DOMESTIC HOMICIDE REVIEW EXECUTIVE SUMMARY

Report into the death of Ibukun

October 2020

Independent Chair and Author: Simon Steel

Date of Completion: 9 June 2023

Table of Contents

1. THE REVIEW PROCESS

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

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

Pseudonym	Relationship	Age at the time of the incident	Ethnicity
Ibukun	Deceased	24	Black African
Brian	Ex partner		
Mum	Mother		Black African

1.3 The inquest into the death of Ibukun concluded on 3rd March 2021. The inquest determined that Ibukun died as a result of accidental death.

1.4 The Newham CSP reviewed the circumstances against the criteria set out in the Multi-Agency Statutory Guidance for the conduct of Domestic Homicide Reviews and the chair of the CSP determined that a DHR should be undertaken. The chair ratified the decision, and the Home Office was notified on 8th of April 2021.

1.5 Agencies that potentially had contact with Ibukun and Brian prior to the point of death were contacted and asked to confirm whether they had involvement with them.

2. CONTRIBUTORS TO THE REVIEW

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

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

Agency	Nature of the 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

2.3 IMRs were completed by authors who were independent of any prior involvement with Ibukun.

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

3. THE REVIEW PANEL MEMBERS

3.1 The review panel members included the following agency representatives.

Name	Job Title	Agency
Simon Steel	Review Chair	Independent
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	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	University of East London (UEL)
Adam Cockerton	Det Sgt – Force review Team	West Midlands Police

3.2 The review panel met on 6 occasions.

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

4. AUTHOR OF THE OVERVIEW REPORT

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

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

5. TERMS OF REFERENCE FOR THE REVIEW

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

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

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

5.3 Case specific key lines of enquiry included the following:

- 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. SUMMARY CHRONOLOGY

Family Perspective (Mum)

6.1 Mum explained that Ibukun was born in Nigeria into the Muslim faith. Mum came to the UK in 2004 to undertake a PHD and the children which included Ibukun stayed in Nigeria with their father. Around 13 months later the children came to the UK to be with their mother.

6.2 Mum explained that Ibukun went to the local primary school and then went on to do GCSE and A levels. Following this Ibukun did various college courses and subsequently studied at university.

Metropolitan Police

6.3 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)

6.4 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.

6.5 There was also an incident on 05/01/2020 when Ibukun contacted the 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.

Victim Support

6.6 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.

Health Agencies

GP

6.7 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 her 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.

6.8 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 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.

BARTS

6.9 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.

ELFT

6.10 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.

6.11 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.

Education UEL

6.12 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.

6.13 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.

WMP

6.14 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.

6.15 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.

7. CONCLUSIONS AND KEY ISSUES ARISING FROM THE REVIEW

7.1 Tragically it has not been possible to build a picture from Ibukun's perspective. The review has had to rely on anecdotal reports collated by involved agencies. Based upon these accounts, Ibukun appears to have faced regular challenges with her mental ill health.

7.2 On numerous occasions she reached out to her GP for support and the panel are satisfied that the support was appropriate from the GP.

7.3 In her dealings with the MPS 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.

7.4 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 opposed 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.

7.5 The Metropolitan MPS have a very clear Domestic Abuse policy. It is 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.

7.6 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 where 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.*

7.7 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.

7.8 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.

7.9 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.*

7.10 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.

7.11 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.

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

7.13 Ibukun's interaction with WMP was not positive. This investigation was sub optimal. The basics of any investigation where 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.

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

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

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

7.15 The only evidence of Ibukun's immigration status becoming apparent is when she discloses it to ELFT when she attended hospital in relation the incident on 14/10/20. 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 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.

7.16 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 report's 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.

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

7.18 Other reports provide important information, such as the statistical link between self-harm and suicide. A national strategy 'Preventing Suicide in England' [1] 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.

7.19 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 [2] "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 studied" Conversely, the department of Health in its publication 'Best Practice in Managing Risk'[3] cites 6 tools in assessing risk of suicide.

7.20 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.

7.21 The conundrum of assessing risk is perhaps informed by a BMJ article that summarises,[4] "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

[1] *Preventing suicide in England - A cross-government outcomes strategy to save lives (publishing.service.gov.uk)
[2] Suicide risk assessment and intervention in people with mental illness | The BMJ
[3] Best Practice Managing Risk Cover (publishing.service.gov.uk)
[4] Suicide risk mitigation - Symptoms, diagnosis and treatment | BMJ Best Practice

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".

Sharing of Information

7.22 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.

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

7.23 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 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.

Dynamics of gender in a relationship

7.24 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.

Was identity, faith and or culture a barrier

7.25 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 were 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 felt this is significant.

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

7.26 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.

8. LESSONS LEARNED

8.1 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.

8.2 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.

8.3 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

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

9 GOOD PRACTICE

9.1 Victim Support

- Continuity of trained panel members at the start of this DHR proved an issue for Victim Support. However, this has been reflected on and they have trained more staff to be able to service a DHR process as appose having what could have been seen as a single point of failure.

9.2 University of East London

- UEL as a non-statutory agency have provided an outstanding service to this review. The shear fact that they completed their own independent review and acted on recommendation's well before this DHR process was commissioned speaks volumes for their proactive caring approach. Introducing their own IDVA & ISVA service is one example of their excellent work.

10. RECOMMENDATIONS

10.1 Local IMR Recommendations

The following local recommendations have been agreed by the panel.

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.

10.2 National Overview Report Recommendations

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