being made. Informing the recipient to expect a call within the next 3 working days from a withheld number and that should they wish to access support before then they can call the London Inbound number or use the Victim Support 24/7 Support line or live chat facility. There is a newly embedded data driven approach to quality and contact – i.e. control charts which show VS where pressure is building in the system and which crime types are driving this e.g. Fraud
- Volumes of referrals and possible impacts such as delays to allocation or delays between referral and initial contact are standard agenda items on Regional Managements meetings that are held every 2 weeks and are monitored monthly and quarterly by the LVWS commissioners.
- LVWS has developed an exception approach to clearing any build ups of cases or delays, this should avoid problems stemming from staffing crises such as those experienced during the pandemic.
- VS introduced an enhanced overtime rate to incentivise staff to do extra work when there are staffing issues.
- VS now have a national resilience team to support areas where the staffing is compromised.
- VS review all practical and affordable steps to remain within the timescales of internal policy and contract requirements in order to provide a safe service.

16.5.10 The DA Operating Procedure is Victim Support's (VS) procedure for supporting people affected by domestic abuse (DA) in multi-crime services (of which the IVA section of the LVWS is a part) stipulates that contact must be made within 2 working days, unless otherwise specified in the local contract. The local contract states that contact should be made within 72 hours of the referral.

16.5.11 The IDVA Operating Procedure sets out the mandatory service parameters for managing and delivering Victim Support's (VS) Independent Domestic Violence Advisor (IDVA) services safely, effectively, and always to the highest standards. This stipulates that IDVAs make first contact attempts with service users within 48 hours of receipt. Referrals are prioritised by risk. If it is not possible to reach the service user, then a minimum of 3 further contact attempts are made over a 5 day period at varying times to avoid repeated calls when the service user is unavailable . Where resources allow, IDVAs continue contact attempts as many times as possible during this 5-day period.

- **Victim Support LVWS Contact attempts policy:**

For standard and medium risk cases there are three contact attempts. The first contact is the SMS, then a call will be attempted within three working days, if no contact is established then victims will be sent a final SMS letting them know we have tried to make contact and if they require support to call the London Inbound service or Support-line/Live Chat. The referring agency is also made aware if no contact is established. Attempts should be made on different days: 1 contact is warning SMS, 1 contact attempt by phone 3 working days later, if no contact then 3rd contact is final SMS sent after the call is made.

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

16.5.12 The chair has been concerned about the level of support to this process provided by victim support. They have provided 3 separate, different panel members and did not attend the panel on 17th January 2023. This is not helpful to the wider panel, the chair or indeed the VS manager attending. However, it is acknowledged the absence of the first panel member was unavoidable and since she has re-joined the panel the chair is very grateful for the insight and support, they have provided which was to a very high standard. However, during this process Victim Support have identified this gap and as a result have had more staff trained in the DHR process which has satisfied the panel that there is no requirement for a recommendation.

16.5.13 The only involvement of victim support was wholly unacceptable given the amount of time taken to make contact on 4/11/20. Of course, by that stage Ibukun had already died. However, no one can say that had the contact been almost immediate, whether that interaction could have had a positive impact that could have assisted Ibukun.

16.6 INTEGRATED CARE BOARD – GP SURGERY

16.6.1 Ibukun was well known to her GP surgery. She was diagnosed with a number of mental health diagnoses. She was estranged from both of her parents and had very little support and significant mental health concerns.

16.6.2 Her primary record is extensive for someone of her age. She contacted her GPs on multiple occasions every month, sometimes twice in the same day. Nearer the end of her life, she made online consultations, but GPs were not able to get through to her to discuss her concerns on her phone. She died during the covid pandemic when most patients were being seen virtually. Leading up to her death she was under the care of a number of services including the local mental health team and had been offered DBT sessions for her emotionally unstable personality disorder. She had attended one but had not wanted to further engage. Her GPs were aware that she had been offered treatment but not that she had not engaged. Given the number of her calls, GPs treated her with patience, discussing her various symptoms individually.

16.6.3 The vast majority of her calls (18 in total) were regarding gynaecological / abdominal symptoms. She was fully investigated and seen by the sexual health team. Patients with similar presentations are often able to access treatment via the pharmacy however the ability to be able to pay for prescriptions may have been a factor for her. It may have been that after the sexual assault she became hypersensitive to the nature of these symptoms and formed a part of her ongoing trauma. *Comment: The issues nationally with funding for Pharmacy are a factor in this case.*

16.6.4 Her complex mental health was mainly managed in primary care which is not unusual for those with personality disorders who often find it difficult to engage with DBT / group therapy programmes. She was also drinking heavily and not engaging with alcohol services which precluded her attendance at iCope.

16.6.5 After the domestic abuse was reported via the online consultation platform GPs attempted on numerous times to get through to her by telephone. On the 6th attempt they are able to get through. Her current mental health status was assessed as were her physical symptoms from the assault. She was given analgesics, sleeping tablets, advised when to seek medical attention and signposted to solace (domestic abuse partners) for support. There was not proactive questioning regarding domestic abuse within the consultations concentrating on her mental health prior to the allegations which were made prior to her death. Active questions is something that is encouraged but still appears to require embedding into routine questioning.

16.6.6 Ibukun had complex needs and difficulty engaging with the services that would have helped her. Primary care were reactive to her needs and she was able to see the same GP for all of the consultations regarding her mental health in the final few months of her life. The GP conducted thorough assessments of her mental health and she had been referred to the appropriate teams. The safety plan was reiterated on a number of times. She has been referred to CMHT

after Ibukun believed that she had bipolar disorder. She was also seen by the psychological service who had referred her for DBT, and the practice based mental health team were aware of her case. Ibukun also wanted to be referred for ADHD, but this assessment did not happen as psychiatry felt that it would be more prudent to engage with her further in primary care.

16.6.7 There were 18 contacts in primary care between the beginning of January 2020 and October 2020 regarding her mental health. At the beginning of October 2020, she was due to start DBT and was reporting that she felt stable however this quickly changes after the realisations of her partners infidelity and the assault. The practice used an online consultation platform for patients to request appointments, Ibukun was able to navigate this system with ease, sometimes sending multiple e-consults in the same day. The GP provided a letter for university to support her and referred appropriately.

