Hackney COMMUNITY SAFETY PARTNERSHIP

Norfolk COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY

Report into the killing of Bobo

March 2020

Independent Chair and Author of Report: Mark Yexley

Associate, Standing Together Against Domestic Abuse

Date of Completion (sent to CSP): October 2023

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Dedication from Bobo's family:

"Bobo was a daughter, mother, sister, nanny, great nanny, aunty, and friend to many, to know Bobo was to love her.

Our Bobo was the glue to our family. She was the go-to member of the family that would go the extra mile with supporting the other family members and friends, her door was always open and the kettle on. She was a loyal friend and very sociable. She was kind, caring and nothing was too much trouble when helping others. Bobo's priority in life was her children. She was a brilliant mother, sister, nanny and auntie.

What has happened to Bobo should never happen to anyone, the hole it has left in our family has been enormous. We have spent the two years adapting to a different norm.

This has had massive effect on her children, grandchildren, and family members, knowing that the traditions around birthdays, holidays and Christmases have now gone forever. Bobo was close to her sisters and brother, and they had a bond that was created from the love of each other. She would be the one to who would keep the peace, with 7 sisters and one brother this could be a full-time job. Her home was where all her friends and family would gather passing the time of day, drinking tea, and laughing about life. This was a tradition that had been going for many years but has now become too difficult to continue. Bobo made new friends wherever she went, she joined a local darts team, and it didn't take long before everyone knew when Bobo had arrived. She was truly loyal and an amazing friend.

Bobo liked socialising with people. She was always buying little gifts for people, she loved her dream catchers, candles, room sprays and perfumes, she loved her home to smell nice, and if she found an item of clothing, she liked she would buy it in every colour, which used to make us laugh.

This poem relates to how family, friends and those that knew Bobo feel:"

I NEVER GOT TO SAY GOOD-BYE.

I never got the chance to say I love you.

I never got the chance to say I'll miss you.

Nobody told me you were going to die.

It hurts. I never got to say Goodbye.

Where are you now, please talk to me.

Show yourself and let me see.

I know that can't happen no matter how much I try.

All I want to do is say Goodbye.

I hope you are happy wherever you are.

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I have you in my heart no matter how far.
To the heavens above, I wish I could fly.
Only to give you a warm Goodbye.
I will remember you each day that I live.
You were such a good person with so much to give.
Such a privilege to have known you, no one can deny.
I think it might be time to say Goodbye.
I will keep with me the good times we shared.
I want you to know just how much I really cared.
Till we meet again, on God we must rely.
I love you; I will miss you and for now, Goodbye.

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1. Preface

1.1 The Review Process

1.1.1 This summary outlines the process undertaken by a joint Hackney Community Safety Partnership (CSP) and Norfolk CSP Domestic Homicide Review (DHR) panel in reviewing the homicide of Bobo. Bobo had been resident in Hackney for a few months before her death but had spent most of her life living in Norfolk.

1.1.2 The following pseudonyms have been in used in this review for the victim and perpetrator (and other parties as appropriate) to protect their identities and those of their family members:

The Principal People Referred to in this report						
Referred to in report as	**Relationship to the victim**	**Age at time of homicide**	**Ethnic Origin**	**Faith**	**Nationality & Immigration Status**	**Disability**
Bobo	Victim	57	White European	N/K	British	None
Mike	Perpetrator	40	Black British/Mixed Heritage	N/K	British	None
Stephen	Son	29	White European	N/K	British	N/K
Julie	Daughter	38	White European	N/K	British	N/K

1.1.3 Criminal proceedings were completed in July 2021, and Mike pleaded guilty to manslaughter. He was sentenced to an Extended Sentence of 10 years, comprising of six years imprisonment and four years on licence.

1.1.4 The process began on 16 April 2020 when the Hackney Community Safety Partnership informed the Home Office of the decision to hold a DHR. All agencies that potentially had contact with Bobo and Mike prior to the point of death were contacted, asked to confirm whether they had involvement with them, and instructed to secure their records. Norfolk CSP formally agreed to joint commissioning of the DHR in April 2021.

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1.2 Contributors to the Review

1.2.1 This review has followed the 2016 statutory guidance for Domestic Homicide Reviews which was issued following the implementation of Section 9 of the Domestic Violence Crime and Victims Act 2004. A total of 38 agencies were contacted to check for involvement with the parties concerned with this review. Of these, eight had only limited contact and submitted a Summary of Engagement (SoE) / Short Report or Chronology only. However, 10 had more extensive contact and were asked to submit Individual Management Reviews (IMRs). The chronologies were combined, and a narrative chronology written by the Chair.

