Domestic Homicide Review

Overview Report

Suicide- MANPREET

Died September 2017

Author: Dr Russell Wate QPM

July 2020

Contents:

1. Timescale for completion

1.1 This report was commissioned by the Safer Lincolnshire Partnership (This is Lincolnshire's name for their Community Safety Partnership). They are a statutory partnership which brings together a number of agencies with the aim of reducing crime, disorder and anti-social behaviour across the county. These agencies work together to improve the safety of residents and visitors by information sharing and partnership activity. One of the key safeguarding roles of the partnership is that of tackling domestic abuse.

1.2 On 24th January 2018 Lincolnshire Partnership NHS Foundation Trust (LPFT) notified the Chair of the Safer Lincolnshire Partnership that the death of Manpreet was being investigated as a suicide, and there was domestic abuse in her relationship. This was in accordance with the Lincolnshire Domestic Homicide Review Protocol. The Chair of the Partnership Board considered the case, in conjunction with other key agencies that had contact with Manpreet, and concluded that the case did meet the criteria and justification for a Domestic Homicide Review. The Home Office were notified accordingly. In terms of cases where the person like Manpreet has died as a result of suicide the Home Office guidance states: *'Where a victim took their own life (suicide) and the circumstances give rise to concern, for example it emerges that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable*.'

1.3 The SLP held an initial scoping meeting on January 2018 and commissioned the review appointing as the Independent Chair and author, Dr Russell Wate QPM, who has compiled this overview report.

1.4 The review panel feels it is really important that at the very beginning of this report that they highlight that the report is about Manpreet and her lived experience. The name Manpreet is a pseudonym, the advisor to the panel from the Sikh community felt it was an appropriate one to use as it is commonly used female name in their community. Manpreet was at the time of her death 40yrs old. A lady of Indian heritage and a Sikh by religion. Manpreet came from the Midlands area and had previously had an arranged marriage; it was from this marriage that she has two children. Manpreet left her husband approximately 7yrs before she died, to be with the perpetrator of the domestic abuse Brian (also a pseudonym) (this is according to the information that Manpreet told her neighbours). Her family, including her ex-husband, and children from that time on, had almost nothing again to do with her. Her mother and brother also had minimal contact. The relationship with Brian has been described by neighbours and friends as a turbulent one. Four years before Manpreet died they moved into a house that she bought in a semi-rural location of a small close of homes that is a few miles from its nearest town. They set up a business together and Manpreet totally relied on the income from this business. During her last few months

there was a Domestic Abuse (DA) incident, where Brian was arrested and placed on remand in prison for a period. There were also four possible suicide attempts by her and involvement with a number of agencies in particular health agencies. This period culminated in Manpreet dying as a result of suicide following this period in her life.

1.5 Her brother, at the inquest, described Manpreet "*Growing up, I had about five friends and she had hundreds - she was very popular and a lot of her friends went to the funeral.*" One of her neighbours described Manpreet as "*Strong willed, very warm, caring and thoughtful."*

1.6 In order to ensure the review into the circumstances that led to Manpreet taking her own life, was dealt with in a timely manner, the following timescales were agreed by the DHR panel:

June 2018

- 6 June 2018 - Panel meeting with appointed Chair/Author to agree Terms of Reference
- Name of IMR authors to be sent to the DHR Administrator
- Family and friends informed of DHR (in consultation with the police Senior Investigating Officer)

July 2018

- 13 July 2018 - Deadline for submission of completed chronologies

September 2018

- Deadline for submission of completed IMRs to DHR Chair by 13 September 2018
- IMRs to be circulated to panel members – 20 September 2018

September 2018

- 27 September 2018 - IMR presentation meeting

October 2018

- 12 October 2018 – Deadline for additional information and amended IMRs

November 2018

- First draft overview submitted to panel. Discussed with family members.
- 26 November 2018 – 2nd Draft Overview Report to be submitted by author and circulated for comment. Action plan to be circulated by DHR administrator to panel members.

December 2018

- Panel meeting to present draft Overview Report – 3 December 2018
- Amended Overview Report submitted to Panel members for comment 17th December 2018

January 2019

- Comments returned 10th January 2019
- Amended Overview report to panel members- 21st January 2019

- Action plan completed by all agencies and returned to DHR administrator 7th January 2019
- Panel Meeting, Overview report, Executive summary and action plan signed off by panel members on 28th January 2019 followed by the Chair of the Community Safety Partnership on 29th March 2019
- Report submitted to the Home Office March 2019

2. Confidentiality

The findings of this review are confidential. Information is available only to participating officers/professionals and their line managers. Include pseudonym/s and used in the report to protect the identity of the individual(s) involved.

3. Terms of reference:

The Specific Terms of Reference examined by the agencies and addressed within this report are;

a) The IMR authors to ensure consideration is given in all the below headings the risk of Manpreet dying as a result of suicide due to her being a victim of domestic abuse.

b) To examine whether there were any previous concerns, incidents, significant life events or indications which might have signalled the risk of violence to any of the subjects, or given rise to other concerns or instigated other interventions.

c) When, and in what way, were practitioners sensitive to the needs of the subjects, knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

d) When, and in what way, were the subject's wishes and feelings ascertained and considered? Were the subjects informed of options/choices in order to make informed decisions? Were they signposted to other Agencies and how accessible were these services to the subjects?

e) What were the key points or opportunities for assessment and decision-making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?

f) Was appropriate professional curiosity exercised by those Professionals and Agencies working with the individuals in the case; this includes whether Professionals analysed any relevant historical information and acted upon it?

g) Were the actions of agencies in contact with all subjects appropriate, relevant and effective to the individual and collective family needs and risks identified at the time, and continually monitored and reviewed?

h) Did the agency have policies and procedures for domestic abuse and safeguarding and were any assessments correctly used in the case of the subjects? Were these assessment tools, procedures and policies professionally accepted as being effective? Was the victim subject to a MARAC or other multi-agency fora?

i) Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?

j) Were any issues of disability, diversity, culture or identity relevant?

k) To consider whether there are training needs arising from this case

l) To consider the management oversight and supervision provided to workers involved

m) Was any restructuring during the period under review likely to have had an impact on the quality of the service delivered

The critical dates for this review have been designated by the panel as 1st April 2017 to 5th September 2017; however, the panel chair has also asked the agencies providing IMR's to be cognisant of any issues of relevance outside of those parameters which will add context and value to the report. These dates were felt to be the most relevant in the life of Manpreet as it was during this time that the domestic abuse, her health and wellbeing and the risk of suicide was most evident. At the IMR authors event the timescales were again reviewed by the panel and were still felt to be appropriate.

4. Methodology

4.1 The purpose of this Domestic Homicide Review overview report is to ensure that the review is conducted according to good practice, with effective analysis and conclusions of the information related to the case. 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 abuse including their dependent children. 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. Apply these lessons to service responses including changes to policies and procedures as appropriate; prevent domestic homicide and improve service responses for all domestic abuse victims and their children through improved intra and inter-agency working.

4.2 This overview report has been complied with reference to the comprehensive Individual Management Reviews (IMR's) prepared by authors from the key agencies

involved in this case. Each author is independent of the victim and family and of management responsibility for practitioners and professionals involved in this case. Where IMRs have not been required, reports from other agencies or professionals have been received as part of the review process. The review panel tried on a number of occasions to obtain information from the GP practice, for Brian in Devon, but were never furnished with any information. They also asked the Home Office QA panel for advice to assist with the obtaining of the information. The review panel also asked for information from the mental health trust in Devon, and only received the information a number of months later towards the end of the review report writing process.

4.3 The overview author has also fulfilled a dual role and has chaired the panel meetings in respect of this case. This is recognised as good practice and has ensured a continuity of guidance, context for the review. There have been a number of useful professional discussions arising and the panel meetings have been referenced and noted appropriately for transparency.

4.4 The review author has also made several requests to agencies and individuals for clarity of issues arising and is grateful for the participation of individuals and agencies throughout. The professionalism of the panel members and the overall quality of the responses has been of a high standard however the review author must mention to the partnership that there were delays in the receipt of a number of the reports.

4.5 In support of the information received from agencies, the author has also engaged with the friends and neighbours of the deceased, her family and others who knew her where appropriate. Some of the information within the report will not be, where possible, personally referenced, and the author has due regard for any confidentiality and sensitivities required.

4.6 The author has also sought additional information outside of the date parameters this has assisted in context to examine some background history.

4.7 It is important that this Domestic Homicide Review has due regard to the legislation concerning what constitutes domestic abuse which 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.

4.8 The Government definition also outlines the following:

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.

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.

4.9 Section 76 of the Serious Crime Act 2015 created a new offence of controlling or coercive behaviour in an intimate or family relationship. Prior to the introduction of this offence, case law indicated the difficulty in proving a pattern of behaviour amounting to harassment within an intimate relationship.[1] The new offence, which does not have retrospective effect, came into force on 29th December 2015.

5. Involvement of family, friends, work colleagues and community.

5.1 Unexpected deaths are tragic for not just for the family, but for friends and work colleagues alike. In this case, there has also been some considerable impact to the small neighbourhood and community where Manpreet had been living for four years preceding her death. It was in fact the Manpreet's close neighbours who alerted the emergency services on the day that she was discovered at her home, having discovered her body in such traumatic and upsetting circumstances. The overwhelming effect that this has on those individuals can endure and the author is grateful for their participation, frankness and openness. Equally, their privacy must also be respected and any willingness to assist agencies further must be of their own volition. The review author has visited this small community and met a number of them.