16.6.8 She saw a private psychiatrist via her own means in May 2020. She reported to him that it had been difficult to get her needs met in the NHS. However, there was good evidence of her having received extensive support within the NHS. She had last been seen in December 2019 requesting some more medication as she had been taking it intermittently. They had recommended for her to self-refer to icope, she had reduced her drinking which would have meant she could access the service. The time prior to this was between January and March when she had been assessed by iCope due to her concerns about bipolar disorder. They had been unable to further assess as she was drinking heavily. They had signposted to Better Lives for support for her to stop drinking.

16.6.9 *Comment: It is the view of the panel that GP practice engaged well on the whole with Ibukun who had complex MH needs, but she was well supported by primary care and had been referred to the right services.*

16.6.10 GPs need to be educated to remind them that proactive questioning for domestic abuse when seeing patients with mental health concerns should be strengthened. This case occurred in 2020 and since then a pop-up Humiliation Afraid Rape Kick (HARK) template shows on the medical record when you code a mental health consultation. HARK is a four question self-reported screening tool that represents different components of Intimate Partner Violence (IPV) including emotional, sexual and physical abuse. However, it is accepted that templates that come up all the time are sometimes underutilised, and this needs to be addressed.

Comment *the need for trauma informed care is paramount, which was a significant feature in this case. Teaching on this for GP's would help them approach this cohort of patients with compassion and confidence.*

16.6.11 The training of the GP's could be enhanced within the DA and the trauma arena. Newham is trialling, Identification and Referral to Improve Safety (IRIS), as a pilot across the borough for 12 months from 01 April 2023. This is seen as a significant enhancement on the current service and is fully endorsed by the panel.

16.6.12 If those without any financial concerns can access treatments by paying at a pharmacy, then of course those without such financial stability are disadvantaged. Those cohorts of people which the author will state is getting larger due to the current economic situation therefore are at a disadvantage when being the victim of such a serious crime as sexual assault. It is noted the decline in services nationally of Pharmacy first and more needs to be done to provide this facility. In the context of capacity issues in General Practice any service which appropriately aids patients in accessing care directly via pharmacies is welcome.

16.6.13 On the 21st there was an online consult. Ibukun contacted the surgery. The content of this was: She was wondering whether it is possible that the diagnosis of BPD was a misdiagnosis and was just PTSD triggered and caused by the emotional abuse and psychological warfare from her ex-partner. "I only ask this because I have been in the mental health system for a decade also and I have never had a further diagnosis of BPD but this year when he made me homeless and broke up with me several times and begged for me back. I felt something was wrong with me and was seeking answers. However now I am realising nothing it's probably wrong with me he was causing all this self-doubt and chaos in my mind and Head. Is there a way to reassess me? I was assessed at the time of trauma and when I felt I was worthless. I am away from him now and I know the truth about his abuse and behaviours. I just want to turn back everything he has put on me that I have absorbed the past year and I think this might be one of them."

The practice responded the same day thank you for your query. I would start by contacting I cope if you wanted further support regarding your mental health issues. Please visit this site for more information www.iCope.nhs.uk

Comment – This was quite a generic response which didn't directly address her concerns. They had spoken to her at length the day before and on the online consult she doesn't state that she was feeling more depressed or suicidal, that she would like to be assessed for PTSD. Her previous requests for further assessments were acted on and the advice was to continue to engage her in one service. The panel considers this response reflects this sentiment but would have been delivered better face to face / via telephone. However, this was in the COVID 19 pandemic, and she had been seen the previous day and was not reporting new concerning psychiatric symptoms.

16.6.14 Much has been written over many years regarding the roll out of Pharmacy first nationally and indeed Scotland are due to take this one step further. Articles that inform some thinking on this are https://www.centredsolutions.co.uk/news/just-how-close-are-we-to-a-pharmacy-first-model-in-england and https://www.thepharmacist.co.uk/views/after-years-of-talk-why-is-there-still-no-sign-of-pharmacy-first-in-england/ . There is much literature in this field but put simply had this service been available within Newham it is the view of the panel that this could have provided a fast and efficient way to help Ibukun with many of her interactions with help regrading vaginal symptoms.

National Recommendation (NR1) – National investment should be made in Pharmacy first to make this service accessible to more communities.

Recommendation (LR3) – Local investment should be made in Pharmacy first to make this service accessible to patients within Newham.

Attendance and Routine Questioning regarding Domestic Abuse

16.6.15 Their only entry on the chronology, for Ibukun relates to the recent Oct 20 case of domestic abuse. The other entry relates to a disclosure from when she was a young child and it's not clear in what country that abuse occurred from the timescale but more likely than not to have occurred in Nigeria. This reported via the online consultation platform, GPs attempted on numerous times to get through to her by telephone. On the 6th attempt they are able to get through. Her current mental health status was assessed as were her physical symptoms from the assault. She was given analgesics, sleeping tablets, advised when to seek medical attention and signposted to solace (domestic abuse partners) for support. There was no proactive questioning regarding domestic abuse within the consultations, concentrating on her mental health prior to the allegations which were made shortly before her death.

16.6.16 Whilst the GP chronology did not indicate significant Domestic Abuse the panel did consider the merits of 'routine enquiry' when patients visit their doctor. NHS Guidance notes[1], confirm that 95% of women are quite happy to answer questions about domestic abuse and violence and therefore it seems to be reasonable that routine questions could be asked of potentially vulnerable patients. In particular patients who have had childhood trauma and have complex mental health needs. This case occurred in 2020 and since then a pop up HARK template shows on the medical record when you code a mental health consultation. However, we also know that templates that come up all the time are sometimes underutilised.

GP practices in Newham (Ibukun accessed care in Islington) have commenced IRIS training after IRIS were recently awarded the contract and this includes a robust education programme of which proactive questioning is a feature. This pilot commenced 1st April 2023.

Recommendation (LR4) – Newham continues to fund and embed IRIS for GP Practices. If IRIS is not a long-term provision identify a suitable alternative.

Recommendation (LR5) – GP practices in Newham to embed a trauma informed approach.

16.7 INTEGRATED CARE BOARD – BARTS HOSPITAL TRUST

[1] Domestic Abuse Statutory Guidance (publishing.service.gov.uk)

16.7.1 Ibukun attended the Emergency Department (ED) based at Newham University Hospital (NUH) on 14th October 2020 (during the COVID pandemic) complaining of pain in her thumbs and wrist. She alleged that she had an argument in the street with her ex-partner the night before and he pulled her thumbs back. Evidence of swelling and bruising was seen. She also stated she ran into traffic as she wanted to kill herself to get away from her ex-partner, she was not hit by any vehicles at this time. There was then a video outpatient appointment with the hand clinic on 21st October 2020, where the Dr seeing her acknowledge the argument with her ex-partner in the documentation but did not appear to have addressed this with Ibukun at the time. She was discharged from the clinic, as she reported that her hand was improving, with safety net of returning to the GP for a referral back to hand clinic if there were further concerns.