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

Agency	Contribution
East of England Ambulance Service NHS Trust (EEAST)	Chronology Only
East London NHS Foundation Trust (ELFT) Mental Health	IMR and Chronology
Department of Work and Pensions (DWP)	Summary of Engagement – request chronology
Hackney CCG for General Practitioner (GP)	IMR and Chronology
HMP Norwich	IMR and Chronology
HMP Rochester	Chronology Only
Leeway Domestic Violence and Abuse Services	Summary of Engagement – re contact with Bobo on her son in 2012
London Ambulance Service (LAS)	Chronology Only
London Borough of Enfield – Children's Social Care	Summary of Engagement

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L&Q (Housing)	Short Report
Metropolitan Police Service	IMR and Chronology
National Probation Service	IMR and Chronology
Norfolk Community Health and Care NHS Trust (NCHC)	IMR and Chronology
Norfolk Constabulary	IMR and Chronology
Norwich City Council	IMR and Chronology
Norfolk and Suffolk NHS Foundation Trust (NSFT)	Chronology Only
Norwich GP	IMR and Chronology
Virgin Care	IMR and Chronology

1.2.3 Independence and Quality of IMRs: The IMRs were written by authors independent of case management or delivery of the service concerned.

1.2.4 Most IMRs/Short Reports received were comprehensive and enabled the Review Panel to analyse the contact with Bobo and Mike, and to produce the learning for this review. Where necessary, further questions were sent to agencies and responses were received.

1.3 The Review Panel Members

Name	Job Title	Agency
Latoya Alfred	Named Nurse Children's	

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	Safeguarding	Homerton University Hospital NHS Foundation Trust
Justin Armstrong	Detective Sergeant – Independent Review Officer	Specialist Crime Review Group (SCRG), Metropolitan Police Service (MPS)
Matt Beavis	Detective Sergeant - Independent Review Officer	SCRG, MPS
Diane Bedwell	Senior Clinical Lead	Virgin Care
John Binding	Head Adult Safeguarding	Hackney Adult Social Care
Laura Bleaney	Service Manager	Hackney Children's Services
Saranna Burgess	Director for Patient Safety and Quality	Norfolk and Suffolk Foundation Trust (NSFT)
Kevin Clark	Deputy Governor	HMP Norwich
Daniel Dray	Safeguarding Specialist	London Ambulance Service NHS Trust (LAS)
Michelle Frazer	Refuge Coordinator	Leeway Domestic Violence and Abuse Services, Women's Aid Norwich
GP - Hackney	General Practitioner GP from Hackney Practice	Hackney GP Practice
Heather Harvey	Director of Research and Development	NIA Ending Violence
Andy Hill	Detective Inspector	Norfolk Constabulary
Kathryn Hunt	Head of Service, Brent PDU	National Probation Service (NPS)
Wayne Hylton	Anti-Social Behaviour and Estate Safety Manager	Hackney Council

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Zahid Iqbal	Named Professional for Safeguarding Adults	East London NHS Foundation Trust (ELFT)
Maria Karretti	Named GP for Adult Safeguarding	Norfolk & Waveney CCG
Lucy Kennedy	Implementation and Transformation Manager	Turning Point
Graeme Malcom	Services Manager	Change, Grow, Live
Susan Mason	Deputy Safeguarding Lead - Adults	Norfolk Community Health and Care NHS Trust (NCHC)
Jim Mitchell	Detective Inspector, Safeguarding Central East BCU (Hackney & Tower Hamlets)	MPS
Bernice Molyneaux	Domestic Abuse Specialist	Claudia Jones Organisation (CJO)
Amanda Murr	Head of Community Safety	Office of Police and Crime Commissioner for Norfolk
Daniel Newbolt	Assistant Director	Norfolk Children's Services
Rachel Omori	Independent Living Manager	Community Safety, Norwich City Council
Mary O'Reardon	Adult Safeguarding Lead	North East London CCG
Mark Rowlands	Deputy Safeguarding Lead for Adults	Norfolk Community Health and Care NHS Trust (NCHC)
Cathal Ryan	Service Manager and VAWG	Hackney Domestic Abuse Intervention Service, Community Safety, London Borough of Hackney
Timothy Samwell	Head of Offender Management Services	HMP Rochester
Jo Sapsford		Norwich City Council

