Safer Lincolnshire Partnership

Domestic Homicide Review

DARDR Carol

June 2023

Executive Summary

Author: Dr Liza Thompson

Commissioned by: Safer Lincolnshire Partnership

Review completed: September 2025

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Carol was described by her family as fun and vivacious, a respected member of the local community and the hairdressing community. She was described as a gregarious friend, and a loving and responsible mother who adored her children and would never have wanted to cause them physical or emotional pain.

The Safer Lincolnshire Partnership, Independent Chair and all involved in this review extend their condolences to Carol's family and friends.

OFFICIAL SENSITIVE

EXECUTIVE SUMMARY

1. The Review Process

1.1. This Domestic Abuse Related Death Review (DARDR) examines agency responses and support given to Carol, a resident of Town A, prior to her death in June 2023.

1.2. On 14th March 2024, the Lincolnshire Coroner recorded multiple traumatic injuries as Carol's medical cause of death. With the conclusion that "this was a deliberate act carried out with the intention of ending her own life" and reached a conclusion of suicide.

1.3. This DARDR examines the involvement that organisations had with Carol - a white British woman in her early fifties, and her husband Gareth - a white British male also in his early fifties - prior to Carol's death.

1.4. The key reasons for conducting a DARDR are to:

a) establish what lessons are to be learned from the death about the way in which local professionals and organisations work individually and together to safeguard victims;
b) identify clearly what those lessons are both within and between organisations, how and within what timescales will be acted on, and what is expected to change;
c) apply these lessons to service responses including changes to policies and procedures as appropriate; and
d) prevent domestic violence and abuse, and improve service responses for all domestic violence and abuse victims and their children, through improved intra and inter-organisation working;
e) contribute to a better understanding of the nature of domestic violence and abuse; and
f) highlight good practice.

2. Contributors to the Review

The following agencies contributed to the review.

Agency/ Contributor	Contribution
Children's Social Care	IMR Chronology
GP Practice A	IMR Chronology

Lincolnshire Police	IMR Chronology
Lincolnshire Partnership NHS Foundation Trust	IMR Chronology
Hospital A	IMR Chronology
Adult Care and Community Wellbeing	IMR Chronology
Hospital B	IMR Chronology
East Midlands Ambulance Service NHS Trust	IMR ogy
Lincolnshire Community Health Service NHS Trust	IMR Chronology
School A	IMR Chronology
Lincolnshire Domestic Abuse Specialist Service	IMR Chronology
Southwest London Elective Orthopaedic Centre – St Georges Hospital	Summary report Chronology
British Transport Police	Information provided following Carol's death

3. Review Panel Members

3.1. The review panel involved the following members – none of which had any prior contact with Carol or her family prior to Carol's death.

Agency	**Name**	**Job Title**
Vimar Solutions Ltd	Liza Thompson	Independent Chair and Author
Safer Lincolnshire Partnership	Jade Thursby	Domestic Abuse Business Manager
Lincolnshire Police	Rachael Cox	DCI – DA Lead Lincolnshire Police
North Kesteven District Council (District Council A)	Julia Miller	Housing Options Manager
LCC Children's Services	Laura Bonner Paula Bexon	Head of Service Children's Services Head of Service Children's Services

LCC Children's Health	Dawn Firth	Locality Health Manager
LCC Education Support	John O'Connor Debbie Barkes	Head of Service Education Support Pathfinder Education Lead
LCC Adult Care and Community Wellbeing	Angela Copestick	Area Manager – Safeguarding
Lincolnshire Community Health Services NHS Trust	Jennifer Parker	Named Nurse for Safeguarding
United Lincolnshire Hospitals NHS Trust (Hospital A)	Elaine Todd	Named Nurse for Safeguarding Children and Young People
NHS Lincolnshire Integrated Care Board (ICB) – conduit for primary care	Claire Tozer	Head of Safeguarding Adults and Primary Care
Lincolnshire Partnership NHS Trust	Anthony Mansfield	Head of Safeguarding Public Protection and Mental Capacity
EDAN Lincs/Lincolnshire Specialist Domestic Abuse Service	Sharon Walker	IDVA Manager
Practice Plus Group (Hospital B)	Cathy Woods	Safeguarding Lead
East Midlands Ambulance Service	Charlotte Salt	Named Professional for Safeguarding Adults
Lincolnshire County Council Public Health	Kate Cooper	Public Health Officer

Support to the Panel

Legal Services Lincolnshire	Toni Geraghty	Legal adviser to the Partnership
LCC Business Support	Teresa Tennant	Administration

4. Author of the Overview Report

4.1. The Independent Chair and Author of the review was Dr Liza Thompson.

4.2. Dr Thompson is an AAFDA accredited Independent Chair, who has extensive experience within the field of domestic abuse, initially as an accredited Independent Domestic Violence Advisor, and later as the Chief Executive of a specialist domestic abuse charity. As well as DHR's, Dr Thompson also chairs and authors Safeguarding Adult Reviews (SARs). She delivers domestic abuse and coercive control training to a variety of statutory, voluntary, and private sector agencies, and is the current Independent Chair for the Rochester Diocese Safeguarding Advisor Panel (DSAP). Her doctoral thesis and subsequent publications examine the experiences of abused mothers within the child protection system.