16.7.2 There is recognition of good clinical practice during her visit on 14th October 2020. However, whilst staff recognised domestic abuse there was no evidence to suggest they had offered Ibukun a referral for IDVA support or sign posted her to where she could access support. There was not a record of a DASH risk assessment being completed or considered. The details of Ibukun's ex-partner were not recorded within her records. Also, when she attended her video outpatient appointment with the Dr on the 21st of October 2020, despite the fact he had documented in her records the injury was as a result of a 'fight' with her ex-partner, there is no evidence of this being explored, whether she felt safe and whether she had support.

16.7.3 The outpatient appointment that Ibukun had was during the COVID pandemic and at that time most outpatient appointments were being held virtually unless it had been identified for either safety or clinical need for the appointment to be face to face. In reviewing her records her appointment would not have met criteria for a face-to-face appointment however there was an opportunity for the Dr to make enquiries to how she was feeling since the incident that brought her to ED and for them to explore if she was accessing support from other professionals.

16.7.4 The panel have had sight of the Barts trust policy named "Responding to Domestic Violence and abuse" dated March 2019. This is currently being reviewed. Also the panel has had sight of the training slides as used as part of the Level 3 Safeguarding adults course. The author find's the policy lacks any reference to immigration status and the flow chart confusing on what staff are to do with disclosures. In fact, in this case there is no evidence presented of anyone doing anything with the disclosure for the reason for attendance at A&E. There is no questioning at all in the follow up outpatient appointment, despite it being absolutely clear the reason for her injury was a domestic assault.

Recommendation (LR6) – Barts staff should receive bespoke DA training and also include the effects of immigration status

Recommendation (LR7) - Barts policy need to reflect the impact on immigration status for victims of DA and the process chart should be designed as an easy read for staff actions on a disclosure.

16.8 ELFT

16.8.1 On 14/10/2020 Ibukun was assessed by ELFT Psychiatric Liaison Service at Newham General Hospital. Prior contact with mental health services had happened with Camden and Islington Mental Health Trust. A clinical handover from Campden & Islington was received by the Psychiatric liaison team to inform the clinical and risk assessment that was undertaken.

16.8.2 The documentation from contact with Psychiatric Liaison Services indicates that during the assessment there was a disclosure around incidents of domestic abuse with her ex-partner the previous day. Experiences from this relationship during the last period of her life had impacted on her wellbeing to the extent that she felt suicidal and had acted upon this distress by attempting to take her own life.

"She was looking at his phone, and he was trying to take it back, resulting in a "brawl"

He grabbed both her thumbs and bent them backwards, she heard a "pop" in the left thumb
He also choked her - she felt pre-syncopal but did not lose consciousness
Unsure whether she hit her head. Does not clearly recall which parts were injured as it happened quickly - but has pain in both thumbs, right forearm, left knee, right ankle, nose
Had epistaxis for several hours, now stopped"

Ibukun provided the assessing practitioner with a domestic abuse safety plan which she had formulated herself:

"*Has applied online for restraining order against ex-partner, awaiting update*
Does not fear for her own safety if discharged, as her partner does not have access to her home, and she does not feel he can hurt her.
Does not wish to contact MPS as feels they cannot help as her boyfriend always gets away with everything.
Reports she has lost all her friends because of her boyfriend; she left them because she "loves" him"

16.8.3 Concerns were noted around the plan, she had applied for a restraining order online. Noted she thinks her boyfriend is invincible. ELFT noted Ibukun was hesitant to get agencies involved due to her immigration status. The viability of the plan does not seem to have been robustly tested out in line with best DA practice around undertaking of DASH RA. *Comment: There is no evidence of any proactive work by ELFT in regard to Ibukun; concerns around her visa status.*

16.8.4 The outcome of the clinical assessment was that Ibukun had Capacity and was given contact details for a crisis line. Ibukun had a diagnosed borderline personality disorder, anxiety and depression. *"Has insight and has capacity to make decisions about her treatment as she able to understand, retain, use and weigh up and communicate that she feels she has used mental health services when she needed it for herself and was doing it to better herself. She does not want to resort to mental health services to deal with the impacts of her relationship with her boyfriend. She believes it will bring more trauma. She believes she will be able to do this on her own and knows how to seek help if she needs it. She reports she just wants to go home and shower and get on with her life."*

16.8.5 Implementation of best DA practice would have been for the DASH risk assessment to be carried out whilst she was in psychiatric liaison services. There was no discussion with Ibukun around working with a domestic abuse service locally as such or support from an IDVA. There was no consideration around refuge given. Given the nature of the violence perpetrated against Ibukun it would have been expected that a safeguarding adults referral be raised into London Borough of Newham in order to share the risk with partner agencies. Ibukun references trauma from the recent events, identified, early childhood trauma from her relationship with her mother but a trauma informed perspective on capacity/insight are lacking.

16.8.6 The Psychiatric Liaison Nurse undertook a mental health assessment of Ibukun's needs. Ibukun was assessed not to be depressed in mood or experiencing psychotic symptoms or any other acute symptoms of mental illness. Ibukun declined community mental health follow up stating she could manage without it, though aware of how to access support. Advice on how Ibukun could access crisis support was given. On the basis of a clinical risk assessment Ibukun was deemed to be safe to discharge from the department and that inpatient care, either informally or under compulsory powers of the Mental Health Act, 1983 was not necessary. The rationale for this decision was on the basis that Ibukun denied current suicidal ideation, was future orientated talking about completing her university degree and progressing with her and cited protective factors of social network and was not reporting or displaying signs/symptoms of acute mental illness. Ibukun was assessed to have mental capacity in relation to her mental health care and treatment. The plan was discussed and agreed with the ELFT on call doctor.

16.8.7 Ibukun stated that she did not want to self-report to the MPS given that she feels her partner will not be punished and due to her immigration status. In respect to overriding her decision

(with capacity) not to report the risk assessment around the DA should have informed if they were to override this decision and report in the wider public's interest, or in her best interest if she had been believed to lack capacity. Reflectively as Section 20 of the Domestic Abuse Act 2021 has now introduced the offence of non-fatal strangulation as a specific offence whilst not in force at the time demonstrates the emphasis placed around this act of violence as a risk to others. With this in mind had a DASH RA been completed and the responses provided deemed it as High Risk, then this should have been referred to the local MARAC. However, in this case no DASH was completed hence its unknown what the risk was assessed as at that time.