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	Early Intervention and Community Safety Manager	
Eleonora Serafini	VAWG Specialist Practitioner	Hackney Community Safety
Claire Sidney-Jenkins	Safeguarding Officer	LAS
Andrea Walton	Interim Safeguarding Adult Lead (First four meetings)	Homerton University Hospital NHS Foundation Trust
Ben Wayland	Safeguarding Specialist	LAS
Beverley Williams	Detective Sergeant	Serious Crime Review Group, MPS
Irene Willie	Named Nurse	Homerton University Hospital NHS Foundation Trust
Jenny Wood	Lead Nurse for Safeguarding (from fifth Meeting onwards)	Homerton University Hospital NHS Foundation Trust
Jessica Woods	Primary Care MARAC Liaison Nurse	Hackney
Gary Woodward	Adult Safeguarding Lead Nurse	Norfolk and Waveney CCG
Lovevita Wright	Regional Housing Manager	L&Q Group
Mark Yexley	Independent Chair	Standing Together Against Domestic Abuse

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

1.3.2 The Review Panel met a total of five times, with the first meeting of the Review Panel on 18th November 2020. There were subsequent meetings on 24th March 2021, 20th April 2021, 19th October 2021 and 25th May 2022.

1.3.3 The Chair of the Review wishes to thank everyone who contributed their time, patience and cooperation to this review.

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1.4 Chair of the DHR and Author of the Overview Report

1.4.1 The Chair and author of the review is Mark Yexley, an Associate DHR chair with Standing Together. Mark has received Domestic Homicide Review Chair's training from Standing Together and has chaired and authored 19 DHRs. Mark is a former Detective Chief Inspector with 39 years' experience of dealing with domestic abuse and was the head of service-wide Strategic and Tactical Intelligence Units combating domestic violence offenders, head of Cold Case Rape Investigation unit and Partnership Lead for sexual violence in London. Mark was also a member of the Metropolitan Police Authority Domestic and Sexual Violence Board and Mayor for London Violence Against Women Group. Since retiring from the police service, he has been employed as a lay Chair for NHS Health Education England Services in London and the South East. This work involves independent reviews of NHS services, training and selection for foundation doctors, specialty grades.

1.4.2 *Independence:* Mark Yexley has no connection with the Norfolk area or CSP or any of the local agencies involved in this case. Mark's only previous contact with the Hackney area came as commissioner for the post of an Independent Sexual Violence Advisor (ISVA) for Sex Worker service run by City and Hackney and Homerton Hospital. Mark retired from the MPS in 2011 and has had no operational involvement with the service since that time. Mark's Health Education England work is not linked to any NHS Trust mentioned in this report.

1.5 Terms of Reference for the Review

1.5.1 At the first meeting, the panel shared information about agency contact with the individuals involved, and as a result, established that the time period to be reviewed would be from 1st January 2018 to the date of the homicide in March 2020. This timeframe was chosen because: at the first panel meeting it was not known exactly how long Bobo and Mike had known each other. Mike was a serving prisoner until April 2019 and he had been planning to move in with Bobo before his release. It was considered that a start date for a detailed chronology was appropriate from January 2018. Panel members agreed to include information on significant events before 2018.

1.5.2 *Key Lines of Inquiry:* The Review Panel considered both the generic issues as set out in the 2016 statutory guidance and identified and considered the following case specific issues:

- The communication, procedures and discussions, which took place within and between agencies;
- The co-operation between different agencies involved with Bobo and Mike [and wider family];
- The opportunity for agencies to identify and assess domestic abuse risk;
- Agency responses to any identification of domestic abuse issues;
- Organisations' access to specialist domestic abuse agencies;

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- Analyse the experience of Bobo as a woman in a bi-racial relationship and whether this would impact on her access to services.
- Analyse whether substance misuse impacted on Bobo or Mike's access to services.
- Analyse whether Bobo's vulnerability and starting a relationship with a prisoner, affected her and whether procedures should be adapted to consider this.
- Analyse whether Mike's presentation as a carer for Bobo was considered as a factor by services that she was accessing.
- Analyse whether Bobo's mental health impacted her ability to access to services.
- Analyse whether Bobo's experience of Adult Family Violence affected her access to services.
- Analyse whether Bobo was subject to coercive control through economic abuse and if this impacted on her access to services.

1.5.3 To address specific issues in this case (including in relation to equality and diversity as identified in 1.5) the following agencies were invited to be part of the review due to their expertise even though they had not been previously aware of the individuals involved:

- Substance misuse - Change, Grow, Live.

1.5.4 The panel gave consideration to the involvement of specialist organisations on economic abuse at the drafting stage of the report. The CSPs balanced the cost of the involvement and the relevant experience of the DHR Chair and decided not to employ further specialists. It was acknowledged that the CSPs could benefit from working with economic abuse specialists, such as Surviving Economic Abuse (SEA), outside the DHR process.