4.3. Dr Thompson has no connection with the Community Safety Partnership and agencies involved in this review, other than currently being commissioned to undertake Domestic Homicide Reviews in Lincolnshire.

5. DHR Methodology

5.1. The detailed information on which this report is based was provided in Individual Management Reports (IMRs) completed by each organisation that had significant involvement with Carol and/or Gareth. An IMR is a written document, including a full chronology of the organisation's involvement, which is submitted on a template.

5.2. Each IMR was written by a member of staff from the organisation to which it relates. The IMRs considered the contact each agency had with Carol, Gareth or their children during the period 1St December 2019 to June 2023, however IMR authors were also required to provide any relevant information pertaining to domestic abuse, mental health, chronic pain, or substance misuse, linked to Carol or other family members from 1st January 2012.

5.3. Each IMR was signed off by a Senior Manager of that organisation before being submitted to the DARDR Panel. Neither the IMR Authors nor the Senior Managers had any involvement with Carol or Gareth during the period covered by the review.

5.4. In addition to information provided in the IMRs, information from the family's statement to the coroner and an undated statement written by Carol in support of a claim for negligence against Hospital B have also been used within this report. It is thought that the statement was first written by Carol following complications arising sometime after the surgery. The panel thank the family for providing this information, which allowed an insight into Carol's state of mind and her experiences during this time.

6. Terms of Reference for the Review

6.1. This review established whether any agencies have identified possible and/or actual domestic abuse that may have been relevant to the death of Carol.

6.2. Where domestic abuse was disclosed, or identified, the review focused on whether each agency's response to this was in accordance with its own and multi-agency policies, protocols and procedures in existence at the time. The review examined the methods used to identify risk and any action plans put in place to reduce that risk. The review examines whether, and how patterns of behaviour were recorded, and what information was shared across agencies.

6.3. The full subjects of this review were Carol and her partner Gareth. Full health and social care records were gathered for Carol; however, agencies were asked to only provide proportionate information about Gareth, which would be relevant to the review. There was no indication that Gareth had any previous criminal history, and the information regarding allegations of domestic abuse against Carol are included below in the chronology.

6.4. Specific issues which were considered, and if relevant, addressed by each agency in their IMR were as follows:

a) Were services accessible to Carol, Gareth, and/or the children?

b) Was Carol offered a range of available options and services when she asked for help from agencies? Include in your analysis the ability, or otherwise, of your service to view Carol through more than one "lens" when she presented with one or more of her complexities of needs.

c) An understanding of the historical involvement of agencies with Carol/Gareth specifically linked to domestic abuse and mental health, including an analysis of potential bias and assumptions made by professionals due to the historic incidents spanning many years.

d) Did agencies work well together in order to share information, assess risk and develop appropriate safety plans?

e) An analysis of how the family accessing private health care services impacted on the ability of agencies to work well together, in order to share information, assess risk and develop appropriate safety plans.

f) When risk assessments were completed, was Carol's risk of harm from herself identified, and linked to the harm from Gareth due to his coercively controlling behaviour?

g) An understanding of the potential link between Carol's mental and physical health, and the deterioration of the relationship with Gareth; particularly the increased reporting of Coercive and Controlling Behaviour (CCB) and financial abuse.

h) Was consideration given to the link between any, or all, of Carol's vulnerabilities and needs, including ongoing chronic pain, domestic abuse, menopausal

symptoms, mental ill health, alcohol misuse, and suicidal ideation? What learning can the review highlight regarding these links?

i) Was consideration given to the concerns raised by Carol's family members regarding her reliance on pain medications, and the effects of the medication on Carol? Was there an exploration of possible alternative treatment in place of ongoing prescriptions?

j) Think family – were the children identified as being at risk of harm within the home environment?

k) Understanding the role of family members as informal carers – carer assessments and care needs assessments.

l) An understanding of the financial pressures, and the effects of these pressures within the family.

m) Consideration of how the DA Act 2021 may have led to a different response during 2017-2019 – regarding the "verbal arguments" and threats of self-harm.

n) Consideration of how professionals identify that a person is "coping".

o) What was the impact of the MARAC involvement with Carol and Gareth?

p) What learning can be identified around the understanding and application of typologies when responding to cases such as Carol/Gareth's?