16.8.8 Operationally across the Directorate there is a recognition that staff need further upskilling around DA practice. The Corporate safeguarding team are assuming a lead role in this through quarterly safeguarding events, 1 day training for the November days of Action from DA providers, local bespoke training events and Trust Wide Training such as the Level 3 Safeguarding training that incorporates domestic abuse as part of the learning. As part of the support around safeguarding practice it is understood that the principle of safeguarding adults being everyone's business needs to be firmly embedded in best practice. Within ELFT the Corporate Safeguarding team support in learning around DA and Best practice through a multilayer approach:

1: Quarterly Safeguarding Adults supervision: This happens with every team across the trust. These sessions are often open sessions where colleagues bring cases for discussion, but are also used to offer brief training sessions, SAR/DHR feedback opportunities etc

2: Quarterly Safeguarding Adults Events: These are 1-day events with 4 separate sessions involved, each session is a 1.5-hour bespoke training session, and a DA session is always included in the event. These are open to the Trust staff across all the directorates that Elft covers.

3: Bespoke training sessions for teams: these are generally small training opportunities targeted to teams. In reference to this DHR where the team involved from an ELFT perspective was Psychiatric Liaison the local question, the corporate safeguarding team is having if we should roll out a DA best practice training session across all Psychiatric Liaison teams jointly or continue locally within our own directorates.

4: The Level 3 Safeguarding Adults 1-day training program which is part of the mandatory training schedule has a section on DA, DASH, MARAC, and some brief on safety planning and advocacy

5: In November 2022 they held in light of the 16 days of action a 1-day Domestic Abuse training event for all Trust staff where we had speakers from, Mankind, DA sign health, Beyond the streets, and NIA.

Going forward as part of the training strategy as a team its recognized the need to really drill down on key issues and topics that are encompassed in the very global framework of DA, so for example they are meeting with the LD/ASD Refugee in Newham to ask if they can present across the trust on some of the key issues that affect the community, and they have agreed to share the adapted DASH RA that they are producing so that we can also implement. Similarly, with many issues/groups, we hope to focus on in more in-depth training either presented by ourselves as the Elft Safeguarding team or inviting key speakers to support.

16.8.9 The Newham NHS Foundation Trust has a clear policy with regards to Domestic Abuse and harmful practices policy produced in September 2019 and is currently being re written. It's clear in this case the policy was not followed, and the policy does not contain any information in relation to immigration status.

Recommendation (LR8) – ELFT to update new Policy in relation to immigration status.

Recommendation (LR9) – ELFT to implement training of all staff in relation to immigration status.

16.9 University of East London (UEL)

16.9.1 At the time of her death Ibukun was a student at UEL. What is important to highlight is the excellent practice that UEL had undertaken prior to the formulation of this review. UEL had instructed an independent expert within the University sector to carry out a review. This was done and completed prior to this DHR being established.

16.9.2 Ibukun was an undergraduate student studying for a degree at the University of East London (UEL). She was in year two of a three-year undergraduate degree course at the time of death. The University was informed of the death on 12 May 2021 in response to proactive enquiries on their part.

16.9.3 Ibukun was a registered disabled student. She stated she was estranged from her family. She had provided to the university a next of kin who was not a family member. She engaged with Student Services to access Disabled Students Allowance (DSA) support in November 2019, during her first term at UEL. Her disabilities related to dyspraxia, depression, and anxiety. Reasonable adjustments were made based on these disabilities and related recommendations from the assessor.

16.9.4 She had shown satisfactory engagement with her academic course through year one (academic year 2019-20). Her last recorded attendance on campus was on 13 March 2020. This aligns with the point when the UK went into 'lockdown 'as a consequence of the Covid19 pandemic. Her engagement from the beginning of the 2020-21 academic year became a concern. There was no recorded academic attendance with her course during the term prior to her death in October 2020. She did engage with the Moodle virtual learning environment during this term.

16.9.5 Ibukun appears to have been aware of the full range of support available from Student Services at UEL. She attended a wellbeing drop-in session on 11 March 2020 during her first year. At this session she raised concerns about other students on her programme accusing her of bullying them. Her presenting concern was that she was being ostracised. She was provided with advice and information about her options. The case worker did not identify immediate safety risks to Ibukun in relation to the risk assessment they undertook at this time. Ibukun did not make any further contact regarding the bullying accusation against her after this meeting.

16.9.6 At the start of the 2020-21 academic year the University, via Student Services, received a copy of an updated DSA Needs Assessment Report for Ibukun. This would be a routine transaction at this time. Student Services emailed Ibukun inviting her to contact the Disability and Dyslexia Team if she had any queries about this report.

16.9.10 On 19 October 2020 Ibukun self-referred by email to the wellbeing service again. A Wellbeing Practitioner telephoned her the same day arranging an appointment the following day, 20 October 2020. At the appointment on 20 October 2020 Ibukun met with an experienced Wellbeing Practitioner. She cited a range of complex issues, including self-harm and suicidal feelings. The case notes of that meeting record discussion of an historic abusive relationship. Ibukun indicated that she had reported this matter to the MPS. She said she had removed herself from the relationship. She indicated she was safe from the abuser with no ongoing contact. The Wellbeing Practitioner conducted a suicide risk assessment at the meeting on 20 October 2020. This is routine in an engagement such as this one. Ibukun indicated that she continued to experience panic attacks and had experienced suicidal thoughts in the past. However, she specified that she had not made any plans to act on these thoughts. The Wellbeing Practitioner specifically noted that the Ibukun was future oriented and her studies at UEL were a protective factor.

16.9.11 The risk assessment did not flag a significant risk, and an action plan was agreed with Ibukun regarding the presenting issues. An appointment was offered and accepted with a Mental

Health Practitioner seven days later on 27 October 2020. This was to explore the presenting issues more fully. An appointment was also offered and accepted with a Student Counsellor to take place on 29 October 2020. Ibukun was provided with information on external agencies, internal funding opportunities and information on how to access counselling appointments, workshop appointments and UEL self-help resources.