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2. Summary of Chronology

2.1.1 At the start of the period under review Bobo was living in Norfolk. She had lived all of her life in that county. She lived in rented local authority housing with her son Stephen. Her daughter Julie and siblings lived nearby. Bobo did not know Mike.

2.1.2 **Imprisonment of Mike**. In November 1999 Mike was sentenced to 12 years imprisonment for 10 counts of robbery and firearms offences. Whilst serving Mike was sentenced to an additional eight years imprisonment for drugs offences.

2.1.3 **Mike's mother smuggled drugs into prison.** In 2003 Probation Service report that Mike's mother was sentenced to three years imprisonment for smuggling heroin into prison to Mike. After her release Mike's mother lived a housing association flat in the London Borough of Hackney, this is the premises where Bobo was later killed in 2020.

2.1.4 **Bobo commences a relationship with Mike in prison**. From 2012 Bobo is believed to have started a relationship with Mike, as a pen pal, whilst he was a serving prisoner. They were introduced by a member of Bobo's family.

2.1.5 The relationship developed into Bobo visiting Mike in prison. Mike sent numerous letters to Bobo and the details of those letters were revealed to the DHR panel. Mike sent lengthy letters to Bobo and he asked for money to be sent to him. Letters suggested that Bobo had been supplying drugs to Mike in prison. Bobo's family confirmed that she had been passing drugs to Mike during prison visits.

2.1.6 During his time in custody Mike was found to have breached laws on possession of prohibited items. He was also concerned in assaults and threats towards prison staff. Mike was refused parole and had to serve his whole sentence.

2.1.7 **Mike released from prison**. On 18th April 2019 Mike was released from HMP Norwich. He was subject to Probation Supervision for three months after his release.

2.1.8 **Mike moves into Bobo's home**. Mike was released to the London area but it was clear that he wanted to live in Norfolk. Mike was seen at Bobo's home, in Norfolk, by Probation Officers but was told it was not suitable for him to live there. Mike gave a new address, of Bobo's sister, but he did not move and carried on living with Bobo and her son.

2.1.9 **Mike reported thoughts of self-harm to GP**. In June 2019 Mike attended his GP for a repeat prescription and a painful knee. The GP notes indicate he was 'recently unsure of his own mental health stability, occasionally gets thoughts of self-harm that he may/may not act upon, admits to trying to hang himself in prison, says partner found him in room trying to put on ligature, but wouldn't elaborate'. Mike was referred urgently to local NHS Mental Health Services. He was followed up with contact from the local mental health crisis team.

2.1.10 **Mike reported being assaulted by Bobo's son**. On 14th July 2019 police were called by Bobo, via 999 service, to her home. She said that her son was trying to fight with her partner and there was glass and blood everywhere. On arrival of police Mike reported being assaulted by Bobo's adult son, Stephen, causing an injury to his head. Stephen was arrested and interviewed. Mike declined to make a victim statement and No Further Action (NFA) was taken against Stephen.

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2.1.11 Bobo made application to move house in Norfolk from her family home. She gave Mike authority to speak to the housing department on her behalf. Mike asked for Stephen's name to be taken off the housing application. The housing office spoke to Bobo and she said she would think about amending her application. She did not follow up the application.

2.1.12 **Mike's mother believed to have died in October 2019.** Mike applied for tenancy of his mother's flat in Hackney.

2.1.13 **Bobo moved with Mike to Hackney in November 2019.**

2.1.14 **Bobo reported missing and concerns of domestic abuse**. On 25th November 2019 Bobo's sister called Norfolk Police to report Bobo as a Missing Person. Bobo told her sister that she was going to London to see her partner. The sister had been unable to contact Bobo since. The police call handler recorded *'there are unreported domestic issues. Mike has been seen with his hand over Bobo's mouth and is very controlling'*. Family later told police that Bobo had been seen with unexplained bruises. There was no incident of domestic abuse reported by Norfolk Constabulary. Norfolk Constabulary made enquires with the Metropolitan Police Service (MPS) to trace Bobo. Bobo was found in London. She was not spoken to as a potential victim of domestic abuse.

2.1.15 **Mike referred to mental health services in Hackney.** On 9th December 2019 East London NHS Foundation Trust (ELFT) received a referral from Mike's Hackney GP. It was reported that he had depression and insomnia.

2.1.16 In January and February 2020 Mike attended appointments with ELFT. Bobo accompanied Mike but she was not introduced as his partner.

