Domestic Homicide Review

Executive Summary

Suicide- MANPREET

Died September 2017

Author: Dr Russell Wate QPM

March 2019

Contents:

1. The Review Process

1.1 This executive summary outlines the process undertaken by the Safer Lincolnshire Partnership domestic homicide review panel in reviewing the suicide of Manpreet who was resident in their area.

1.2 The following pseudonyms have been used during the review process for the victim and perpetrator to protect their identities as endorsed by the review panel.

Manpreet	**Asian British**	**Victim**
Brian	**White British**	**Perpetrator**

1.3 There were no criminal charges in this case. An Inquest held in May 2018 the ruling by Her Majesty's Coroner was that the deceased took her own life, and the Assistant Coroner recorded a verdict of suicide. This concluded all proceedings in connection with the tragic death.

1.4 In January 2018, The Safer Lincolnshire Partnership was notified on the death of Manpreet by the LPFT. Later that month, the Partnership determined that it was considered that the circumstances of the death of Manpreet met the criteria, in accordance with the 2016 Home Office Statutory Guidance, for a domestic homicide review and the partnership commissioned the review appointing the Independent Chair and overview author. All relevant agencies, having had contact

with the deceased and perpetrator prior to her death, were notified of the review and were asked to confirm what, involvement that they had with them.

1.5 In total, some 15 separate agencies were contacted during the review process whom had contact with the victim and perpetrator and those agencies provided Individual management reviews or information confirming details of contact. Additionally, the panel and Independent author sought contributions from agencies and independents with expertise in matters such as domestic abuse, suicide, Sikh culture and mental health to assist the DHR panel and to provide a wider vision.

1.6 Of the agencies providing IMR's, all the authors of those reports were independent of involvement in the management of the deceased or perpetrator or of staff involved with such processes. The panel were satisfied with the level of independence of each author accordingly.

2. Contributors to the review

Agency	Contribution status
GP Practice, Lincolnshire	IMR
GP Practice, Devon	No information
ULHT	IMR
LPFT	IMR
Cygnet Healthcare	IMR
MARAC	Report
IDVA	Report
EMAS	IMR
HMPS	Report
Mental Health Services, Devon	Report
Lincolnshire Police	IMR
EMSOU	Report
Northamptonshire Police	Report
Devon and Cornwall Police	IMR
SSAFA	Report
Mental Health Services Devon	Report

3. Review Panel Members

Agency	Name
End Domestic Abuse Now (EDAN) Independent DA advisor	Jane Keelyside
Independent Sikh Advisor	Amerjit Singh
Independent Advisor on Suicide	Shabana Edinboro
Independent Advisor 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 Health Care	Martin Graham
Lincolnshire County Council	Linda MacDonnell
Lincolnshire County Council	Teresa Tennant (Business support)
Legal Advisor to review	Toni Geraghty
Lincolnshire MARAC	Natalie Watkinson
DHR Chair and report Author Support to Chair	Russell Wate James Bambridge

To ensure the review into the circumstances that led to Manpreet taking her own life, was dealt with in an effective and timely manner, the the DHR panel, met in person on four occasions and virtually 2 further occasions. All panel members are independent of these circumstances of this case.

4. Author of the Overview report

Dr Russell Wate, QPM, is the Independent DHR chair and overview author. He is a retired senior police detective serving to the rank of Chief Superintendent. 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.

Dr Wate has no connection with the Safer Lincolnshire Community Safety Partnership other than previously providing professional and Independent services about one other unrelated Domestic Homicide Review which occurred in 2017.

5. Terms of reference for the review

5.1 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 practitioner's 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

5.2 The critical dates for this review have been designated by the panel as 1st April 2017 to 5th September 2017, however the panel chair asked the agencies providing IMR's to be cognisant of any issues of relevance outside of those parameters adding context and value to the report.

5.3 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.

5.4 The IMR authors were also referred to the generic areas of consideration in accordance with the 2016 Home Office Statutory guidance, in particular coercive and controlling behaviour.