5.2 The Home Office leaflet has been sent to family members on two occasions and the letter on each occasion that accompanied it also emphasised the opportunity to access an advocate to assist them in the DHR process in getting their views and feelings across. The review author has also contacted Manpreet's brother opening up another communication channel if there is anything that he or Manpreet's mother would wish to add or know about the review. The review has decided to honour Manpreet's wishes that she stated on occasions which she asked LPFT to ensure they recorded officially that she didn't want her first husband to know anything about what was happening with her. This review has sought to obtain any views through Manpreet's brother on behalf of the children. It is also fully acknowledged by the review panel that no one in her family knew much about her from the time she left 7yrs earlier.

5.3 The review panel has also written to Brian on two occasions, and asked him if he wishes to participate in the review. There has been no response to this request.

5.4 Key matters pertaining to individuals will be addressed in the respective narrative of this report, but it is acknowledged by the review that they are survivors of this tragic episode, not least the family of the deceased and this review must be seen as a way forward in supporting others who may have similar needs and obtaining individual and sometimes personal views, may identify intervention opportunities for agencies in future cases.

6. Contributors to the review:

[1] The Statutory Guidance cites the following cases - Curtis [2010] EWCA Crim 123 and Widdows [2011] EWCA Crim 1500.

6.1 The following agencies have contributed to the review: Each of the agency authors is independent of any involvement in the case including management or supervisory responsibility for the practitioners involved. The review panel has made numerous attempts to engage health agencies in particular the GP practice in Devon, but they have not shared any information with the review.

- East Midlands Ambulance Service (EMAS)
- Lincolnshire Police
- East Midlands Special Operations Unit (EMSOU)
- Devon and Cornwall Police
- Lincolnshire Partnership NHS Foundation Trust (LPFT)
- United Lincolnshire Hospitals NHS Trust (ULHT)
- Cygnet healthcare, Harrogate.
- General Practitioner – A Lincolnshire General Practice
- Lincolnshire Multi Agency Risk Assessment Conference (MARAC)
- Lincolnshire Independent Domestic Violence Advisor (IDVA)
- Lincolnshire County Council Adult Services
- Devon NHS Mental Health Trust

7. Review Panel members

7.1 The following individuals and agencies comprise the DHR panel

Agency	Name
Independent Domestic Abuse advisor to panel End Domestic Abuse Now (EDAN)	Jane Keenlyside
Independent Sikh Advisor to panel	Amerjit Singh
Independent Advisor to the panel on Suicide	Shabana Edinboro
Independent Advisor to panel on mental health issues	Catriona Paton
Lincolnshire Police	Jon McAdam
Devon & Cornwall Police	Philip Hale
Lincolnshire Partnership NHS Foundation Trust	Liz Bainbridge
United Lincolnshire Hospitals NHS Trust	Elaine Todd
Devon NHS Trust	Penelope Rogers
Lincolnshire CCG's	Claire Tozer
GP Practice (Lincs)	Dr Nation

GP Practice (South West)	Caroline Sandford-Wood
Lincolnshire Community Health Services	Gemma Cross
East Midlands Ambulance Service	Zoe Rodger-Fox
HM Prison, Lincoln	Marcus Riley
Cygnet Healthcare	Martin Graham
Lincolnshire County Council, Adult Care and Community Wellbeing	Linda MacDonnell
Lincolnshire County Council, Community Safety Strategy Co-ordinator-DA lead	Jade Sullivan
Lincolnshire County Council, DHR Business Support	Teresa Tennant
Legal Advisor to review	Toni Geraghty
Lincolnshire MARAC	Natalie Watkinson
DHR Chair and report Author Support to Chair	Russell Wate James Bambridge

8. Panel Chair and author of the overview report:

8.1 Dr Russell Wate is a retired senior police detective and senior investigating officer. He is currently the Independent Chair of the Cambridgeshire and Peterborough Safeguarding Children and Safeguarding Adults Boards. He has extensive experience in partnership working within safeguarding environments, and authoring Serious Case Reviews. He also has extensive experience in conducting Domestic Homicide Reviews; having authored several such reviews across the country as well as internationally.

8.2 Dr Wate has authored several national publications, contributed to a number of specialist publications, in particular concerning the investigation of child deaths and homicide.

8.3 Dr Wate has no connection with the Safer Lincolnshire Partnership other than previously providing professional and Independent services in connection with one other unrelated Domestic Homicide Review.

9. Details of any parallel reviews:

9.1 The death was immediately reported to HM Coroner. Following an initial homicide investigation, completed by the East Midlands Special Operations Unit (EMSOU) the matter was decided that this was not a homicide but was referred to the Coroner for them to conclude.

9.2 The review author however would like to highlight and worth further thought for criminal justice agencies in the future, is the research carried out in the report: 'Domestic abuse and suicide Exploring the links with Refuge's client base and work force' by Ruth Aitken and Vanessa E. Munro on behalf Warwick Law school and Refuge.

9.3 Within that report it states *'The suicide of Gurjit Dhaliwal, who took her own life after enduring years of physical and psychological abuse, was the impetus for this research. Dismayed at the apparent inability of the legal system to punish perpetrators who drive their victims to suicide, and by its failure to recognise the psychological injury which precedes it as a legitimate offence, we were moved to act'*.

9.4 The review author is not suggesting that this could have been possible in this case, but agencies do need to challenge existing norms, in order to try and protect victims of DA in the future and to not let perpetrators walk free of any punishment for their actions.

9.5 LPFT identified that the death of Manpreet met the criteria as a serious incident (NHSE 2015) but did not carry out a root cause analysis as a separate form of investigation; instead they agreed with health commissioners that the most appropriate process of review and investigation was to investigate using the IMR and DHR process.

9.6 The Inquest was held by Her Majesty's Coroner in May 2018 and the conclusion was that the deceased took her own life, and the Assistant Coroner recording a verdict of suicide.

9.7 The Assistant Coroner stated in recording the suicide verdict, that she was satisfied that Manpreet had died as a result of the inhalation of the products of combustion. She commented in response to the services provided to Manpreet: *"She was not shy about contacting them for help. She was not forgotten by Mental Health Services – they did all they could to help her".*

10. Equality and diversity

10.1 The author is satisfied that the IMR authors and the DHR Panel have addressed, where appropriate the nine protected characteristics under the Equality Act 2010 and in accordance with the terms of reference. Specific comment is made accordingly within the report narrative where appropriate in respect of those characteristics which are;

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race
- religion or belief
- sex
- sexual orientation

10.2 Manpreet was a practising Sikh. All of her friends and neighbours state that Manpreet demonstrated her religion on a daily basis; they knew that she prayed several times a day and also made use of other articles of her faith.

10.3 As in other families and communities, but which also applies to Sikh communities, is the feeling that domestic abuse remains a taboo subject, for which there is still a lack of acknowledgement that both genders can be victims, and what constitutes domestic abuse. There is a trend of not speaking out, even to family members due to fears of bringing "shame upon the family'. Manpreet grew up in this culture and was as already stated a practising Sikh, so it is a fair assumption that her thoughts and actions in relation to domestic abuse will mirror this from her community.

10.4 The Sikh religion does talk about arranged marriage and that traditionally the union is between Sikhs. There are times when this does not work out though, as in Manpreet's case. The religion talks of equality between the sexes (which when the religion began was very radical thinking in the 1500s), and they feel this should always be the basis of any relationship. However culturally some in the Sikh society have struggled with this concept, finding that they still have a subservient mentality between men and women, with the women being dominated. Generations have fought for this ideal of equality though and will continue to do so.

10.5 There isn't a Sikh temple in Lincolnshire and furthermore there aren't any known community groups or hubs. There are some identified Sikh families in Lincoln and also within the student community at the University of Lincoln. So, in essence there was nowhere locally for Manpreet to engage with for religious and cultural support. Which the review panel felt in theory made her even more isolated.

11. Dissemination

11.1 This anonymised report and executive summary have been prepared by the author for publication in accordance with the policy of the Safer Lincolnshire Partnership at the conclusion of the review process.

12. Background Information:

12.1 In September 2017 Lincolnshire Police were alerted to an incident in a rural location within their area, where neighbours of Manpreet had reported concerns that they had not seen her for well over 24 hours and there was no electrical power to her house. There was also an indication that the neighbours were concerned that she had shown suicidal tendencies. By the time that the police arrived a short time later, a couple of neighbours had already entered the house and had discovered Manpreet deceased in the bathroom. The immediate and associated circumstances of her death were of concern and senior detectives attended and assessed the scene.

12.2 The circumstances of the discovery of the deceased, which are not needed to be repeated in this report, led the attending agencies to conclude that the facts of her death

appeared to be suspicious and a homicide investigation was launched by the police. Lincolnshire Police handed the investigation over, under protocols, to the collaborated East Midlands Special Operations Unit (EMSOU). Following a number of immediate enquiries, which also included the arrest of Manpreet's husband Brian, on suspicion of murder, from his then current place of temporary residence outside of the area. The pathology examination concluded that the facts indicated that the deceased had in fact taken her own life. The cause of death was given as the result of inhalation of the products of combustion. No action was taken against Brian. The friends and neighbours when they spoke about the scene in the house were clearly affected by what they saw, and they should be praised for their compassion and care in trying to ensure that Manpreet was safe.

12.3 On 24th January 2018 LPFT notified the Chair of the Safer Lincolnshire Partnership that the incident was being investigated as a suicide, in accordance with the Lincolnshire Domestic Homicide Review Protocol. The Chair of the Safer Lincolnshire Partnership Board considered the case. In conjunction with other key agencies that had contact with Manpreet, and concluded that the case did meet the criteria and justification for a Domestic Homicide Review in accordance with the Domestic Violence, Crime and Victims Act 2004. The Home Office was notified accordingly. The panel appointed an independent chair and author to conduct the review into the circumstance of how Manpreet came to take her own life by suicide.