2.1.17 **Mike refused tenancy.** In February 2020 Mike was informed that he did not meet the criteria to succeed to the tenancy of the flat previously occupied by his mother. He was advised to give vacant possession within 28 days. He was advised to contact the local authority housing department to register for housing.

2.1.18 Three days before she was found dead, in March 2020, Bobo telephoned her daughter and told her that her head was hurting. Her daughter told her to go to hospital, Bobo refused, due to the COVID19 pandemic. Her daughter said that she was scared but Bobo said she was fine and loved her unconditionally.

2.1.19 Two days before Bobo was found dead, Bobo's daughter stated that she called the police to check on her mother.

2.1.20 On the same day ELFT Outreach Practitioner telephoned Mike to rearrange an appointment, as face-to-face appointments were being cancelled due to COVID19. Mike hung up the phone and did not answer when ELFT tried to call back. Also on that day Mike failed to attend his DWP telephone appointment.

2.1.21 **Mike reported that Bobo had died**. On the day that Bobo was found dead, Mike attended Stoke Newington Police Station and stated that he thought his partner was dead due to an overdose of drugs. Police attended the flat in Hackney and found Bobo deceased in bed with a number of injuries. Mike was arrested on suspicion of murder.

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3. Conclusions and Lessons to be Learnt

3.1 Conclusions

3.1.1 The killing of Bobo resulted in the loss of a kind and loving sister and mother, and is devastating. Mike is the person responsible for this act.

3.1.2 Bobo had lived close to her family for majority of her life. She was a caring person who would support others and looked out for her children and grandchildren.

3.1.3 The Review Panel extends its sympathy to the family and friends of Bobo. Their involvement in the review process has provided a valuable insight on Bobo as a person, and some of her experience of agencies. This review aims to use their contribution and the work of the panel to bring improvements for other people and to help prevent future tragedy. Bobo's family have fully supported this review in the hope that it will somehow reflect her as a person. It is recognised that the family received support throughout this process from VSHS. The Chair would also like to extend thanks to VSHS for their support and professional communication.

3.1.4 This review is a learning process and the aim is to share that learning across all agencies to improve services in the future.

3.1.5 In this case Bobo's family brought to the panel's attention a series of letters from Mike, in prison, to Bobo that went back beyond the period originally under review. The letters give some insight on Mike's method of coercively controlling Bobo, economically and emotionally abusing her. Injuries to Bobo's face seen by Bobo's family would suggest the presence of physical violence long before her death.

3.1.6 Mike's propensity for controlling women outside prison was known for many years and does not appear to have been considered in intelligence, risk management or investigation processes between NPS and HM Prisons. Mike was known to have used his mother to traffic drugs. There was an apparent lack of curiosity and assertiveness in the management of a prisoner, who was a ViSOR nominal known to exploit women.

3.1.7 There were no links made between Mike's later drug use and possession of phones in prison and the timing of Bobo's visits. Bobo's family have disclosed that Bobo was taking drugs into her visits with Mike. The review has clearly shown that Mike 'groomed' women from the confines of his prison and exploited Bobo. He effectively targeted a vulnerable woman through the prison visiting system. It is of great concern that Mike was able to carry out a course of conduct over many years in prison without those managing him identifying this behaviour and the risks to others. Mike was sanctioned for his offending behaviour within prison but it appears that no consideration was given to his links in the community.

3.1.8 Controlling behaviour continued after Mike's release from prison. Mike isolated Bobo from her family before he eventually killed her. It is accepted that we will never know the full extent of Mike's abusive behaviour. Whilst agencies would not have been aware of what was happening to Bobo, there were areas were adherence to processes and improved communication could have provided opportunities to identify abuse and protect Bobo.

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3.1.9 The economic abuse of Bobo was clear. Mike's demands for funds whilst in prison are evident in his communication with Bobo. When he left custody he effectively gained free accommodation from Bobo. He later went on in attempts to sabotage her housing, it appears with the intent to isolate her from family. When Mike moved into his deceased mother's home and attempted to gain tenancy where he presented himself as a single person.

3.1.10 When Bobo went to London with Mike, her family had concerns for her. They made clear reports to Norfolk Police of their concerns for domestic abuse. It appears that these were incorporated into the Missing Persons Enquiry, but they were not recorded as separate third-party reports of domestic abuse. It is appreciated that Norfolk Police asked the police in London to check on Bobo's welfare but they did not request that a DASH risk assessment was conducted with her.