6. Summary chronology:

6.1 The review panel felt that is was essential that at the very beginning of this review that they highlighted the review is about Manpreet and her lived experience. The name Manpreet is a pseudonym, the independent Sikh advisor felt it was appropriate to use as a popular female name within the Sikh community.

6.2 Manpreet was at the time of her death aged 40, of Indian heritage and Sikh by religion. Manpreet originated from the Midlands area of the UK and had previously had an arranged marriage. It was from this marriage that she has two children.

6.3 Manpreet left her first husband approximately seven years before she died, to be with 'Brian'. the perpetrator. Manpreet had known Brian for a few years and had been in a relationship with him She had reportedly left her marriage which she had described to health professionals as being that of an "*arranged and controlling relationship".* She had been married to Brian for a little over a year before her death.

6.4 From the time her first marriage ended her family, including her two children, had almost nothing to do with her. Her mother and brother, with whom she had been very close to prior to the break-up of her marriage, also had minimal contact with her.

6.5 The relationship with Brian has been described by neighbours and friends as being turbulent. Four years before Manpreet died they moved into a house that she bought in a small semi-rural location. Brian and Manpreet set up a business together from which financially Manpreet totally relied on the income from this business. Brian also pursued business interests outside of the UK on which he was not accompanied by Manpreet. He became involved in a relationship with another woman. He had disclosed this relationship to Manpreet within the two years prior to her death.

6.6 During the last few months of her life, there was a DA incident, where Brian was arrested and placed on remand. There were also four suicide attempts by her which resulted in involvement with several agencies in particular health professionals.

6.7 Brian was understood to be suffering from Post-Traumatic Stress Disorder (PTSD) either following from or during his service in the Royal Air Force (RAF). The review author however can confirm that there is no information to support Brian ever being in the RAF although he did serve for a very short time in the reservist Army Air Corp, but not active service. It does however appear that Manpreet was unaware of this prevarication and although the review author has no clear evidence, this suggests it may be another tactic used by Brian to exercise coercive control on her.

6.8 On the 18th April 2017, Manpreet was admitted to accident and emergency. She had suffered a facial injury, 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, several disclosures were made by both Manpreet and Brian to the LPFT (CRISIS) staff. Manpreet 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 disclosed to professionals that he had formed a relationship with another woman.

6.9 Brian was regularly present with Manpreet during her in-patient treatment which was due to Manpreet's insistence. Manpreet was discharged having received several contacts from mental health services, which also continued for several days following her discharge. Although Manpreet engaged with the two health services and she was offered domestic abuse support, she was quite clear in her views and indicated that she would not co-operate with any domestic abuse referral.

6.10 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 Brian had armed himself with two kitchen knives. Police attended finding Brian at the house in a threatening and confrontational manner armed with a knife. Manpreet was out of the house by this time, having reportedly disarmed Brian of a shotgun.

6.11 Manpreet had discovered that Brian had been having a text conversation with another female had discovered some explicit messages on his mobile 'phone. This led to an argument and Brian removed one of his shotguns from the gun cabinet which Manpreet then took from him. A further violent argument took place with Brian grabbing Manpreet by the throat. Friends had arrived at the house and they removed Manpreet to safety. Brian remained in the house until he was arrested. The inference by those present is that the initial argument leading to the violence was fuelled by both Manpreet and Brian having consumed alcohol.

6.12 The incident was deemed a domestic abuse incident by the police and the firearms involved significantly heightened the risk to Manpreet. Brian was charged and 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) 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 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 the incident Manpreet made a conscious decision not to inform professionals how that injury was caused although she disclosed at least to two other friends and neighbours that Brian had caused the injury.

6.13 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 at the time of the initial occurrence and had revoked the shotgun licence.

6.14 Although several individuals and agencies had contact with Manpreet, other than the close neighbours it is not clear what other support mechanism that she had. With Brian remanded to prison, it appears that Manpreet was at this point in a position of relative isolation, and a definitive risk factor to her well-being.