16.9.12 Independently from her self-referral to the Wellbeing Team Ibukun's lack of academic engagement was flagged by her School to SERT on 21 October 2020. This related to the period since the academic term began in September 2020. It appears this was entirely unrelated and coincidental to Ibukun's presentation to Wellbeing in the preceding days. Despite Covid-19 restrictions there had been some limited opportunities at this time for in person learning on campus. Ibukun's disabilities were not of a physical nature that would have required her to 'shield'.

16.9.13 Of note is preceding Ibukun's death the MPS did not make the University aware that Ibukun had died at the time, or pro-actively at any time afterwards. However, it was not clear from the evidence presented whether or not the MPS were aware Ibukun was an enrolled student at UEL. It is noteworthy that all actions which follow from this point would have been different had the MPS taken action to inform the University of Ibukun's death. Because the University was not informed of the death, it continued to use established processes over the following months to respond to what appeared to be an absent and latterly missing student. Comment: *The panel believes that UEL should have reported Ibukun as a missing person to the MPS. Whilst its understandable on occasions just because a student does not attend university it does not make them a missing person. Given the meeting on the 20th October and the presentation in that meeting, following the missed appointment on 27th October the author believes this is the point she should have been reported as a missing person or as a fear for welfare.*

16.9.14 Consequently, from not being aware of the death of Ibukun, UEL Student Services staff were not in position to enact protocols the institution operates for managing its response to a student death in a timely way. These protocols are written down and well established. It was indicated during the review meetings the protocols have proved effective in previous cases.

16.9.15 Student Services continued to make all reasonable attempts to contact Ibukun. It was not until 12 May 2021 that UEL established Ibukun had died despite extensive best efforts.

16.9.16 Recommendations from their own review have already been made and the below is a schedule of them and their current status.

MPS liaison/relationship management: UEL should consider reframing the relationship with the local MPS around safeguarding (alongside the existing operational campus security approach. Such a change might go some way to moderating the risk of the chain of events in this case. It may be helpful to identify a senior University officer who can liaise with the local Borough Command Unit as a starting point. There may be existing MPS liaison models at other

London universities which UEL can adopt. The university should consider a specific data sharing relationship with the MPS (if one is not in place).

Managing individual students in crisis and risk: UEL appears to be very reliant on Student Services senior management to directly manage the response to individual students who are in crisis. This reliance appeared risky to the reviewer. Given both the growth in demand nationally and the nature of the personal and reputational risks involved, UEL may wish to consider a more detailed review of its resourcing and approach to individual student crisis management. Additional resource would permit management to engage in higher level activities which appeared absent to a degree in the Ibukun case; for example, establishing a predetermined, structured approach to case conferencing which might have aided understanding and information sharing across the different stakeholders. UEL now have a duty role for unexpected student incidents that can escalate appropriately to senior managers. Within the wellbeing team they now have a clinical lead in addition to the Head of Wellbeing and Student Support.

Violence and abuse disclosures: UEL may wish to explore expanding and enhancing referral pathways where students (and/or staff) experience violence, abuse or harassment. The Office for Students (OFS) has funded a number of pilots in this space. UEL's campus locations may mean there are third sector partners locally who could work in partnership with the University on these issues with relatively modest investment. UEL appointed a dedicated Independent Sexual and Domestic Violence Advisor (ISDVA) in January 2022. Implementation of a reporting system (Report and Support) to enable anonymous and non-anonymous reports to the university and to link up with MARAC and MASH referrals externally.

Integrated CRM and case tracking: It may be that some of the communication in this case would have been more efficient if supported by a better integrated customer/client record management tool. Such a CRM might benefit from access being available to academic staff, provided this does not compromise confidentiality and student confidence in student support provision. It is noted that SERT has moved under the Student Services line management which should assist in facilitating an easier sharing of working practices and information. UEL now have an integrated CRM system which enables Disability, Wellbeing and ISDVA to see notes relating to attendance, visa issues, money concerns etc.

Mission statement/purpose of Student Services. UEL may wish to review/refresh the published mission and purpose of Student Services. It may wish to seek assurance that all stakeholders can easily and quickly understand the difference between the responsibilities of an HE student support service and that of statutory services. UEL are clear about the role of Student services and the limitations of a HEI service and statutory services and promote this through training academic staff, and in the information, they share with students.

Suicide Safer models. UEL may wish to explore options around development and expression of 'suicide safer 'models in an HE setting. This could set out specific reference to post intervention actions and processes. This would help members of the university understand

what to expect after a death. This may aid transparency and understanding across the university. A joint project between the sector and Papyrus has provided a range of practice examples which may help thinking on this matter. UEL at the time of writing have a suicide safer policy (in draft) and are working with local authority to be partners in the Newham suicide safer strategy group.

Mental Health Strategy. UEL may wish to review relevant strategies and practice against the UUK Stepchange framework toolkit. Going forward the University may wish to consider an appropriately resourced, longer term Student Mental Health Action Plan. Mental Health Strategy: We have a health gain and wellbeing strategy and have undertaken an external audit relating to our mental health strategy and support.

Policies regarding student deaths, students who may be missing. These policies do not appear to have failed in the Ibukun's case. The University was arguably failed by a lack of information coming into it from the statutory services and a lack of responsiveness from the next of kin. The University may, however, wish to engage in a light touch review of these documents to ensure they reference each other adequately. The University may wish to set more specific timelines with regard to guiding when it will act where a student may be missing. This is in line with the comment by the author. Updates are completed annually to ensure that after every death/near miss we review the process and policy to make improvements. Immediate action is taken to escalate contacts relating to missing student where student does not respond. This means we contact trusted contacts and MPS within 48 hours of serious concerns being raised.

16.9.17 It has been acknowledged by the panel that UEL did some excellent work in undertaking a review prior to this review. It is noted the many areas that they have developed since in accordance with that review such as IDVA and IDSA roles are now in place. However, it is the view of the panel that UEL should have reported Ibukun missing to the MPS. It is felt the proportionate time to have done this is after she failed to appear for the arranged appointment on 27th October 2020. Whilst Ibukun is already sadly dead by this point this would have saved the university a significant amount of work. Likewise, it is recognised by the author, that had a welfare check been carried out at the home address on 27th October and the landlord been spoken to, information relating to the death of Ibukun would likely have been passed and again saved the university a significant amount of work. UEL have however already made strides in this area and their policy has already been updated and the panel are confident should they be presented with similar circumstances in the future that the mechanism is in place to report a student as a missing person.