12.4 In May 2018, an inquest concluded that Manpreet had taken her own life and a verdict of suicide was recorded by the Assistant Coroner.

12.5 In June 2018, The Safer Lincolnshire Partnership held a panel meeting in order to discuss the case and agree terms of reference, for the review. In accordance with the 2016 Home Office Statutory Guidance for conducting domestic homicide reviews, the coroner's verdict of suicide and the circumstances surrounding the death of Manpreet, led the Safer Lincolnshire Partnership to conclude that a domestic homicide review would be commissioned.

A "domestic homicide review" means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by;

(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or

(b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death.

12.6 The Safer Lincolnshire Partnership Panel paid due regard to the guidance within the 2016 publication which states;

Where a victim took their own life (suicide) and the circumstances give rise to concern, for example it emerges that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable.

12.7 Subsequently Dr Russell Wate of RJW Associates was appointed as the Independent DHR chair and overview author. Further panel meetings have taken place in the interim to structure and agree the terms of reference and a presentation day was held on 27th September 2018, where the respective agencies discussed the findings of their IMR's with the DHR panel.

13. Chronology

13.1 As already mentioned earlier in this report Manpreet had previously been married but it is understood by the review panel that she had left that relationship to be with Brian, whom she had known for a number of years. Manpreet had two children (now aged ten and thirteen respectively) from her first marriage, both of whom continue to live with her former husband. Her first marriage was an arranged marriage in accordance with Sikh traditions. The relationship within her first marriage was reported by Manpreet to health professionals as being that of an "*arranged and controlling relationship".* Manpreet divorced her first husband and then married Brian about 12 months or so before she died.

13.2 It is suggested that Manpreet and Brian had been in a relationship for approximately seven years, although they had known each other for a much longer period. It is referenced by several agencies that Brian was understood to be suffering from Post-Traumatic Stress Disorder (PTSD) either following or during his service in the Royal Air Force (RAF), although the circumstances leading to this are unknown. The information of this originated principally from comments made by Manpreet. The review panel however can confirm that there is no information to support Brian ever being in the RAF. However, he did serve for a very short time in the reservist Army air corp. He has never been on active service. A number of the friends and neighbours were suspicious of his claims. Brian's father in fact told one of the neighbours that Brian was not telling the truth. It is though pretty clear that Manpreet was unaware that this wasn't true and although the review author has no clear evidence, suggests it may be another tactic used by him to exercise coercive control on her.

13.3 It was disclosed by both Manpreet and Brian that she suffered from '*significant mood swings*, although these mood swings were described as being short lived but temperamental. Manpreet also had type 2 diabetes and on occasions required medical support and advice for fluctuations in her blood/sugar levels, which were generally provided by her GP or practice nurse at the surgery.

13.4 Brian and Manpreet had set up a company providing professional electrical and plumbing trades targeted to the locality within which they lived. Brian also pursued business interests outside of the UK during which he does not appear to have been usually accompanied by Manpreet. It appears that Manpreet was the key person running the business. It was during his business trips that he met and became involved in a relationship with another woman. He had disclosed this relationship to Manpreet within the previous two years.

13.5 On the 18th April 2017, Manpreet was admitted to accident and emergency department, which falls under United Lincolnshire Hospital Trust's remit. She had suffered a facial injury and was unconscious on arrival having been taken by ambulance from her

home. The incident was reported by Brian and he provided a synopsis to the attending paramedics indicating she had taken an 'overdose' following an argument with him. During what was a short period of in-patient treatment following on from her admission, several disclosures were made by both Manpreet and Brian to the LPFT (CRISIS) staff. She also disclosed that Brian had assaulted her some months beforehand, injuring her wrist. Brian made a separate disclosure that he had caused Manpreet a 'black eye' and in addition, he stated to professionals that he had formed a relationship with a woman that he had met during a business trip.

13.6 Manpreet spent a few days in hospital and was discharged home on the 21st April 2017. Brian was regularly present with her during her in-patient treatment and admission, which was as much due to Manpreet's insistence as opposed to that of Brian. Manpreet was discharged having received several contacts from mental health services, which also continued for a number of days following her discharge. Although Manpreet engaged with the two health services and she was offered domestic abuse support, Manpreet was quite clear in her views and indicated that she would not co-operate with a domestic abuse referral, should professionals determine that it was necessary.

13.7 On the 27th April 2017, Lincolnshire Police received a 999 call from Manpreet stating that her *"husband was going to kill her*". A short time later a second call was made from a neighbour who stated that a male at the scene had armed himself with two kitchen knives. Police attended finding Brian at the house in a threatening and confrontational manner. Manpreet was out of the house by this time, having reportedly disarmed Brian who hadn't threatened her with the shotgun, but Manpreet believed he would harm himself with it. Following a refusal by Brian to disarm himself of the knives, a police dog was deployed and Brian was arrested. The neighbour who was in the house spoke to the review author who explored with her the impact on Manpreet and her of Brian having a shot gun. The neighbour stated that Manpreet told everyone including the police that he didn't threaten her with the shotgun but felt the threat was to himself. He didn't have the shotgun when she entered the house, but did find Brian's whole behaviour quite threatening not to her personally but about the situation in particular.

13.8 It transpired that the background to this incident was that Manpreet had discovered that Brian had been having text conversation with another female and Manpreet had further discovered some explicit messages on his mobile phone. This in turn led to an argument and Brian removed one of his shotguns from the gun cabinet which Manpreet had then taken from him. A further violent argument took place and Manpreet reports that Brian grabbed her by the throat. Friends had arrived at the house and they removed Manpreet to safety away from the house. Brian remained in the house armed with kitchen knives. One of the neighbours was also in the house, and wasn't able to leave until the Police firearms unit had arrived. Brian refused to co-operate with the police and was arrested, suffering a dog bite as a consequence. The inference by those present is that the initial argument leading to the violence was fuelled by both Manpreet and Brian having consumed alcohol.

13.9 The incident was treated as a domestic abuse incident by the police although the use of the firearm and the attendant circumstances significantly heightened the risk to Manpreet,

and of course for the neighbour who was unable to leave the house safely until the police arrived. The matter was deemed so serious that following later charges, Brian was remanded in custody. Manpreet was provided with initial telephone support via the LPFT Crisis team and was visited the following day by the police domestic abuse liaison officer in order for support in accessing other services. Her risk was assessed using a Domestic Abuse Stalking and Harassment (DASH) form as being high and the matter was referred to Multi Agency Risk Assessment Conference (MARAC). It was during the visit by the police liaison officer, that Manpreet indicated that Brian had been violent towards her on a number of previous occasions, although these were not specifically detailed. She stated that those occurrences were not reported to the police or other agencies although she had received treatment for a broken wrist caused by Brian some months previously. At the time of that incident Manpreet made a conscious decision not to inform professionals how her injury was caused. Manpreet had however told at least two other friends and neighbours that Brian had caused the injury to her. The neighbours confirmed this on their conversations with the review author.

13.10 Manpreet consented to the appointment of an Independent Domestic Violence Advisor (IDVA) to support her and other arrangements for her well-being and safeguarding were discussed. The police had already removed the firearms [shotguns] at the time of the initial occurrence and had revoked Brian's shotgun licence.

13.11 Brian was remanded to prison following the incident of the 27th April 2017. Although a number of individuals and agencies had had contact with Manpreet in the interim, other than the close neighbours it is not clear what support mechanism in particular from family and friends, that she had. Although it was definitely the right action for Brian to be in prison, it appears that Manpreet was now at this point in a position of relative isolation, which was a significant change to her personal circumstances, and a definitive risk factor for her.

13.12 On the 30th April 2017, a neighbour, having concerns for Manpreet's well-being went to her house and found her unconscious. He called an ambulance having found evidence of wine and tablets having been apparently taken by her. Manpreet was admitted to hospital and it became apparent that she had indeed taken an overdose of prescribed medication. Although she did not express suicide ideation an assessment completed by the mental health services concluded that she was unable to identify any protective factors and a significant part of this was the fact that Brian was on remand and she felt isolated and all alone. It appears that Manpreet was expressing significant symptoms of hopelessness and she was making unrealistic suggestions about her discharge which included plans for her and Brian. She was assessed as being vulnerable and at significant risk of self-harm.

13.13 The combination of risks was considered to be so high that Manpreet was offered and agreed to an informal admission to an acute psychiatric ward. However, this was out of her home county due to the lack of local female beds. The fact that she consented to treatment would suggest that she had and was deemed to have capacity and that there was no requirement to suggest that any other action was necessary under the Mental Capacity Act (2005). The facility is managed by Cygnet Healthcare.

13.14 An alert was added to Manpreet's ULHT patient record upon receipt of the Agenda for the MARAC meeting at which Manpreet's situation was discussed and, having been identified as a high risk of domestic abuse, although Brian was on remand, there is evidence that there was a useful exchange of information between the Police, ULHT and the Cygnet healthcare facility. She was referred to the community mental health team and her GP practice was notified accordingly. Other actions completed or initiated at the MARAC were as already mentioned and Manpreet agreed to the MARAC referral. The actions were for the IDVA to make contact, and provide feedback of the action plan. A Critical Register Marker to be placed on the address. A P701 (The police form that helped the DASH to be completed and comes out High Risk. The Stop Abuse form (adult) submitted. An Alarm was deemed not applicable. LPFT worker to make contact, albeit in Cygnet hospital as an inpatient. On discharge, from the hospital Manpreet returned to her home and the follow-up from the community mental health services which reported her as functioning well, on both personal and telephone consultations. On the day prior to her discharge from hospital she had made it clear to her IDVA professional that she intended to resume her relationship with Brian once matters had been resolved.