6.15 On the 30th April 2017, a neighbour discovered her unconscious and evidence of wine and tablets having been consumed. Manpreet was admitted to hospital. 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, significantly the fact that Brian was on remand and she felt isolated and alone. She was assessed as being vulnerable and at further significant risk of self-harm.

6.16 The combination of risks was high that Manpreet was offered and agreed to an informal admission to an acute psychiatric ward. However, this was out of county due to the lack of local beds. She 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) as she consented to treatment.

6.17 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 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 Cygnet healthcare. Other MARAC actions completed were that She was referred to the Community Mental Health Team and her GP practice was notified, and for an IDVA to make contact. On discharge, Manpreet returned to her home and the follow-up from the community mental health services reported her as being, on both personal and telephone consultations, as 'functioning well'. 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 were resolved.

6.18 The practice nurse at Manpreet's GP surgery contacted her whilst she was in treatment at Cygnet to discuss her diabetes and 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, the GP noting no obvious concerns for her welfare.

6.19 On the 1st June 2017, Brian was released from prison on conditional bail to reside out of the area and 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 should have been worthy of separate consideration.

6.20 On the 12th June 2017, Lincolnshire Police responded to a third-party report from where Brian was a voluntary in-patient having been admitted to hospital following two suicide attempts. Manpreet had been sending Brian text messages and an image to his phone of her suggesting a possible suicide attempt. Brian had said he had blocked Manpreet's phone number, but clearly hadn't. The inference of this was that Manpreet was attempting to get Brian to breach his bail conditions by contacting her. 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.

6.21 Officers established there was no apparent evidence of any such communications as alleged by Brian. Manpreet told the officers that she in her opinion, had had little assistance from the LPFT crisis team and needed somebody to talk to when things became difficult for her. Whilst the officers

did not feel she needed immediate safeguarding, they referred Manpreet to Lincolnshire Social Care, however, a further referral could have been made to mental health services in the area. As it transpired, Lincolnshire police received contact later that day from LPFT, the mental health provider whom had been contacted in respect of the same information.

6.22 Between June 26th and June 30th 2017, Manpreet attended her GP's practice for consultations and was referred to accident and emergency department, with reported wrist pain and reduced movement. 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 and DA was unlikely.

6.23 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. There was no evidence, that despite her mood, that she was failing to function. She showed no indication of either an immediate or enduring mental health issue. She was referred to support services.

6.24 On August 3rd 2017, Brian was given a six-month custodial sentence suspended for twelve months. Later that day, he and Manpreet met each other and he alleged that following this they argued and Manpreet took a bag from him containing his medication. The Police acted to safeguard him as he had threatened to harm himself. The following day, Brian returned to Devon, having removed some of his possessions from the home.

6.25 On August 8th 2017, Brian's father contacted the police concerned 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, they were informed by neighbours that Manpreet had been taken by ambulance to hospital. Officers took no further action 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 that included being referred to the LPFT's crisis team. 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 was no evidence of this within the clinical record.

6.26 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 when she had disclosed that she felt that she had not received an appropriate level of support from a Community Psychiatric Nurse since her discharge in May 2017. Manpreet was assessed as presenting with depression, difficulty in making decisions, loss of appetite with associated weight loss, poor sleep, diabetic regulatory issues and irrational behaviour. 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. Compounding factors were her social isolation, and disclosures of financial pressures.

6.27 In discussion with Manpreet during the crisis team assessment, she disclosed she was back in contact with Brian by text messaging. Brian though stated that he didn't respond so as not to breach his bail conditions. Although Manpreet was not offered domestic abuse support 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. She was referred to a Consultant Psychiatrist. All the friends and neighbours seen stated Manpreet was absolutely obsessed with Brian and by inference he remained in control of her thoughts and actions.

6.28 On the 18th August 2017, Manpreet contacted the Crisis Team by telephone reporting that she had taken an overdose of prescribed medication. She was advised to seek medical advice, but no 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.

6.29 On the 29th August 2017, Manpreet left a voice message to Community Mental Health cancelling her assessment on the 8th September 2017 as she had a job interview. 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.