16.10 West Midlands Police (WMP)

16.10.1 Ibukun had only one interaction with West Midlands Police. This was in relation to a sexual assault on 18/08/19. She reported this to WMP via webchat on the 19th of August 2019.

16.10.2 She stated that between 1041 hours and 1048 hours on the 18th of August 2019 she was sexually assaulted. She stated that she had been to a house party and met a male with whom she left the party, going with him to the address he was staying at. When she woke up, she could not wake the male, who was supposed to give her a lift home. She then went into the offender's bedroom and asked if he would arrange a lift for her.

16.10.3 Ibukun stated that whilst at the address she was sexually assaulted by an unknown male. She subsequently made some enquiries with the host of the party to try and identify who had assaulted her but did not receive any details of the person.

16.10.4 WMP attempted to contact Ibukun later that day, but her telephone number had been recorded incorrectly. Ibukun contacted WMP again on 20/08/2019 and her correct number was recorded for contact for officers to obtain details. She contacted WMP again later that day and again on 21/08/2019. She was then contacted and advised an appointment had been made for the 23/08/2019 at 1200 hours. Ibukun was not happy with this. She later web-chatted and stated that she was leaving Birmingham and intended to approach the offender herself with friends. She was advised against this.

16.10.5 Ibukun did not answer her phone on the 23/08/2019 for the scheduled appointment. Several calls were made to try and obtain details of the offence. Contact was eventually made on 25/08/2019 and Ibukun requested the appointment be on the 27/08/2019. This was arranged and finally on the 27/08/2019 full details of the incident were taken from Ibukun, and the matter formally given a crime number.

16.10.6 The case was reviewed by the Review and Allocation Team who transferred the report to the inbox of a team to enable allocation and further investigation. It was not until the 17/12/2019 that a sergeant for the relevant team reviewed the report. The sergeant identified that Ibukun had provided a name, address, and phone number for the offender. The sergeant checked WMP intelligence systems, but the name and phone number provided were not known. It was noted the details for the party host were not known, that the forensic opportunity to obtain the offender's DNA had been lost and CCTV enquiries had not been conducted and due to the time lapse, this opportunity had been lost. The sergeant notes that the matter was one word against the other, with no supporting evidence and so would not meet the threshold for CPS. The matter was therefore filed no further action. The sergeant attempted to call Ibukun but could not make contact. A letter was sent explaining that the matter would be filed and provided their details if she wished to discuss the matter further.

16.10.7 It does not appear that any enquires were made into this offence. The four-month delay before the report was looked at again was completely unacceptable and deeply concerns the panel. Even when the incident was reviewed four months after the offence, enquiries could have been made to identify the offender from the phone number, from enquiries with the phone company, in-person enquiries at the offender's address, as the description provided of the offender was quite distinctive and also enquiries with the party host to identify the offender and witness.

16.10.8 Home Office Counting Rules for Recorded Crimes came into effect from April 2022. This states that a crime must be recorded as soon as possible after the person receiving the report is satisfied that it is more likely than not that a crime has been committed. Where the information obtained at the first point of contact satisfies the CRDMP the expectation is that identified crimes will be recorded without delay. It is expected that such crimes will be recorded on the same day the report is received, and be recorded, with a crime number, on the force crime system within 24 hours of the time the initial report was received. Exceptionally, in circumstances where a victim or person reasonably assumed to be acting on the victim's behalf, cannot be located to confirm that a victim-related crime occurred then recording may be extended for up to seven days. If this incident were to be reported now, the call would be logged within 'Control Works' (WMP log system) and details obtained. Upon identifying that the offence of sexual assault was made out a crime number would be generated by the operator and the report created. Enquiries would be recorded within that report, and it would be sent through to the Review and Allocation Team for review. Upon completion of review, it would be sent to the appropriate team's inbox for further review and allocation.

16.10.9 In relation to the call handler mis-recording Ibukun's phone number, it was a typographical error due to human error. This was unfortunate and led to a delay in contact being made with Ibukun, but genuine typographical errors sometimes occur, are down to individual error and are not common. The Rape and serious sexual offence (RASSO) initial WMP contact policy clearly states that the incident is forensically live within seven days of the incident occurring. The contact staff should grade the incident as an immediate response if the matter is forensically live. An argument could be made in terms of the response being graded as a priority response given that the victim was safe, and the suspect was not on scene. Either response classification would have been sufficient. This was not done, and forensic opportunities do not appear to have been considered by the staff creating the incident log, or by any staff reviewing the log in the proceeding days.

16.10.10 THRIVE+ was completed with the note that the matter was a sexual assault, required further investigation, the victim was safeguarded and did not know the male offender. The incident was graded a P4, requiring a response within three days. Again, this did not happen, and an appointment was not completed with Ibukun eight days after her first contact with WMP.

16.10.11 This investigation was sub optimal. The basics of any investigation were not done. Preserve evidence, identify scenes, and identify a suspect. In effect from the information provided by WMP nothing was done. Ibukun reported the matter chased up the response and it took almost 4 months for a supervisor to review the investigation (or lack of) and simply file the case no further action. The sighting of one word against another is wholly unacceptable as this is very often the case in Sexual offences (one word against another). What WMP should have done is investigate the offence in a timely manner.

16.10.12 The panel have sought reassurance from WMP that this was an error and not an organisational issue. It is accepted that WMP has a significant footprint, and the uncomfortable reality is that

mistakes will happen. WMP like many other forces have a refocus on VAWG. The panel needed to be reassured that this was a one-off mistake as a pose to organisational issues.

16.10.13 WMP has gone through significant changes since this incident. Part of that change has seen work previously carried out by central Public Protection Teams transferred to local investigation teams, enabling more resources to be used for sexual offending and similar offences. Also, and importantly, they now have a Log Quality Team who review closed logs to ensure that all relevant enquiries have been conducted and that all offences are recorded correctly in line with Home Office Counting Rules. Monthly Quality Assurance surveys are conducted regarding Complex Adult (encompassing sexual) cases to review investigations. Regular qualitative reviews will continue in the not-too-distant future.

16.10.14 Operation Soteria (their response to VAWG) aims to enable truly transformative change in police investigations of rape and other sexual offences resulting in higher charge rates and better victim experience for victims of all backgrounds. Fair, consistent and balanced rape investigations to focus on the crime, including the entirety of the suspect's relevant behavior, without disproportionately over-investigating the victim. It aims to prevent sexual offending by disrupting repeat perpetrators and will improve officer competence, confidence and well-being.