13.15 It is also noted that the practice nurse at Manpreet's GP surgery made contact with her whilst she was in treatment at Cygnet to discuss her diabetes and the practice nurse was made aware of the reasons for her admission. On discharge she was seen by her GP practice where the previous incidents of overdose were discussed and the GP noted at that time no obvious concerns for her welfare.

13.16 On the 1st June 2017, Brian was released from prison on conditional bail which included him residing out of the area, with his father, and for him to have no contact with Manpreet. It is not clear at what point Manpreet was notified by the police or other agencies of the fact that Brian had been released. Although this did not heighten any immediate physical risk to her, the psychological effect on her was worthy of separate consideration.

13.17 On the 12th June 2017, Lincolnshire Police responded to a third-party report, from a mental health trust in Devon, where Brian was now, as a voluntary in-patient (he was admitted to hospital on the 10th June 2017, after two previous suicide attempts, and being depressed), that Manpreet had been sending Brian text messages and an image to his phone of her apparently with a ligature around her neck, suggesting a possible suicide attempt. It is of note here that Brian had been telling people that he had blocked Manpreet's phone number. He clearly though hadn't. The inference of this from the mental health worker (who asked that they be noted as a third party, so as not to alert Manpreet as to where Brian was at that time), was that Manpreet was attempting to get Brian to breach his bail conditions by responding to her and making contact with her, but more importantly concerned for her welfare. Lincolnshire police, whilst understanding this perspective, rightly took the view that this in fact raised a significant safeguarding concern for Manpreet and officers were despatched to her home.

13.18 When they made personal contact with her, she appeared safe and well and allowed officers to examine her phone, where there was no apparent evidence of any such communications as had been alleged with Brian. She did, in conversation with the police

officers, express a view that she had had little assistance from the LPFT crisis team and needed somebody to talk to when things became difficult for her, Manpreet presented in reasonable spirits however did become emotional when discussing marital issues. Manpreet told the officer that she lives alone and was disowned by her family in West Midlands following her marriage to Brian which went against her relatives' traditional values. Whilst the officers did not feel she needed immediate safeguarding, they nevertheless referred Manpreet through a 'Stop Abuse' form as a possible vulnerable person to Lincolnshire County Council, where it ended up in The Customer Service Centre via the police referral unit. There was a robust discussion that took place at one of the panel meetings and following this is seen as an appropriate action by the review author, but believes that a further referral could have been made to mental health services in the area. As it transpired, Lincolnshire police also received contact later that day from LPFT, the mental health provider. They had also been contacted by the mental health worker from Devon in respect of the same information and the police determined that as this was the same information, no further action was necessary and that it was not a further or additional report of concerns for her welfare. (The system has now changed, and the use of the Stop Abuse form has stopped. An officer now submits a Public Protection Notice which outlines the concerns, this is then screened by the Protecting Vulnerable People (PVP)-Police Safeguarding Hub (PSH) and using this case as an example can be sent through to LPFT for their assessment. However, LPFT also sit within the PVP-PSH (most days of the week), so discussions can take place as to cases and thresholds and advice in person which is hugely beneficial.)

13.19 Between June 26th and June 30th 2017, Manpreet attended her GP's practice for consultations and was also referred to accident and emergency department at the hospital, with reported wrist pain and reduced movement. She was also referred to her GP and later attended a fracture clinic from which she was discharged. On her initial attendance at accident and emergency department the MARAC alert was identified, although it was established that Brian was not in the locality. Manpreet was asked if the injury was caused as a result of trauma and this was denied by her.

13.20 In July 2017, Manpreet was seen/consulted by her GP practice on three occasions for a diabetic review, given a prescription for sleeping issues for a seven-day period, none of which appear to be remarkable of any note or indeed observation by the respective practitioners.

13.21 On August 1st 2017, Manpreet contacted the Community Mental Health Team stating that her mood was low and in consultation by 'phone', she was advised of support available from counselling services. The counselling service is Step2Change and is a self-referral service. There was no evidence, despite her apparent low mood, that she was failing to function and she showed no indication of either an immediate or enduring mental health issue. She was referred to appropriate support services. This contact was initiated by Manpreet.

13.22 On August 3rd 2017, Brian appeared at court and the charges against him were concluded (In relation to the firearms offence the case was dismissed at Lincoln Crown Court when no evidence was offered. He pleaded guilty to the public order offence and was

given a six-month custodial sentence suspended for twelve months), and he was released. Later that day, he and Manpreet met each other and he alleged that following this they argued and consequently Manpreet had taken a bag from him containing his medication and had driven off with it. The circumstances of disclosures made to police officers by Brian, about this incident, and how he felt his mental state was, led to them taking action to safeguard him in accordance with section 136 Mental Health Act (1983) as he had threatened to harm himself. A DASH risk assessment was completed, with Brian as the respondent for this, in view of the altercation with Manpreet, although no actual offences were recorded or reported. The police were contacted again by Brian following his release from 136 suite the following day, to request support for him whilst getting access to his belongings from Manpreet, this did not take place and it is reported by the police that this was conducted by Manpreet and Brian with support from their neighbours. What appears to be the case is that Brian then returned to Devon and did not remain at their marital home.

13.23 On August 8th 2017, Brian's father contacted the police raising a concern about the welfare of Manpreet. On the same date Manpreet's neighbours had called an ambulance having discovered her to have taken an apparent overdose. When the police attended in response to the contact from Brian's father, they were informed by neighbours that Manpreet had earlier been taken by ambulance to hospital. Officers took no further action given the circumstances on their arrival, although the hospital contacted the police that day to ascertain details of the history relating to Manpreet and Brian. The actual circumstances of her admission to hospital were not in fact predicated by her having taken an overdose, but this seemed to be a combination of her low mood and her lack of appropriate nutrition for several days. She was seen in accident and emergency department, and discharged the same day with a safety plan in place that included being referred to the LPFT's crisis team for follow up. The friends and neighbours state that when Manpreet returned home they couldn't believe that she had been released as she could hardly hold herself up due to being so weak (there is no evidence of this clinical picture within her hospital records), and one of them had to take her in and tried to feed her.

13.24 On the 9th August Manpreet was seen at home by the crisis team for an assessment of her mental state. She had also been seen by her GP earlier that same day and described during that consultation, that she felt that she had not received an appropriate level of support from a Community Psychiatric Nurse since her discharge in May 2017 from Cygnet. The GP consequently made an urgent referral to the Crisis team following her comments. When seen later that day by the Crisis team, Manpreet was assessed as presenting with depression; she had difficulty in making decisions, loss of appetite with associated weight loss, poor sleep, diabetic regulatory issues and irrational behaviour. There was also a reference to damage to property, although that specific aspect wasn't explored. It was noted that she was further distressed by Brian telling her that he had been admitted to the hospital in Devon following an overdose.

13.25 Compounding all those factors was her social isolation, her apparent feeling by now that her neighbours were being too intrusive, and a disclosure that she had financial pressures in respect of both her mortgage and business.

13.26 It was apparent in discussion with Manpreet during the crisis team assessment, that she was back in contact with Brian and a great deal of discussion took place concerning him, although the inference was that the contact was only by text. Brian states when he was an in-patient that this was only her texting him, and he didn't respond so, as not to breach his bail conditions. We have no evidence to suggest this is correct. Although Manpreet was not offered domestic abuse services, she appeared well informed of the issues of domestic abuse within their relationship. It was noted by professionals that she did appear to place Brian's needs on a higher plateau than her own. All of the friends and neighbours state that she was absolutely obsessed with Brian and even though not there, he was totally in control of her thoughts and actions. There was some considerable effort by professionals to ensure that Manpreet was fully supported with mental health services. She was referred by her GP to a Consultant Psychiatrist. There was good communication between the respective agencies and professionals in order to ensure that Manpreet was able to access acute services.

13.27 On the 18th August 2017, Manpreet contacted the Crisis Team by telephone reporting that she had taken an overdose of prescribed medication in unknown quantities. She was advised to seek medical advice (there is no record that Manpreet did this), but no immediate call was made to emergency services. Although further contact by phone was made with her the following day to check on her welfare, she declined a face to face meeting and assessment. However, her mood appeared to have been more positive in that she disclosed that she was looking to leave the area having applied for other jobs.

13.28 On the 29th August 2017, Manpreet left a voice message to the CMHT cancelling her assessment on the 8th September 2017 as she had a job interview, although this message was not actioned until the 4th September. This did not raise any concerns as it was known that Manpreet was looking for work out of the area, although at that point she had not been seen by the Consultant Psychiatrist, having been referred by her GP.

13.29 On the 3rd September 2017, Manpreet met with an unknown man in Northamptonshire. Brian was also at the same location, although it is not apparent how or why this was the case although the inference is that Manpreet had possibly told him and he had travelled to Northampton to confront her. The friends and neighbours however, say that he had an application on his phone that allowed him live tracking of Manpreet's phone and would have known where she was through this.

13.30 Although the other man left the location following the confrontation between Brian and Manpreet, which took place in public in front of staff and guests, the other man suggested to staff '*not to trust dating websites'*, an inference that Manpreet was using such websites. Following the altercation, Brian and Manpreet left separately. It is perhaps of note that this occurrence was the last known independent sighting/contact of Manpreet before her death.

13.31 On the 5th September, a neighbour, concerned for the welfare of Manpreet, gained entry into her house and discovered her deceased in the bathroom of the property. Evidence of self-immolation was present which was later confirmed as being the cause of her tragic death. Manpreet did not leave any note, message at the time of her death.