6.30 On the 3rd September 2017, Manpreet met with a man in Northamptonshire. Brian was also at the same location. It transpires that Brian could track her movements through a mobile 'phone application. A confrontation took place between Brian and Manpreet although there was no violence and all parties left the location. This was the last independent sighting of Manpreet before her death.

6.31 On the 5th September, a neighbour entered her house and discovered her deceased in the bathroom.

7. Key issues arising from the review

7.1 Manpreet presented to A&E predominantly following overdoses of both prescribed and non-prescribed medication. These occurrences were identified by professionals as being incidents of attempted suicide and there were referrals made to mental health services. Professionals also identified there were elements of self-harm as opposed to them being an unequivocal attempt at suicide. Manpreet denied suicidal intent but the events had resulted due to Brian's affair as well as her distress from the separation from him.

7.2 All occurrences in respect of Manpreet have been well 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 indirectly through signposting. This activity included discharge plans which involved and personal safeguarding considerations addressed.

7.3 When the mental health crisis team became involved with Manpreet that they were proactive in delivering their service to her and they worked extensively to engage her when she was not at home by returning at different times of the day to her home unannounced when she had not answered the phone to them.

7.4 Specifically, in relation to the exploration of DA, the circumstances of Manpreet's admission to hospital on the 18th April 2017 was questioned by health professionals, given the concerns for the potential of domestic abuse as the cause of her injury, which was recognised by all practitioners. This emphasises the value of awareness of front-line practitioners in the signs and symptoms and warning indicators of domestic abuse. The later disclosure during the same admission by Manpreet that Brian had caused an injury to her wrist some months previously was also identified as being an indication of domestic assault.

7.5 Brian also disclosed that he was responsible for causing an historical injury to Manpreet, although his admission was of a completely different injury and was possibly an effort to minimise the true nature of the incident, the details of which were never fully established despite considered efforts by practitioners. It is possible that these were two separate occurrences of historical domestic abuse. 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 heightened risks to Manpreet from her mental health perspective.

7.6 In respect of both disclosures, a DASH risk assessment was not consented to, and there was insufficient information to suggest a referral to DA agencies based on professional judgement alone. What those disclosures identified was that the domestic abuse was present at least some 18 months prior to the April 2017 events. The review process looked at historical events to ensure matters were examined contextually with no other indications of DA established. Sign-posting to DA services was offered to Manpreet but was declined.

7.7 The disclosure by Manpreet of a different form of abuse to LPFT staff during the same hospital admission period, which she declined to elaborate further, was attempted to be explored by professionals. This was good practice, however, there may be opportunities herein for future considerations to be made for referral to the police and for expert and independent intervention by specially trained officers. Had a robust information sharing process 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 with an approach then made to her at home.

7.8 Manpreet was separated from her children, her neighbours indicate that she was depressed by this, although she inferred that she accepted this lack of contact in order to be with Brian. This feeling of loss and separation for Manpreet was particularly evident at birthdays and significant dates and appears compounded by little or no contact with her mother and brother adding to her social isolation.

7.9 Although all agencies have 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 detail. Not one of the agencies mentions 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. Within 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 abuse is. There is a trend of not speaking out, even to family members due to fears of bringing shame upon the family.

7.10 The DASH risk assessment facilitated a referral to the IDVA service concerning the incident of April 27th 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.

7.11 Following the arrest of Brian on the 27th April 2017, Manpreet felt isolated and although she was given support from the police domestic abuse liaison officer, other contact and information she had is unclear and there seems to be some conjecture as to how Manpreet was kept up to date with her husband's arrest, detention, subsequent charge and remand. This identifies a gap in professional practice. On the 8th May 2017, Cygnet health care, received an email from Lincolnshire Police to confirm that Brian would appear in court on 30th May. Manpreet was upset to receive this information by email. There may be other methods that could be considered by the police working in conjunction with other agencies, to update or inform victims where there are issues concerning the victim's 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 agencies should consider how best to deal with individuals whom have little knowledge of the criminal justice system.