3.1.11 In the months leading up to Bobo's death it was apparent that Mike's mental ill-health was an issue. The NHS Mental Health Trust in London engaged with Mike in timely way. Mike's long-term healthcare had previously been provided in Prison. The NHS team requested access to Mike's long-term records, but the subsequent supply of years of notes without an effective handover summary highlights the need to change practice and service provision. A key area that was not highlighted, in prison medical notes, was any potential risk that Mike would have presented to women or to medical professionals dealing with him. The panel recognises that the medical professions may encounter patients who present risks to staff, and there are specialist practitioners to manage this. It is important that all medical professionals identify and highlight risks in clinical notes, so that it clear for all staff to see on handover.

3.1.12 It is disappointing that there was such poor engagement from the private healthcare, prison service, provider with the DHR. The poor standard of written submission, from the private provider to this review may reflect the challenges NHS services had to face when managing Mike's healthcare needs in the community.

3.2 Key Themes and Learning Identified

3.2.1 This case shows that there needs to be a strong multi-agency partnership focus on tackling and preventing domestic abuse. It should also be recognised that the DHR process and homicide investigation have resulted in some immediate changes in the protocols and procedures. This demonstrates a willingness to implement change and improvements across the areas. There are some key areas that concern national services that require action elsewhere.

3.2.2 **Coercive control from persons detained in HM Prisons**: Mike clearly used coercive controlling behaviour from prison. The Prison Service, National Probation Service and other agencies need to be alert to the possibility that detainees can exploit or abuse others from within the confines of a prison. There should be a consideration of information held within prison and probation records and how that can be used to assess risks to those communicating with detainees. HM Prisons need to consider an intelligence led approach to

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preventing harm within the prison, and consider their wider responsibility, as a public authority, to prevent harm to the public.

3.2.3 This translates into Recommendations I,1, and 5.

3.2.4 **Recording reports of third-party reports of domestic abuse**: The review has established a failure of police to record reported third-party concerns of domestic for investigation. Police need to be alive to the fact that any missing person's report could contain allegations of abuse of some form. The recording of domestic abuse requires the consideration of risks in a formal DASH Risk assessment. There needs to be robust processes in place to ensure that all reported concerns of abuse, be they from victims or third parties, are correctly recorded. This should include enquiries under Clare's Law by victims and families. The correct recording of reported domestic abuse can ensured that the case is managed by specialist officers and links are made to Domestic Abuse agencies.

3.2.5 This translates into Recommendations H, 4, and 8.

3.2.6 **Handover of patients between HM Prisons and NHS**: When a person leaves prison health services it is essential that medical records are passed to the primary healthcare services covering their release address. Even when a medical professional is aware that a person had just been released from prison, it can take time to assess information held within records. It is also essential that prison healthcare records clearly highlight risk factors for people in contact with the for the area where they are living. It is also essential that records highlight any potential risk presented to healthcare staff encountering the person.

3.2.7 This translates into Recommendations C, D, I, Q, and 3.

3.2.8 **Routine Enquiry**: The use of routine enquiry, by primary care services, into a persons' relationships and safety at home features in many DHRs. This form of enquiry would sometimes be made on registration with a new GP. In this case Bobo had remained with the same GP in Norfolk for many years. It could be considered that a change in a person's home circumstances would trigger enquiry, this could include a new partner attending appointments with a person when they had always previously attended alone. There needs to be training in place to outline what constitutes domestic abuse if we want our healthcare professionals to recognise the presence of abuse. Bobo registered with a new GP two weeks before her death, at the time that GP did not routinely ask about a person's safety at home. This GP practice does now routinely enquire into abuse. The panel recognised that GPs should not be working in isolation and all opportunities for information between agencies should be used.

3.2.9 This translates into Recommendations D, E, J, K, and P.

3.2.10 **Economic Abuse**: It is clear from Bobo's family that there was economic abuse present early in the contact between Mike and Bobo, through her regular supply of funds. Whilst prison authorities were not aware of this, the release from prison and contact with probation services should consider the economic impact on those the prisoner intends to stay with. It is clear that Mike imposed himself on Bobo's housing status and initiated contact with the housing provider. We know that this all took place at a time when Bobo was in arrears in

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relation to her housing. Mike effectively sabotaged her living arrangements and housing, economically abusing Bobo. Economic abuse should be treated in the same way as any other form of domestic abuse, as opposed to treating it as a property crime. Training in awareness of economic abuse, with systems set to highlight concerns and professional curiosity can evidence economic abuse with the aim of protecting potential victims.