14. Overview

14.1 In examining agency contact and involvement with Manpreet and endeavouring to try and see what life was like for Manpreet a number of facts are apparent. Manpreet had been living in the area for four years, having moved from the Midlands area. As already stated, this is an area with no Sikh community evident. She married Brian after they arrived there, and together they ran a small business involving securing trade services for plumbing and electrical work. There was no information of the presence of DA in her previous marriage other than that which she eluded to professionals.

14.2 Brian and Manpreet ran what is reported as being at first a 'successful business', however it is not clear as to the actual extent of the business, nor how the business was managed and administered, given that Brian appears to have spent time at the start out of the country. There appears to be a link between the relationship that Brian had disclosed to Manpreet concerning the woman that he met on business, the implication being that the individual was latterly part of the company structure. In looking at the wider implications that that relationship had to Manpreet, this was not explored by professionals and may have assisted in building a more informed background about Brian and Manpreet as a couple and the influence of the relationship between Brian and this other woman, and the impact to Manpreet who relied on him both emotionally (as she left her family and home for him) and financially.

14.3 In respect of the significant and violent incident of the 27th April 2017, there was some effort made by Manpreet to make professionals understand the context of the event by her reference to Brian's alleged PTSD. The review author is keen to emphasise 'alleged' PTSD as there is no provenance within the records examined and agency reports that can verify or identify this as a matter of fact. As the review author has already stated this would appear to be untrue and most probably a way that he used to coerce and control Manpreet, and Brian used this to hide behind a veil of convenience of claiming that he had PTSD to minimise the impact of his actions against Manpreet. It is a fact, as admitted by them both independently, that some months earlier, Brian had caused Manpreet a significant injury to her wrist, which she had covered up when receiving medical treatment for the injury. Manpreet had told the friends and neighbours that Brian had caused this injury. It is of note though that Brian whilst an in-patient himself, was for some reason telling them that he hadn't caused the injury. Throughout Brian's time where he was receiving care from mental health services, he stated to them that it was Manpreet that was totally controlling of him. This could be another way to ensure that these services felt sorry for him.

14.4 Although not explored significantly by agencies, there are also several references to alcohol forming the pre-cursor to the abusive occurrences between Brian and Manpreet.

15. Analysis:

15.1 This analysis seeks to explore the terms of reference in general terms as opposed to referencing each of them specifically, other than where this has particular relevance.

15.2 In examining the agreed timeframe of April to September 2017, Manpreet presented to A&E several times during this period, predominantly because of having taken an overdose of both prescribed and non-prescribed medication. These occurrences were identified by professionals as being incidents of attempted suicide and there were referrals to mental health services, for an assessment. It was also apparent that professionals identified that there were at times elements of self-harm on the part of Manpreet as opposed to all incidents where she overdosed as being an unequivocal attempt at suicide. Manpreet had denied suicidal intent during the A&E attendances. Manpreet reported the overdoses to be as a result of Brian's affair, or due to her distress from the separation from him. This is good practice as it considered the wider issues of self-harm and clinical examinations of Manpreet appear to have taken this into account. Manpreet was asked what other self-harm (part of the standard question set) she may have performed on herself, or contemplated, the answer to this is however not recorded.

15.3 Each of the occurrences in respect of Manpreet (and those separately involving Brian) has been well reported, documented and referenced by the respective agencies and it is apparent that there has been a drive and desire by professionals working individually or together, to ensure that Manpreet could access or was made aware of support services, both directly and alternatively indirectly through signposting. This activity included discharge plans with Mental Health liaison services fully involved and personal safeguarding considerations addressed. An example of this is exemplified on the 18th April 2017 where LPFT made a clear identification of the risk of domestic abuse on admission to the hospital and subsequent in-patient treatment, where there has been continuity of this acknowledgement within the patient records and timely sharing of the information with the GP practice. On this occasion, it is noted that although MARAC was not initiated, the notes identify that the risk was not considered to be high and based on the facts as known at that time, this is seen as a mature assessment.

15.4 It is also of note that when the mental health crisis team became involved with Manpreet that they were proactive in delivering their service to her. For example, it is shown that they worked hard to engage her when she was not at home by returning at different times of the day and by attending her home unannounced when she had not answered the phone to them. This is seen as a demonstration of good practice.

15.5 Examining the significant occurrences in this case in relation to the exploration of DA. The circumstances of Manpreet's admission to hospital on the 18th April 2017 were questioned by health professionals, given the concerns for the potential of domestic abuse as the cause of her injury, which was recognised immediately by the attending paramedics and then the A&E staff, Manpreet did, when able, affirm that Brian's explanation of how she was injured was correct, and fully corroborated Brian's account. It was however recognised as a possible assault and did occur as a consequence of an argument due to her discovering his affair, which again was a potential indicator of the background of domestic abuse in this household. This emphasises the value of awareness for front-line practitioners in the signs and symptoms and warning indicators of domestic abuse, as identified initially by the EMAS practitioners and ensuring that those safeguarding concerns are adequately communicated and shared with the other professionals.

15.6 The later disclosure during this initial hospital admission, made by Manpreet to LPFT staff, that Brian had in fact caused her an injury to her wrist some months previously was also swiftly identified as being an indication of domestic abuse/assault. The presence of Brian did initially prevent professionals from being able to talk more freely with Manpreet, however it would appear that it was her desire to have him there as opposed to any suggestion of his insistence of being there with her to prevent or reduce the likelihood of any further disclosures being made. Practitioners were in fact able to converse privately and without any suggestion of interference from Brian. He had left the hospital of his own accord in order to return home only to be called back by staff given Manpreet's insistence that he should be with her. This perhaps also indicates how reliant she was on him for support but possibly that she also feared that he would abandon her.

15.7 It is noted that Brian did in fact disclose to practitioners from LPFT that he was responsible for causing an earlier injury to Manpreet on the 20th April 2017 whilst she was receiving in-patient treatment following her overdose on the 18th April. It was he who had approached practitioners, out of the sight and hearing of Manpreet to do so. Brian 's admission was that he had caused her a black eye, but no more information was gathered as to the actual circumstances. It must be highlighted here that none of the friends and neighbours when asked had ever seen Manpreet with this black eye. He also disclosed his relationship with a woman that he had met on a business trip. Manpreet also made an admission of an injury that had been caused by Brian, which she made 3 days later on the 23rd April 2017; however, her disclosure was that he had broken her wrist. The ULHT IMR author found out that this was in fact some 18 months previously and that particular injury was noted to be a fracture, and at the time was reported to have occurred as a result of twisting her wrist whilst picking up heavy logs in the garage. This was more serious by implication than the disclosure that had been made a few days earlier by Brian. It is possible that these were two separate further occurrences of historical domestic abuse that professionals were unaware of. As already mentioned earlier in this report Brian denied when an in-patient to those treating him that he had caused the wrist injury, a topic he raised with them.

15.8 It is not known if the separate admissions by them of the extent of the previous injuries to her were through an act of agreement by them in order to minimise professional curiosity. However, if that was the case, surely, they would both have disclosed the same injury and if anything, this should have made professionals more curious. The fact is that professionals did recognise the signs of domestic abuse and noted them accordingly. Equally, there were several other matters disclosed that had some potential significance and may not have been considered contextually, raising concerns for the overall risks presented to Manpreet. These include the admission of the relationship with another woman by Brian, which combined heightened risks to Manpreet, from a mental health perspective. The connections appear to have been overlooked.

15.9 Although the different health professionals recorded the separate disclosures made by both Brian and Manpreet on the medical notes (it is worth noting here that ULHT and LPFT do not have the same recording system, so neither would see each other's notes), a DASH risk assessment was not completed in either case. It is reported by the ULHT author

that Manpreet did not consent to a risk assessment or referral. In the absence of consent by Manpreet to complete a DASH risk assessment directly with her and in the absence of additional information to complete this DASH risk assessment, there was insufficient information to suggest a referral to DA agencies on the basis of professional judgement alone would be appropriate. The fact of the matters is that it was not one, but two indicators of domestic abuse that could have been considered by other agencies. The review author does accept that the information was held in separate health recording systems. However, there was scope to refer the admission made by Brian as well as the disclosure made by Manpreet. Where an admission is made by the alleged perpetrator, such disclosures are of importance and are generally unusual, if not frequently minimised by the discloser. What those disclosures identified was that the domestic abuse was present at least some 18 months prior to the April 2017 events. Although the scope of this review report has concentrated on the period from April to September 2017, it did look further back and the wrist injury is the only other reference found to agencies having any involvement with Manpreet or Brian in a context that could be associated with DA. As already stated, ULHT staff spoke with Manpreet regarding her disclosure (which was reported as an historic 'wrist injury'). Sign-posting to DA services was offered to Manpreet and declined.

15.10 What is also important for this analysis is that a number of other matters were disclosed to professionals at this time. The panel appreciate that these have been minimised by Manpreet and Brian. However, when taken in the wider perspective they were indicative of some potentially useful background, showing that the life for Manpreet was as a victim of DA.

15.11 For example, the disclosure by Manpreet of another form of abuse to LPFT staff during the same hospital admission period, although this was attempted to be explored by professionals, Manpreet declined to elaborate or engage further. It must be stated here that this is not believed to be perpetrated by Brian as he was present throughout the disclosure. Although the practitioners offered to help Manpreet to get some professional support for her [limited] disclosure, which is good practice, she declined. There may be opportunities herein for future considerations to be made for referral to the police and for expert and independent support by specially trained officers when individuals disclose that they are the victim of other forms of abuse. Had a robust multi-agency system of information sharing been in operation, this may have provided greater opportunity for sharing the information, case analysis and a menu of options with which to approach the victim. Equally, this could have been achieved once Manpreet had been discharged and an approach made to her at home.