7.12 The IDVA felt that Manpreet was minimising the domestic abuse and the situational incident. This was replicated by Manpreet when she minimised Brian's culpability by making excuses for him specifically referencing his PTSD. The review author fully accepts though that this is Manpreet's choice, but highlights that this is another example of the coercive control Brian had over Manpreet.

7.13 On the 1st August 2017, Manpreet told practitioners that she had had no support since being discharged from the Crisis Resolution Solution and Home Treatment Service in June. She stated she was "*close to suicidal"*, was trying not to be by keeping busy, but was under "*a lot of pressure*". Although there was no indication that Manpreet had a severe and enduring mental illness, it was important to listen to the views of Manpreet 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 specifically in relation to the needing to self-refer to the Steps2Change

programme. Manpreet told a neighbour that they would have to contact her as there was no way that she would be self-referring.

7.14 On the 8th August 2017, the key concerns arising were for Manpreet's mental health and her apparent self-neglect as she had been in bed for three days, not eating or drinking. Although being taken to hospital, was discharged the same day with a referral to the crisis team. The following day she had attended her GP whom 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.

7.15 Manpreet and Brian each had mental health issues, and appropriate services were provided to both in a timely and considered manner. The records for Brian from Devon, show a very caring, and alert service that provided a good level of service to his need.

7.16 Following her placement out of area in May 2017, after 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 Manpreet thought she would. LPFT did allocate the Crisis Team, although this had ceased by the end of May 2017 which was just a week after her release from an intensive period as an in-patient. The review author questions whether this discharge plan as an out-patient came too soon for Manpreet to gain any resilience? 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.

7.17 The significance of the incident in the Northamptonshire hotel takes another dimension in that it emphasises Brian's control over Manpreet. It seems clear that this intervention by Brian had an impact on her and came very shortly before her tragic death.

7.18 Although agencies do not infer that alcohol was a significant background issue, there is an inference that alcohol consumption was a catalyst on a few occasions to disagreements. This perspective was not explored in any depth by any of the agencies, and had it been so, this may have assisted in enlisting support from other appropriate services.

7.19 Lincolnshire's current suicide strategy which is dated 2016, has no specific mention of domestic abuse within it. 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, is of value in looking at the inclusion of DA issues.

7.20 Lincolnshire should ensure they update their suicide strategy and include specific detail about DA. It should be noted that Lincolnshire is just one of numerous local authorities that would benefit from considering the wider issues and that they should not be singled out because of this review. However, the Lincolnshire Suicide Strategy should seek to go further for a Zero suicide ambition, as is happening in several areas throughout the country.

8. Conclusions

8.1 Although this review is different from the usual context of domestic homicide reviews in that in the victim has not died in an act of murder directly at the hands of her intimate partner, the decision by the Safer Lincolnshire Partnership to conduct a domestic homicide review was a mature and robust decision in accordance with the 2016 Home Office Statutory Guidance. This is a particularly positive aspect of the manner within which the Safer Lincolnshire Partnership examines multi-agency statutory roles, principles, learning and its overall safeguarding responsibilities.

8.2 Manpreet's first marriage was arranged in the Sikh tradition. The manner within which her first marriage ended seems to have left her in a position of isolation and she frequently referred to the word 'disgrace' as to how her family and possibly the Sikh community, felt about her. The isolation and the impact of this should not be underestimated. Manpreet had left her family/close relatives/children to be with Brian. There could be the sense of 'shame' by the way in which she had ostracised herself from her family due to her perceptions. Her children remained with their biological father and it is widely reported that she had no contact with the children.

8.3 Manpreet did make several contacts with health. The response that Manpreet was given on each occasion she made personal contact, was supportive and responsive to her needs at that time. There is a comprehensive record of engagement with her recorded by agencies and professionals throughout.

8.4 Although professionals have explored Manpreet's mental health with specific reference to her self-harm and attempts of suicide, she gave no indication of what could potentially lead to her death in such incomprehensible circumstances. There is no indication from within the police investigation or subsequent coroner's inquest, that there was any sign of this. Friends and neighbours however were quite clear that Manpreet had researched suicide methods on the internet and was looking to buy appropriate drugs on the 'dark web', but this had not previously been shared with any professionals.