3.2.11 This translates into Recommendations E, R, 6, and 9.

3.2.12 **Substance Misuse:** It is apparent that substance misuse was a factor in the relationship between Mike and Bobo. It is known that Mike exploited his mother to bring drugs into prison and Bobo's family have told the review that he did the same to her. There were also mentions of Mike exploiting Bobo's family to supply drugs. It is known that Bobo reported her own use of cannabis to manage pain, but she was never referred to substance misuse services. It is known that Bobo had cocaine in her body when she died but there is no evidence that she had ever been exposed to Class A drugs before she met Mike. It is known that Mike exerted controlling behaviour in exposing Bobo to drugs. Agencies should be aware of abusers can exploit people either through involving them in criminality or risk from personal use of controlled substances.

3.2.13 This translates into Recommendations D, Q, and 3.

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4. Recommendations

4.1 Recommendations from the review

4.2 Single Agency Recommendations (Identified by Individual Agencies)

4.2.1 The following single agency recommendations were made by the agencies in their IMRs.

4.2.2 These recommendations are also presented by agency in the single agency recommendation action plan template in **Appendix 2**. These recommendations should be acted on through the development of an action plan, with each agency reporting on progress to the Hackney and Norfolk Community Safety Partnerships.

4.2.3 **East London NHS Foundation Trust (ELFT) Mental Health**

4.2.4 **Recommendation A:** The ELFT Safeguarding Adults Team to provide some form of safeguarding supervision to the team involved in this case to help offer practitioners there an opportunity to discuss safeguarding concerns and reflect on cases through the lens of safeguarding adults. The ELFT Safeguarding Supervision Policy is currently being drafted up but it is hoped that once this is published, the Safeguarding Lead for Hackney will have a conversation with the Service Manager to understand how best safeguarding supervision can be delivered to this service. This could realistically start to take place in the next 3 months once the policy has been ratified.

4.2.5 **Hackney CCG for General Practitioner (GP)**

4.2.6 **Recommendation B:** Review of Domestic Violence and Abuse Policies to ensure up to date information and correct local referral pathways reflected within the next three months.

4.2.7 **Recommendation C:** Review of safeguarding hand over in Primary Care specifically for post-prison registrations with a GP including history of violent offending, mental health and substance misuse.

4.2.8 **Recommendation D:** Registration form to be explicit in asking about illicit use of substances and offering onward referral to local services.

4.2.9 **Recommendation E:** All staff at the GP practice would benefit from a domestic abuse awareness update within the next three months.

4.2.10 **HMP Prisons**

4.2.11 **None**

4.2.12 **L&Q Housing Association**

4.2.13 **Recommendation F:** As a learning for L&Q further training is required to support our staff providing an empathetic approach when dealing with sensitive matters.

4.2.14 **Recommendation G:** A review will be undertaken of our Succession Application form as to the information gathered and whether this needs to include more about the applicant's history.

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4.2.15 **Metropolitan Police Service**

4.2.16 **Recommendation H:** It is recommended that Central East (CE) Basic Command Unit Senior Leadership Team (SLT) remind all BCU Operations room supervisors of the importance of using professional curiosity when prioritising and assessing requests to assist other police areas to conduct missing person enquires and to ask for more detailed risk assessments if required.

4.2.17 **National Probation Service (NPS)**

4.2.18 **Recommendation I:** When high risk individuals are being released into community at sentence end date, good practice would be that there should still be a MAPPA meeting so that all agencies are aware of potential risks in the community even if there are limited mechanisms in place to manage risks.

4.2.19 **Norfolk Community Health and Care NHS Trust (NCHC)**

4.2.1 **Recommendation J:** For staff to be professionally curious at all patient interactions. This will be done via training, the NCHC Safeguarding newsletter and Safeguarding Group Meeting will have a focus on Professional Curiosity. Re-circulate the Professional Curiosity Document of 2020 on an annual basis. There is also further support via phone calls, emails and TEAMs calls.

4.2.2 **Recommendation K:** Staff to be aware of the DA Champions role, how to access them and how to become a Champion. Guidance will be updated on the NCHC Safeguarding intranet page, this will include what champion is, what training and support is given and how the Champions are accessed. We aim to have a DA Champion in every locality by end of 2023. This will be communicated in Safeguarding newsletter and Group meeting, via DA lead and at Governance meetings. Registered staff to attend 3 yearly level 3 Safeguarding training day. As well as other subjects the training includes DA, professional curiosity, and the thematic framework. Training content is updated by Safeguarding team. Dates of training are advertised on Safeguarding intranet page, in newsletter and at Governance meetings, and take place approximately 3 times per month.