15.12 It is reported that Manpreet saw nothing of her two children. There is an apparent inference from what information is available that she was in fact isolated from her children and that the children lived with her former husband, and they were kept away from her. The family and neighbours state that this is the case based on what Manpreet told them and that they never saw any sign of contact with her and the children. They do state that Manpreet was depressed by this, but something she told them she fully accepted, in order to be with Brian, that she had to give up her family due to the controlling role of her previous husband and also her culture. However, this feeling of loss and separation for

Manpreet was particularly evident at birthdays and special significant dates. The friends and neighbours state that to their knowledge Manpreet also had no contact at all with her ex-husband and little if not nil contact with her brother or mother.

15.13 Although each of the agencies has identified Manpreet's ethnicity and other key areas in considering equality and diversity, it is not apparent that her cultural background was explored in any significant depth. Not one of the agencies talks about her being a Sikh and how this may have affected her thinking. Her disclosures that she was ostracised by her family because of her relationship with '*a white man'*, is a significant disclosure of how cultural beliefs can affect an individual when they step outside of cultural values or family expectations. Although services acknowledged such a disclosure by her, the impact of Brian's arrest on the 27th April 2017 would seem to have left her particularly isolated as it seems that she had very little support network outside of that which was provided by her close friends and neighbours, or professionally by the respective agencies. Religion and culture may have played a part in this, and this needs to be acknowledged. As already mentioned earlier in this report, as in many families and communities, including Sikh communities, domestic abuse remains a taboo subject for which there is still a lack of acknowledgement that both genders can be victims and what constitutes as domestic abuse. There is a trend of not speaking out, even to family members due to fears of bringing "shame upon the family'. Manpreet grew up in this culture and was as already stated a practising Sikh, so it is a fair assumption that her thoughts and actions in relation to domestic abuse will mirror this.

15.14 The DASH risk assessment facilitated a referral to the IDVA service concerning the incident of 27th April was not received by IDVA until May 3rd 2017. This seems to be a delay, albeit a short one, and by which time Manpreet had been hospitalised following her further overdose and was being treated as an in-patient. The consequence of this was that the appointed IDVA was unaware of Manpreet's admission for mental health treatment and when contact was made by telephone, Manpreet was in some apparent confusion, given that she was receiving in-patient care. Although this sent confusing messages, the professionalism of the IDVA appears to have given Manpreet reassurance that her safeguarding would extend beyond her hospital admission and that there was independent support available to her in addition to the mental health services.

15.15 It was during this initial contact that the IDVA noted that Manpreet had "*over-whelming feelings of helplessness and not knowing what was happening with her husband and the police involvement*". In essence, following the arrest of Brian on the 27th April 2017, Manpreet was alone and isolated and although she was given support from the police domestic abuse liaison officer, what contact and information she had with the subsequent police investigation is unclear. There is a presumption that a 'victim care contract' would have been completed by the police in accordance with the codes of practice as accords with the provisions of the Domestic Violence Crime and Victims Act 2004. However, there seems to be some conjecture as to how Manpreet was kept up to date with her husband's arrest, detention and subsequent charge and remand. The inference from agency reports is that she either appears to have been unsighted as to the progress, or was unaware. For example, she did not appear to understand what was meant by Brian's remand. This appeared to

agencies and her friends and neighbours to have caused her apparent distress on a number of occasions.

15.16 It is also of interest to note that from their IMR reports that the IDVA felt that Manpreet was minimising the domestic abuse and the situational incident. Such behaviour is replicated by Manpreet when she seeks to minimise Brian's culpability by her making excuses for him by referencing his military service and PTSD. The review author fully accepts though that this is Manpreet's choice, but highlights that this is another example of the coercive control he has over Manpreet.

15.17 On the 8th May 2017, Cygnet received an email from Lincolnshire Police to confirm that Brian would appear in court on two charges on 30th May 2017 arising from the incident of 27th April 2017. It is reported that Manpreet was very upset to have received this information, in particular by email and although a nurse gave one to one advice to Manpreet which helped the situation, there may be other methods that could be considered by the police to update or inform victims of domestic abuse where there are clearly issues concerning the individuals' mental health. Whether this reflects around the timeliness or circumstances of the notification should be made on a case by case basis. There is an inference that Manpreet did not understand police terminology and this is something that agencies in general may need to consider when dealing with individuals whom have little knowledge of the criminal justice system.

15.18 On the 1st August 2017, in a telephone triage conducted with Manpreet by the local community mental health team, Manpreet stated she was wondering *"what the hell is going on*" as she stated she was not stressed, but has had no support since she was discharged from the Crisis Resolution Solution and Home Treatment Service in June 2017 and that they had not helped her. She stated to them that she had poor sleep, was feeling low, however, she spoke objectively on the phone, there was no evidence of poverty of speech, no thought blocking, or flight of ideas. She stated she was "*close to suicidal"* but trying not to be by keeping busy and was under "*a lot of pressure*". She was trying to look after their joint business and described family pressures and stress from her neighbours. There was however no indication that Manpreet had a severe and enduring mental illness, she was functioning well, running a business and therefore would not meet the criteria for the Community Mental Health Team. The review author understands the meaning of this mental health classification and also the comments of the Coroner at the Inquest (*"She was not shy about contacting them for help. She was not forgotten by Mental Health Services – they did all they could to help her")*. However, the review author also believes it is important to listen to the views of Manpreet and her thoughts in relation to the service that she felt she had received from mental health services. She relayed these not only to her GP but also her friends and neighbours. This was in particular in relation to the needing to self-refer to the Steps2Change programme. Manpreet told a neighbour (who told the review author) that they would have to contact her and there was no way that she would be self-referring.

15.19 When Lincolnshire Police attended the incident at Manpreet's home on the 8th August 2017, following the contact from Brian's father that he had serious concerns for her welfare, Manpreet had already been removed to hospital by ambulance after a call from a neighbour. There was later direct communication by LPFT to the police following

Manpreet's admission. The key concerns arising from this incident were for Manpreet's mental health and in particular her apparent self-neglect as she had been in bed for three days, not eating or drinking. Although discharged the same day (to the amazement of the neighbour who saw her when Manpreet returned and took her in to her house) with a referral to the crisis team, by the following day Manpreet attended her GP who considered that her risk was so high and with suicide ideations, an immediate referral was required for a face to face visit by the crisis team, which was duly undertaken. A 72-hour care-plan was initiated for home treatment and her needs were comprehensively assessed for that plan. Although other agencies had taken control of the situation, the police made no apparent follow-up with the neighbour and the circumstances of the initial call would suggest that closure of the incident by the police would have been better served by ensuring a 360-degree communication with the other agencies involved in order to ensure a satisfactory response to safeguarding considerations.

15.20 It appears that both Manpreet and Brian were suffering from some form of mental health issues, but it is clear that appropriate services were provided to both of them in a timely and considered manner. The records for Brian as an individual with mental health issues from Devon show a very caring, and alert service that provided a good level of service to his need. An observation is however, made by the review author this concerns the discharge plans for Manpreet following her placement out of area in May 2017, following her overdose on April 30th. Whilst the treatment of her as an in-patient by Cygnet healthcare is comprehensive and supported both her mental health and her safeguarding, it appears to be the case that on discharge she was unable to access CPN support as she had anticipated, however LPFT did allocate the Crisis Team, and the indications are that this had ceased by the 26th May 2017 which was just a week after her release from an intensive period under the care of mental health services as an in-patient. The question arising is, was this discharge plan as an out-patient too soon after the release from psychiatric in-patient care? This is perhaps reflected in her latter approach to services and her GP where she expresses a view that her community care was not there for her from June onwards and she had nobody she felt she was able to talk with. One of the neighbours and friends state that they believe that this discharge was far too soon and she had only been receiving texts from Manpreet the previous day stating how low she felt and suicidal. This the friend feels was a key time and suggests that keeping Manpreet in hospital, would have in her view assisted in the building up of Manpreet's resilience, to live life without Brian.

15.21 The significance of the incident in the Northamptonshire hotel as alluded to by Brian just two days before Manpreet's death should also be considered in context. It appears that the incident took place in a hotel, where Manpreet was meeting another man. The inference is that this was a meeting arranged by Manpreet through a 'dating website', although the actual details are not clear. How Brian came to be at the same location is again unclear, although he appears to have gone to the same location separately as they were both seen to leave the location in their own vehicles. The friends and neighbours state that Brian had an iPhone locator app for Manpreet's phone so he would in their view traced her that way. It seems clear that this intervention by Brian must have had an impact on her.

15.22 Although the use of alcohol does not appear to have been a significant part of Manpreet's medical treatment, there is a clear admission by Manpreet that both she and

Brian did drink together with the suggestion that this may have been a catalyst on a few occasions to disagreements. The use of alcohol may also have affected her insulin levels. The friends and neighbours fully agree that Manpreet and Brian did drink on a daily basis and that whilst 'with drink' arguments between the two did occur. This perspective was not explored in any depth by any of the agencies, which may have helped.

15.23 The review author has reviewed Lincolnshire's current suicide strategy which is dated 2016. This suicide strategy has no specific mention of domestic abuse within it. As already mentioned earlier in this review the report *'Domestic abuse and suicide Exploring the links with Refuge's client base and work force'* by Ruth Aitken and Vanessa E. Munro on behalf Warwick Law school and Refuge. They found that this does not just apply to Lincolnshire.