8.5 The manner with which Manpreet took her own life was clearly planned and carried out. There was clearly desperation in the fact that she had chosen to end her life, but the manner with which she chose to is rarely encountered within the UK. The act of self-immolation is one that is frequently encountered in Asia. India has a high rate of self-immolation relative to Western societies.

8.6 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, indicated that she had no actual suicide ideations nor the will to do so. She had on one occasion, on 8th May 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 there is no evidence to support this.

8.7 Manpreet, on several occasions, attempted to mitigate the impact of the behaviours and actions by Brian by suggesting that his PTSD had a significant. In fact, there is no evidence to indicate that he had suffered from PTSD. The question arising is what had he told Manpreet and was this a smokescreen created by him. If so, it goes some way to indicating his coerciveness to her and

conditioning her into false beliefs to cover up his behaviour and deflect the impact of his actions against her. 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.

8.8 Brian had entered a relationship with a female he had met during his business trips, and Manpreet frequently found herself alone. Although she had her friendship with neighbours, towards the end of her life Manpreet had commented to a number of health professionals that she felt her neighbours had become 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, that Manpreet was suffering from adjustment disorder.

8.9 Adjustment disorder, sometimes referred to as Situational Depression, 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. Social isolation is a key indicator. It is acknowledged that adjustment disorders are associated with a higher risk of suicide and suicidal behaviour, substance abuse.

8.10 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. For example, when discussing her future, she indicated that she was positive about her business, when the company was not in a strong financial position, echoed by the fact that she was seeking employment elsewhere. Financial pressures were a significant if not continuous stressor which compounded when isolated from Brian as she had no income from him.

8.11 There was clearly coercive and controlling behaviour on the part of Brian. This perspective was first identified by the Crisis Team in their assessment of Manpreet on August 9th 2017. This 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 factors including finances and social isolation in addition to domestic abuse. It further indicated a link between social circumstances and negative effect on her mental state, distress and poor coping. Consideration was given to future work around domestic abuse but given her current mental state and that with Brian out of the area, any immediate domestic abuse risk was reduced. The question arising is, was the recognition of the control and coercion shared with other agencies and was the lack of this consideration a factor in the influence that Brian continued to have had upon her?

8.12 Brian's overdose fuelled her distress. Their separation meant she was unable to 'serve' and rescue him, thus resulting in unbearable distress and she was consequently neglecting her own needs further, putting his needs above her own. 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.

8.13 There is clear reference throughout the respective IMRs to 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.

8.14 The EMAS representative did discuss that they currently have a DA pathway with some of the Local Authority areas they cover, but they do not have a DA pathway with Lincolnshire. The DHR panel support the development of this pathway by EMAS and the relevant authorities in Lincolnshire.

9. Lessons to be learned

9.1 Agencies have made significant efforts to share information, however it is apparent that the concerns over public interest disclosure can remain as a barrier to effective partnership sharing. The police had declined to share information to nursing staff on Manpreet's admission on 30th April as 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 those issues. The fact of the matter is that safeguarding should be the primary concern and on occasions the need for dialogue should outweigh queries over data protection especially where there are enduring safeguarding concerns.

9.2 The disclosure by Manpreet, of abuse to professionals, whilst an in-patient, although explored, was then not further referred. 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. However, this could have been shared with the police, who could then have provided specially trained officers to engage with her.

9.3 It is not clear that Manpreet was able to recognise the signs of abuse within her relationship with Brian. Incidents of repeat victimisation are recognised as happening, 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.

9.4 Although the LPFT author identified domestic abuse in their agency's assessments and this was shared with the GP via risk assessments, it was not as explicit as it could have been and required careful reading of the entire risk assessment by the GP. The assessments were not shared with any other partner. 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.

9.5 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 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.

9.6 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.

9.7 Was the identification of Manpreet's Adjustment Disorder 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, or a safeguarding adult process, would have identified and shared this diagnosis at a much earlier stage.

10. Recommendations from the review

The lack of a multi-agency safeguarding hub 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.