4.2.3 **Norfolk Constabulary**

4.2.4 **Recommendation L:** Norfolk Professional Standards Department produces a ‘Learning Times’ magazine of learning points such as this one. This learning point has been recommended for inclusion and circulation to all officers in the next edition. In this case the domestic abuse concern features on compact and a review of the missing circumstances and/or risk assessment by the supervisor before authorising closure of the missing person record could have led to a better understanding of the need for Bobo to be spoken with alone to address that concern. That aspect will be incorporated into the summary of the learning for the proposed magazine item.

4.2.5 **Recommendation M:** The Missing Person Force Policy Document section on completing ‘safe and well’ checks is recommended for amendment to include the following wording; “*where abuse or exploitation are considered to be a possible factor, extensive efforts should be made to speak with the person alone”.*

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4.2.6 **Norwich City Council**

4.2.7 **Recommendation N:** Remind colleagues and partners of opportunity to request general access visits from the tenancy management team and when they might do so.

4.2.8 **Recommendation O:** Update tenancy information to ask tenants to update the council of any additional support needs they have, as this occurs.

4.2.9 **Recommendation P:** Remind colleagues to capture on information management system any new information on vulnerabilities or support needs of customers.

4.2.10 **Norwich GP**

4.2.11 **Recommendation Q:** To improve communication and process between the criminal justice system and the general medical services in Norfolk at the point of release from prison including registration at a new practice, timely transfer of medical records and communication regarding ongoing physical and psychological needs as well as repeat medication.

4.2.12 **Recommendation R:** Norfolk and Waveney primary care services require access to bespoke domestic abuse training which includes an awareness of domestic abuse, how to recognise and respond effectively.

4.2.13 **Recommendation S:** A domestic abuse gap analysis on training and content in Norfolk and Waveney to ensure a consistent system wide appropriate response.

4.2.14 **Recommendation T:** Ensure primary care services have access to distinct guidance on the identification and response to domestic abuse.

4.3 Multi Agency Recommendations (Developed by the Review Panel)

4.3.1 The Review Panel has made the following recommendations during this review in response to learning identified.

4.3.2 These recommendations are also presented in the multi-agency recommendation action plan template in **Appendix 3**. The Hackney Community Safety Partnership and Norfolk Community Safety Partnership are responsible for overseeing then development and monitoring of an action plan.

4.3.3 **Recommendation 1**: That the Ministry of Justice review processes and implements policies within the prison service to ensure that where a prisoner has a known history of domestic abuse and/or violence and initiates further relationships with other parties this is processed through a Domestic Violence Disclosure Scheme process with the local Constabulary to where the prisoner is located. This would ensure should the perpetrator be moved around the prison system this is managed appropriately. (To be monitored by Hackney CSP)

4.3.4 **Recommendation 2**: That the Ministry of Justice ensures processes are in place to ensure that families of victims of homicide are provided with a written record of the Judge's sentencing comments after a trial. (To be monitored by Norfolk CSP)

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4.3.5 **Recommendation 3:** That the Ministry of Justice and HM Prison Service establish that all commissioned Prison Health Services are required to provide a timely written discharge report with a transfer of notes to community services and primary care prior to or on release from custody. There should also be a requirement that commissioned health services support statutory reviews with reports of an acceptable professional standard. (To be monitored by Norfolk CSP)

4.3.6 **Recommendation 4:** That Norfolk Constabulary commission a review of crime recording standards on cases of domestic abuse. This should include a review of calls to domestic incidents, and missing persons reports. Consideration should be given to the routine supervision of incidents, such as missing person reports to identify where abuse has gone unrecorded. The review should include dip sampling by representatives of the Norfolk CSP and local domestic abuse services to ensure transparency and public confidence.

4.3.7 **Recommendation 5:** That the HM Prison Service and National Probation Service actively monitor Mike whilst he is a serving prisoner. To assess communication and visits to manage potential risks on grooming and developing new relationships. The panel STRONGLY recommends that Mike's mail be monitored by HM Prisons in order to prevent harm and abuse. This should also be used to inform licence conditions. (To be monitored by Norfolk CSP)

4.3.8 **Recommendation 6:** That housing services involved in the DHR review their policies and develop new practice to consider economic abuse when assessing housing needs.

4.3.9 **Recommendation 7:** That Norfolk CSP review any targeting awareness campaigns arising from the DHR into the death of "April" in 2019 and consider whether learning from this review can be used to develop work in that area.

4.3.10 **Recommendation 8:** That Norfolk Constabulary review the progress on actions from DHR into the death of "April" in 2017 together with this case to ensure that all DVDS Right to Ask scheme enquires are recorded in a retrievable format. This should be supported by audit against incoming call data.

4.3.11 **Recommendation 9:** That all agencies review policies and procedures to ensure that they include the provisions of the Domestic Abuse Act 2021.

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