'Domestic abuse is a high-risk situation, whether this refers to the immediate risk of serious, physical harm from the perpetrator, or to the longer-term risk to the victim's psychological well-being, to their life chances in terms of lost opportunities and potential, or significant damage to 'the self'. Domestic abuse is also a risk to life, either through homicide or suicide of the victim. Although domestic abuse is mentioned as a risk factor within the national suicide strategy, neither suicide nor suicidality are mentioned within the Government's most recent violence against women and girls (VAWG) or domestic abuse strategy. It seems clear that any meaningful integration of policy or practice across both spheres is lacking[2].'
Lincolnshire should seize the initiative and ensure they update their suicide strategy and include specific detail about Domestic abuse.

15.24 The Lincolnshire strategy should go further and be a Zero suicide ambition, as is happening in a number of areas throughout the country. One of the DHR panel members stated that LPFT as an individual agency have this as their strategy already. Also, they have put in a recommendation to have a process for rapid reviews in the same way as there is for childhood deaths.

16. Conclusions:

16.1 Although this review is different from the context of domestic homicide reviews in that in this case the victim, Manpreet, has not died in an act of murder directly at the hands of her intimate partner, but rather as consequence of issues within her relationship where there is evidence of domestic abuse.

16.2 The decision by the Safer Lincolnshire Partnership to conduct a domestic homicide review under the circumstances as presented by this case was a mature and robust decision and made in accordance with the 2016 Home Office Guidance. The robust application of the guidance is a particularly positive aspect of the manner with which the Safer Lincolnshire Partnership examines the multi-agency statutory roles, responsibilities and its overall safeguarding principles.

[2] Ruth Aitken and Vanessa E. Munro, Domestic abuse and suicide exploring the links with Refuge's client base and work force. © Refuge and Warwick Law School 2018

16.3 In Manpreet's case she did make a number of contacts with health professionals and, that did not go unnoticed, in fact to the contrary, the response that Manpreet was given on each occasion she made personal contact was supportive and responsive to her apparent needs at that time. There is a comprehensive record of engagement with her recorded by agencies and professionals throughout.

16.4 Although professionals have explored Manpreet's mental health with specific reference to her self-harm and attempts of suicide, she gave no indication of how her culture could potentially lead to her death in such incomprehensible circumstances. Whether she had researched this cannot be established, although there is no indication from within the police or subsequent coroner's inquest, that there was any signposting to this or that she had used the internet in the planning or preparation. The friends and neighbours were quite clear that Manpreet had researched suicide methods on the internet and was looking to buy appropriate drugs on the 'dark web'.

16.5 Manpreet's ethnic origins are of an Indian Sikh. Her first marriage was an arranged marriage in accordance with Sikh tradition. Manpreet suggested to agencies that she was a victim of her first husband controlling of her throughout their relationship. The fact that her first marriage ended seems to have left her in a position of isolation and she frequently referred to the word 'disgrace' as a reference to how her family and possibly the Sikh community, felt about her. The isolation and the impact of this cannot be underestimated. Manpreet seems to have left her family/close relatives/children to be with this person. There could be the sense of 'shame' in her actions and the family could have ostracised her from the family. However equally she could have also distanced herself from the family because of her perceived actions and the reactions it would bring to the family/local community.

16.6 Her children remained with their biological father and it is widely reported by a number of professionals, and her friends and neighbours, that she had no contact with the children. One of the neighbours highlighted, that in the 2017 Mother's Day card that Manpreet received, she asserted that the card had been written by her former husband and not her children.

16.7 The manner with which Manpreet took her own life was clearly planned and carried out in what may appear to many readers of this report as circumstances beyond comprehension. All suicides are tragedies invariably for the family, friends and others whom knew the individual. There was clearly desperation in the fact that she had chosen to end her life, but the manner with which she chose is rarely encountered within the UK. However, the method of self-immolation is one that is frequently encountered in Asia, but not elsewhere in the world. India has a high rate of self-immolation relative to Western societies as identified in a 2016 study The Psychology of Arson, but as indicated occurrences such as this within the UK are not widely reported, although individuals have survived such acts. However, it is commented that the motivation is hard to establish as survivors do not talk about it.

16.8 As a comparison figure, the rate of self-immolation suicides in the Delhi region of India is 39% wherein the UK the rate was 1.5%[3]. This is a method of suicide that is therefore rarely seen within the United Kingdom. It has not been possible to explore the ethnicity of the subjects of those UK occurrences as they do not appear to have been publicised.

16.9 In examining Manpreet's contact with professionals, in particular health practitioners and mental health services, although the acts of overdose were perceived as suicide attempts, Manpreet, on each occasion that the incidents were discussed and analysed, indicated that she had no actual suicide ideations nor the will to actually carry them out. At no time, did she give any indication to professionals that she had any inclination to die as a result of suicide in the manner that she chose. She had on one occasion, on 8th May 2017 which was an incident manifesting from her contact with Brian on the 3rd August 2017, told health professionals that she wanted to *"Burn [her] house down and get locked up*". There were indications around that time that she had in fact caused some damage at her home, although it is not clear as to the extent of this damage, although there is no indication that this was by fire/arson. The friends and neighbours were not aware of any damage.

16.10 Manpreet has on a number of occasions, attempted to mitigate the impact of the behaviours and actions by Brian by suggesting that his PTSD had a significant effect upon him. The fact is however, that there is little evidence provided to indicate that he was or had suffered from PTSD. His military service records indicate that he had not participated in any theatre of conflict. The question arising is what had he told Manpreet and whether this was a smokescreen created by him. If so, it goes some way to indicating his coerciveness to her and conditioning her into false beliefs in order to cover up his behaviour and deflect the impact. It does appear, when examining the narrative from mental health practitioners that Manpreet genuinely believed that Brian had some significant mental health issues arising from his PTSD, but was unable to give any clear provenance to that background.

16.11 Brian had entered into a relationship with a female that he had met during his business trips and there is evidence when examining the company records that this individual had become part of the company structure. As Brian made frequent trips out of the UK, Manpreet frequently found herself alone. Although she had her friendship with neighbours however, towards the end of her life Manpreet had commented to a number of health professionals that she felt her neighbours were too intrusive. Combining this with her lack of contact with her children, there is a clear indication and it is identified by some of the mental health professionals, in particular whilst at Cygnet Health Care that Manpreet was suffering from adjustment disorder.

16.12 Adjustment disorder is an abnormal and excessive reaction to an identifiable life stressor. The reaction is more severe than would normally be expected to 'everyday' stressful situations and can result in significant impairment in social, occupational, or academic functioning. Symptoms generally arise within three months of the onset of the catalyst or stressor, but studies have shown that this impairment of functioning tends to last no longer than six months after the stressor has ended. The response may be linked to a single event or multiple events. Stressors may be recurrent events or continuous events.

[3] International Journal of Burns and Trauma 2012.

16.13 Adjustment disorder often occurs with one or more of the following: depressed mood, anxiety, disturbance of conduct (in which the patient violates rights of others or major age-appropriate societal norms or rules), and maladaptive reactions (i.e. problems related to work, physical complaints, and social isolation). It is identified that adjustment disorders are associated with a higher risk of suicide and suicidal behaviour, substance abuse, and the prolongation of other medical disorders or interference with their treatment. An adjustment disorder that persists may progress to become a more severe mental disorder, such as major depressive disorder. Adjustment disorder is sometimes referred to as Situational Depression.

16.14 Whilst professionals have clearly made significant efforts to ameliorate the symptoms and provide a safety net for Manpreet, they were unable to build a sufficient rapport to get her to trust and share with them, her thoughts and feelings. For example, when discussing her future, she indicated that she was being very positive about the business, when in fact there is evidence to indicate that the company was not in a strong financial position as echoed in the fact that she was seeking employment elsewhere. Her financial background although not explored to any great extent, but a number of her comments made, painted a poor picture of this. Financial pressures were a significant if not continuous stressor. A level of financial abuse, due to her reliance financially on Brian, was suffered by Manpreet as with no Brian there was no income coming into the business and this as friends and neighbours point out was a considerable stress to her, and she saw no way out of it.

16.15 There was clearly coercive or controlling behaviour on the part of Brian. 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. 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. This perspective was first identified by the Crisis Team in their assessment of Manpreet on August 9th 2017.

16.16 Following the disclosures made by Manpreet on the 9th August following on from her hospital admission of August 8th, the assessment made by the Crisis Team was a comprehensive assessment which provides documentary evidence of historical and current domestic abuse, dependence on Brian and an indication of control & coercion, which was seemingly the first occasion that this had been recorded by professionals. The resulting risk assessment documented multiple risk factors including finances and social isolation in addition to the domestic abuse. The record further indicates a link between social circumstances and negative effect on her mental state, distress and poor coping. At that time consideration was given to future work around domestic abuse but taking into account her current mental state, this would occur when appropriate. It was identified that as Brian was not in the area that any immediate risk was reduced. The question arising is, was the recognition of the control and coercion shared with other agencies and in the interim, was the lack of this consideration a factor in the influence that Brian continued to have had upon her even though his proximity was not ‘close-by’.

16.17 In that same assessment it was noted that Manpreet disclosed that a family conflict in Devon, had resulted in Brian taking an overdose and he was choosing to limit and control his contact with her, which was further fuelling her distress. This separation meant she was unable to 'serve' and rescue him, thus resulting in unbearable distress and she was consequently neglecting her own needs further. The assessment noted that Manpreet had limited insight into this power dynamic, although after much discussion she did recognise the need to start looking after herself. This perspective of Manpreet perhaps typifies her assertions that she wanted to be a *"Typical Indian wife",* and by which she minimised her well-being placing Brian ahead of her needs. Whether this was by design or by cultural influences is perhaps a wider issue.