Recommendation (LR10) - WMP should commence regular qualitative reviews to ensure standards of investigation are proportionate and timely in sexual offence investigations.

KEY LINES OF ENQUIRY

16.11 Visa status: how unsecure immigration status impacts on DA/SV – is this a barrier for accessing support

16.11.1 One important part of research is the Super Complaint made by Liberty & the Southall Black recognised at 11.14. One of the specific harms that are identified in this super compliant are relevant in this case and encapsulate Ibukun namely:

• victims/witnesses are too afraid to report crimes to the MPS.

16.11.2 The only evidence of Ibukun's immigration status becoming apparent is when she discloses it to ELFT at 16.8.3. However of course the fact that Ibukun considered this was an issue and thus presented as a barrier to her is most relevant. What is concerning is there is no evidence of the ELFT then explaining that immigration status is not a barrier. There is nothing written in the ELFT DA policy regarding immigration status or any evidence of training on this subject.

Recommendation (LR11) – The London Borough of Newham is to highlight the challenges of immigration status on victims/survivors across all its services to ensure providers have policies in place and staff educated.

16.12 Suicide and Domestic Abuse

16.12.1 In 2018, Refuge and The University of Warwick published research that investigated the link between domestic abuse and suicide that was commissioned to fill gaps in the knowledge about factors that might predict, contribute to or mitigate against the risk of victims taking their own lives. This report found 'Almost a quarter (24%) of refuge clients had felt suicidal at one time or another'. The findings of this report provide a useful lens through which to consider agency analysis and the terms of reference. The reports key findings were:

- Damaging *gaps and delays* were observed by staff who referred clients to community services;
- Short term *risk management* approaches were often cited as inadequate to address suicidality, particularly when facilitating its disclosure;
- Limitations of existing *tools* to assess risk of harm from the client to themselves, particularly over a broad timescale were highlighted;
- The need for *trauma informed approaches* to practice, for clients and for the workforce were identified.

16.12.2 The importance of this lens is highlighted by a further recent study conducted by Kent and Medway[1]. They found that 30% of all suspected suicides, locally, are individuals who have been impacted by domestic abuse (either as a victim or perpetrator).

16.12.3 Other reports provide important information, such as the statistical link between self-harm and suicide. A national strategy 'Preventing Suicide in England' [2] notes that groups at high risk of suicide are people with a history of self-harm and at least half of people who take their own life have a history of self-harm'. Ibukun fell into this category.

16.12.4 On considering the available tools for assessing risk, the panel learned that risk assessment in relation to self-harm and suicidal ideation is problematic, with the BMJ reporting [3] "Risk assessment is challenging for several reasons, not least because conventional approaches to risk assessment rely on patient self-reporting and suicidal patients may wish to conceal their plans. Accurate methods of predicting suicide therefore remain elusive and are actively being

[1] Kent and Medway sign up for better mental health | Medway Council

[2] *Preventing suicide in England - A cross-government outcomes strategy to save lives (publishing.service.gov.uk)

[3] Suicide risk assessment and intervention in people with mental illness | The BMJ

studied" Conversely, the department of Health in its publication 'Best Practice in Managing Risk' [1] sights 6 tools in assessing risk of suicide.

16.12.5 On considering the available tools for assessing risk, the panel also explored the use of the PHQ9 tool (patient health questionnaire) that is used to both diagnose depressive illness and to assess its severity. It was learned there had been a requirement historically to use this tool, but this is no longer the case, and it is not deemed as a risk assessment tool.

16.12.6 The conundrum of assessing risk is perhaps informed by a BMJ article that summarises, [2]" Suicide is a behaviour and not a diagnosis". Suicide cannot be predicted accurately in any given individual at a single point in time. Suicide usually occurs as a result of a multifactorial process, where vulnerability to suicide may be generated over several weeks, months, or years" The summary continues "Clinicians, patients, and their carers (supporters) are calling for a paradigm shift in suicide risk assessment that moves away from "characterising, predicting, and managing risk' towards 'compassion, safeguarding, and safety planning".

Recommendation (LR12) – Recognition that self-harm and suicidal ideation are potential indicators of patients experiencing domestic abuse.

16.13 Sharing of Information

16.13.1 Ibukun had accessed MH services across London boroughs. The review asked was there a linked-up system for information sharing across London. The review believes that whilst London is a complex geography to navigate in relation to the number of boroughs and ICB's the information in this case was shared effectively as evidenced by the GP surgery obtaining very quickly the referral from the private phycologist.

16.14 The impact of trauma from previous SSA investigations and how is this viewed.

16.14.1 Ibukun had 2 reported sexual assaults. One in London one in the West Midlands area. Whilst the response in London appeared to be proportionate and dealt with in the correct manner the response in the West Midlands area was not acceptable. By not responding sensitively, thoughtfully, and timely her experience of the WMP investigation could well have created barriers to reporting and lack of trust in policing. However, it's important to note that Ibukun did make subsequent reports to the MPS of incidents. There is clear evidence in the medical

[1] Best Practice Managing Risk Cover (publishing.service.gov.uk)

[2] Suicide risk mitigation - Symptoms, diagnosis and treatment | BMJ Best Practice

notes of the trauma from the Rape in London and the Sexual Assault in the West Midlands. The subsequent poor investigation by WMP may well have added to this trauma.

16.15 Dynamics of gender in a relationship

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

16.6 Was identity, faith and or culture a barrier

16.16.1 Whilst there is no direct evidence within this review that shows faith and culture were a barrier, the issue of identity is highlighted by the panel. However of course any panel would be wrong to consider just because there is no direct evidence that these where not factors given all the research in such areas that this report highlights. How did Ibukun see herself. Her own self-esteem and status within the world. She believed her immigration status was a barrier to reporting. Whilst her immigration status was not a legal issue, and she was in the country legally, the fact she still felt this, is significant.

16.7 How accessible is anonymous reporting advice services for DA/SV, do we have this in place, is it advertised enough.

16.17.1 From a basic internet search a number of anonymous results come back on Sexual Assault Anonymous Reporting - Blue Sky Centre comes back. Likewise for Domestic Abuse anonymous domestic abuse reporting - Google Search. There is also a really useful site within the borough of Newham Help and advice for those who are experiencing domestic abuse and sexual violence – Domestic abuse and sexual violence support – Newham Council. The panel however believe there are always possibilities for enhancement and each agency has undertaken to review their own communication platforms.