16.18 There is clear reference in the respective IMRs to the level of training of practitioners to the identification of signs of domestic abuse. It is noted however that in the EMAS IMR, there were discrepancies between the attending crews on occasions where crews attending two of the incidents to Manpreet made referrals to other agencies, however on two other occasions when the same considerations were present, no referrals were made. This perhaps exemplifies that safeguarding in possible domestic abuse scenarios leaves scope for continually refreshing practitioner's knowledge and understanding and their continued professional development[4]. At one of the Panel meetings the EMAS representative did discuss that they currently have a DA pathway with some of the Local Authority areas they cover, although they have been trying to achieve this in Lincolnshire, they do not have this DA pathway with Lincolnshire. The DHR panel support the development of this pathway by EMAS and the relevant authorities in Lincolnshire.

17. Lessons to be learnt

17.1 Agencies have made significant efforts to share information; however there appears to be an apparent concern, raised by the LPFT that the concerns over public interest disclosure remain a barrier to effective partnership sharing. It is also commented within the report from the hospital admission of Manpreet that the police had declined to share information to nursing staff on Manpreet's admission on 30th April, although this concerned Brian and officers felt they needed to exercise caution because criminal proceedings had been commenced. Had a robust multiagency information process been in place, that could analyse and take appropriate action, this may have alleviated a number of those concerns. The fact of the matter is that safeguarding should be at the centre, and on occasions the need for dialogue should outweigh concerns over disclosures and data protection where there are immediate safeguarding concerns.

17.2 The disclosure by Manpreet, to LPFT staff of a different form of abuse whilst an in-patient, although explored by professionals at the hospital, was not further reported (as already stated Brian was not the perpetrator). The friends and neighbours had never been told this by Manpreet though. The fact that the services offered to Manpreet did include specialist support services shows that the practitioners were thinking in the wider context, despite her reluctance to engage. This could have been shared with the police, who could

[4] https://www.gov.uk/guidance/conducting-a-domestic-homicide-review-online-learning

have provided specially trained officers to support her under the circumstances and would not have breached privacy, given Manpreet's disclosure of an allegation of a different form of abuse.

17.3 It is not clear if Manpreet was able to recognise the signs of abuse within her relationship with Brian. Incidents of repeat victimisation are recognised as being high and it is not clear if Manpreet had recognised this as a factor or whether she had received support and guidance from professionals in this specific regard.

17.4 Although the LPFT author identified domestic abuse in their agency's assessments and that this was shared with the GP via risk assessments, it was not as explicit as it should have been and required careful reading of the entire risk assessment by the GP. The assessments were not shared with any other partner, for example ULHT. The LPFT IMR author expressed the professional view that where there is a risk to a patient's safety due to a safeguarding issue, that this should be highlighted earlier on in the information to the GP with actions taken and any future plans or actions suggested for the GP. Staff never explicitly described to the GP that the transient mental distress of Manpreet was related to domestic abuse as being the key causal factor.

17.5 There was an element of predictability that Manpreet would self-harm by overdose in response to incidents of distress or where there was a combination of stress related factors, based primarily on the frequency of such occurrences. She did in fact seek support for her actions, reporting directly on one occasion on the 18th August that she had overdosed on prescribed medication. Those acts were quite specific in terms of the nature of the medication used to overdose, but at no time did she indicate or even suggest that she was aware of self-immolation.

17.6 On the occasion that Manpreet made contact by phone with mental health crisis team on 18th August 2017, informing them that she had taken an overdose, she was given advice by telephone that she would be visited the following day. Although this was a well-intentioned response, it failed to identify the critical need for immediate medical intervention and one with which Manpreet should have been taken to hospital or arrangements made for an ambulance. She had disclosed taking '*an unknown quantity'* of prescription medication, which in itself was a significant warning sign. The author notes that this omission has been identified within the respective IMR and action taken accordingly to ensure that there is no repetition in similar circumstances.[5]

17.7 Was the identification of Manpreet's Adjustment Disorder particularly by Cygnet health care shared appropriately between professionals? This is a specific disorder that was identified by mental health services but seems to have been compartmentalised and treated in isolation. This is another example of where integrated services (for example in a

[5] For all people presenting following an act of self-harm, initial assessment should include physical risks, risk of psychological harm and further self-harm or suicide and also any safeguarding concerns in children, young people, or vulnerable adults.

multi-agency safeguarding hub) or a vulnerable adult type process would have identified and shared this diagnosis at a much earlier stage.

17.8 Learning from this review is agencies should consider the application of historically 'tagging' addresses to ensure that the attending practitioners are well-informed of previous occurrences which will raise the awareness accordingly. It is also relevant to extend this to individuals. The flagging of individuals as a having DA issues and/or mental health issues or being a suicide risk. This could influence the professional responses and influence the multiagency information sharing and risk management.

Learning Themes

- Information sharing agreement needs adopting by all agencies
- Knowledge of Domestic Abuse required in services that work in suicide prevention. Especially the heightened risk of harm at time of or immediately after separation.
- Resolving Domestic Abuse issues needs addressing first in particular coercive controlling relationships in order to effectively treat any mental health symptoms.
- Adoption of a Multi-Agency risk assessment process for vulnerable adults may have helped in this case.
- The suicide prevention policy needs updating.
- An extended knowledge of culture/religion of minority communities in Lincolnshire would enhance professional practice.
- An awareness of DA in minority/religious communities would be of benefit.

18. Recommendations

18.1 The lack of a robust multi-agency information sharing process within the area is regarded by some agencies as being a significant barrier to effective communication and information sharing irrespective of any existing information sharing protocols or locally agreed practice. Although the author appreciates that there are wider considerations as to the agencies agreeable to such a partnership, other areas have benefitted from such initiatives. The integration of the Crisis Team member for example into the Lincolnshire Police control room, exemplifies the significant benefits that partnership working can bring under one 'umbrella' and that services can be delivered with a greater consideration for the individual(s) actual needs. This also serves to address the concerns as expressed by several of the IMR authors, for the useful sharing of sensitive and personal information, in particular where there are both immediate and enduring safeguarding considerations.

Recommendation 1:
i) The Safer Lincolnshire Partnership should ask partners for assurance that information sharing agreements are in place and being adhered to by all agencies.
ii) The Safer Lincolnshire Partnership is fully aware that agencies in Lincolnshire have taken part in scoping an options appraisal to look at interventions/provisions which improve

communication, information sharing and integrated working amongst agencies. The Safer Lincolnshire Partnership should ask partners to ensure as an outcome from this scoping exercise, that there is a process in place to share information, including the ability to analyse information and take appropriate action that provides individualised safeguarding plans as appropriate.

Recommendation 2:
i) The Lincolnshire Suicide Prevention Steering Group, with the assistance of Public Health, need to update the Lincolnshire Suicide Prevention Strategy to include specific reference to Domestic Abuse and ensure it is ambitious and should seek to have a 'Zero Suicide Ambition'.
ii) In the short term, the Lincolnshire Suicide Prevention Steering Group request that all statutory agencies sign up to this suicide prevention strategy. In the longer term all agencies whether statutory or voluntary sign up to the suicide prevention strategy.
ii) The Suicide Prevention Steering Group should consider implementing a process to review all or at least a proportion of suicides similar to the process already in place for reviewing childhood deaths. This will enable agencies to share and learn lessons with the intention of preventing future suicides, in particular those that involve Domestic Abuse.

Recommendation 3:
The Safer Lincolnshire Partnership, have completed a mapping exercise, in relation to adopting a process that is similar to a Multi-Agency Risk Management Process (MARM). The Safer Lincolnshire Partnership should add endorsement to the running of a pilot in one of the District Areas in Lincolnshire. (Applying this robust process should guarantee all reasonable steps are taken to ensure safety, by a multi-agency group of professionals. This model would include those at risk of harm as a result of self-harm/self-neglect, to improve consistency of approach if the pilot is successful across the whole County).

Recommendation 4:
The Safer Lincolnshire Partnership through the Domestic Abuse Core Priority Group, should use this death as a case study in current and future Multi Agency training and guidance highlighting the lessons learnt within the review as well as ensuring agencies reflect this in their own single agency training;

a. Consider the heightened risk that there is to the victim at the time of or immediately following separation. This should also cover the risk of physical harm, from the perpetrator of the DA, but also note the risk of self-harm through suicide as in this case, where the combination of risks for the victim was high.

b. This review of training should ensure it includes the risks associated with coercive and controlling behaviour.

c. The training review should incorporate the knowledge that in this case the source of the mental health issues was Domestic Abuse and this needed addressing first in order to effectively treat the mental health symptoms.

Recommendation 5

The Safer Lincolnshire Partnership should through their Domestic Abuse Core Priority Group consider with their partners, producing and publishing a learning bulletin (newsletter) for practitioners which raises awareness of minority communities/religions within their areas. This would include what culture and/or religion means to the individual, and how they may need to support change in their professional practice to ensure they consider individuals specific needs. This same bulletin (newsletter) should also raise awareness of domestic abuse in the minority communities/religions within their area.

Recommendation 6

The Safer Lincolnshire Partnership should ask the Domestic Abuse Core Priority Group to consider the development of a Domestic Abuse pathway for East Midlands Ambulance Service in Lincolnshire. East Midlands Ambulance Service already have this in place in other Local Authority areas.

Recommendation 7

The Lincolnshire Partnership NHS Foundation Trust to provide assurance that they have in place a process that considers any safeguarding matters upon location of bed whilst that patient is in receipt of out of county care. This will ensure that information is shared with the providing placement and Lincolnshire's agencies. Also, that safeguarding matters will be considered when prioritising support when that patients care is moved back into Lincolnshire County.