17. CONCLUSIONS

17.1 Ibukun was a bright young woman, and her untimely death was a tragedy and has affected her family deeply.

17.2 For those close to Ibukun her age, (24), has made this all the more difficult. It was known that Ibukun had significant healthcare issues for one so young with significant

trauma throughout her young life.

17.3 This has been a challenge for this review as Ibukun led such a solitary life. She was estranged from her parents and had few friends.

17.4 In approaching learning and recommendations, the Review Panel has sought to do two things. First, to try and understand what happened and consider the issues in Ibukun's life that might help explain the circumstances of the death. Second, to use this case to consider a wider range of issues locally, including provision for victims of domestic violence and abuse.

17.5 It is acknowledged by the panel the effect of the COVID19 pandemic on services provided to Ibukun.

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

LESSONS TO BE LEARNT

17.7 The review identified several learning points that build upon agency IMRs. However, if an agency has already introduced the learning into their practices as a result of the review process, then the need to include a formal recommendation in this review isn't deemed to be necessary. This relates directly to Victim Support who are already undertaking additional IMR author training because of a gap identified within service capability.

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

The themes identified are:

- Impact of immigration status
- Access to medication

- Recognition that self-harm and suicidal ideation are potential indicators of patients experiencing domestic abuse.
- Referrals to support services
- Trauma informed approaches

18. RECOMMENDATIONS

National Recommendation (NR1) – Nationally investment should be made in Pharmacy first to make this service accessible to more communities.

Recommendation (LR1) – MPS need to update their DA policy to make it absolutely clear that DA offences are a priority over any potential immigration offences.

Recommendation (LR2) – MPS need to ensure officers understand the importance of mistakes made when referring to support services and potential consequences.

Recommendation (LR3) – Local investment should be made in Pharmacy first to make this service accessible to patients within Newham.

Recommendation (LR4) – Newham continues to fund and embed IRIS for GP Practices. If IRIS is not a long-term provision identify a suitable alternative.

Recommendation (LR5) – GP practices in Newham to embed a trauma informed approach.

Recommendation (LR6) – Barts staff should receive bespoke DA training and also include the effects of immigration status.

Recommendation (LR7) - Barts policy need to reflect the impact on immigration status for victims of DA and the process chart should be designed as an easy read for staff actions on a disclosure.

Recommendation (LR8) – ELFT to update new Policy in relation to immigration status.

Recommendation (LR9) – ELFT to implement training of all staff in relation to immigration status.

Recommendation (LR10) - WMP should commence regular qualitative reviews to ensure standards of investigation are proportionate and timely in sexual offence investigations.

Recommendation (LR11) – The London Borough of Newham is to highlight the challenges of immigration status on victims/survivors across all its services to ensure providers have policies in place and staff educated.

Recommendation (LR12) – Recognition that self-harm and suicidal ideation are potential indicators of patients experiencing domestic abuse.

APPENDIX 1

Terms of Reference

Domestic Homicide Review

1 Commissioner of the Domestic Homicide Review

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

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

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

2 Aims of Domestic Homicide Review Process

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

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

2.3 To produce a report which:

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

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

3 Timescale

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

4 Scope of the review

4.1 To review events up to this domestic abuse related death of Ibukun this is to include any information known about their previous relationships where domestic abuse is understood to have occurred.

4.2 Events should be reviewed by all agencies for 3 years preceding the domestic abuse related death. However, if any agencies have any information prior to that they feel is relevant, then this should also be included in any chronology/IMR.

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

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

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

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

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

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

5 Key Lines of Enquiry

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

- Visa status, how insecure immigration status impacts on DA/SV- is this a barrier for accessing support?
- How the impact of trauma from domestic abuse contributes to suicidal ideation / suicide.
- The sharing of information. Ibukun had accessed MH services across different boroughs, is there a linked-up system for information sharing in London?
- Impact of trauma from previous SSA allegations and how this is viewed.
- Dynamics of gender within relationships
- Was identity, faith and/or culture a barrier?
- How accessible is anonymous reporting/ advice services for DA and SV-do we have this in place/ is it publicised enough?

6 Role of the Independent Chair

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

7 Domestic Homicide Review Panel

7.1 Membership of the panel will comprise:

Agency
Metropolitan Police
Integrated care Board

Education
Barts Health NHS Trust (Newham Hospital)
Victim Support
East London Foundation Trust (ELFT)
Adult Social Care
Hestia
London Black Women's Project
West Midlands Police

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

8 Liaison with Media

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

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

8.3 **Confidentiality**

All panel members are bound by the agreed confidentiality agreement.

APPENDIX 2

Glossary of Terms

Adult Social Care	ASC

Barts Health NHS Trust (Newham Hospital)	BARTS
Community Mental Health Team	CMHT
Community Safety Partnership	CSP
Domestic Homicide Review	DHR
Domestic Abuse Stalking & Harassment	DASH
East London Foundation Trust	ELFT
General Practitioner	GP
Individual Management Reviews	IMR
London Ambulance Service	LAS
Mental Health Social Care Team	MHSCT
Metropolitan Police	MPS
Multi-Agency Risk Assessment Conference	MARAC
Multi Agency Safeguarding Hub	MASH
Threat Harm Risk Investigation Vulnerability Engagement	THRIVE*
University of East London	UEL
Victim Support	VS
West Midlands Police	WMP

APPENDIX 3

Family Contact

When and by whom	Who to	Method
24/05/22 CSP	Mum	Telephone Introduction

26/05/22 CSP	Mum	Email Introduction letter
31/05/22 Chair	Mum	Email Introduction Letter
09/06/22 Chair	Mum	Email re support
14/06/22 Mum	Chair	Email requesting telephone contact
14/06/22 Chair	Mum	Telephone initial contact
12/07/22 Chair	Mum	Email update from panel 1
13/07/22 Mum	Chair	Email acknowledged updates and requested AAFDA as had been spoken about
13/07/22 Chair	Mum	Email confirming AAFDA
18/07/22 Mum	Chair	Confirming time for contact
18/07/22 Chair	Mum	Email confirming time for call
19/07/22 Chair	Mum	Telephone call
24/08/22 Chair	Mum	In person meeting with Mum and AAFDA
03/10/22 Chair	AAFDA	Email update re panel 2
05/10/22 Chair	AAFDA	Tel update re panel 2

21/12/22 Chair	Mum	MS teams meeting with Mum and AAFDA
03/03/23 Chair	Mum	MS teams meeting with Mum and AAFDA