7. Summary Chronology

7.1. Carol and Gareth had been together since around 2004, and all three children had been conceived following numerous IVF[1] attempts. Carol told mental health practitioners that whilst the many failed conception attempts had affected her mental health, her pregnancies had affected her physical health. Carol had a very small body frame and carrying twins had led to her ongoing hip issues, which started around 2016.

7.2. Carol was described by her family as fun and vivacious, a respected member of the local community and the hairdressing community. She was described as a gregarious friend, and a loving and responsible mother who adored her children and would never have wanted to cause them physical or emotional pain.

7.3. Carol's family described her ongoing chronic pain as contributing to her losing her confidence, and her rising anxiety and depression. They state that Carol's mental health issues were not formally diagnosed, but the family noticed. They also state that Carol did not acknowledge that she had issues with mental health, although she did discuss suicidal plans and thoughts.

[1] In Vitro Fertilization – is a complex series of procedures used to treat infertility.

7.4. Carol told mental health practitioners that she had a supportive relationship with her father but stated she did not get along with her mother. Carol felt that Gareth and her own mother would team up against her. Gareth's mother lived within the same cul de sac as Carol, Gareth and the children, and upon separation from Gareth, a few months before Carol's death, Gareth moved into Gareth's mother's house. Carol described her work positively, stating that when she was at work her mental health was at its best.

7.5. Carol described multiple traumas in her life, relating to the seven attempts at IVF, to conceive the children and several periods of ill-health, including an episode whilst in Egypt which resulted in Carol receiving intensive care due to pneumonia. Carol also spoke about an abusive relationship from when she was in her late teens, which she indicated had led to her developing an eating disorder. There is an indication in Carol's clinical records of consideration being given to Carol suffering possible post-traumatic stress disorder, although this diagnosis was not formally given.

7.6. Carol had received several surgeries to her spine and hips, including a hip replacement which required ongoing remedial surgery. The surgeries had resulted in long term use of codeine medication. Gareth raised concerns that Carol was codeine dependent and believed that the use of codeine-based medication had changed her behaviour and outlook, resulting in Carol accusing him of controlling behaviour.

7.7. Carol was also struggling with menopausal symptoms, which were exacerbated by the chronic pain, resulting in poor sleep and mood swings. Carol self-reported using alcohol to self-medicate, for both the pain and the menopausal symptoms. This included alcohol use whilst taking prescribed codeine-based medication.

7.8. Carol's family and mental health practitioners who had supported her, stated that she took pride in her appearance, and her image was important to her. She described herself as previously being *"bubbly"* and stated, *"I have not always been like this…I was a party girl…when I was younger".*

7.9. Gareth told the Independent Chair that following a series of hip replacement operations, Carol had started legal action against Hospital B. The following information is taken from the statement Carol provided in support of these proceedings. Carol stated that problems started in 2016, when her back began to "lock up", she believed that this was due her twin pregnancy taking its toll on her body. She cited that one day whilst shopping, she was in so much pain that she could not get home and had to call an ambulance to the shopping centre. She was taken to the local hospital and eventually underwent surgery for slipped discs.

7.10. During 2012 and 2015, incidents had happened involving Carol and Gareth which had resulted in police involvement. During 2017, Gareth threatened to take his own life, in front of the children. This led to Children's Social Care becoming involved under a Child

in Need[2] plan. During this time the social worker completed a DASH[3] and identified that Carol was at high risk of harm. A MARAC[4] was heard and an IDVA[5] allocated to Carol. The Child in Need plan ended in December 2017.

7.11. Carol reported Gareth to police in June 2018, for verbal abuse, which had happened in front of the children. A standard DASH was completed, Carol disclosed financial abuse. From November 2018, Carol's chronic pain intensified, and she underwent a series of operations over the coming years.

7.12. In October 2019, Carol disclosed suicidal ideation to her GP, and the LPFT Crisis Team became involved. She remained open to the Crisis Team until late December 2019. During this time, Gareth appeared to be in control of the narrative, making and taking calls for Carol, and cancelling appointments when he could not be present.

7.13. During 2020, Carol's pain intensified, and her menopausal symptoms worsened. Carol was prescribed a series of medication to control her pain.

7.14. In June 2022, Carol spoke to her GP about domestic abuse. She stated she was living with emotional and verbal abuse, and financial restrictions. The GP gave Carol details of a local domestic abuse service. The GP tried to meet with Carol face to face and eventually met with her in July 2022. The GP completed a DASH, which scored medium risk.

7.15. In August 2022, Carol called police to report that Gareth had thrown a vase at the floor, which had hit her foot. There was a delay in sending out an officer due to a lack of available resources, and when there was an officer available two days later, Carol stated that she no longer needed to speak to an officer. She wanted to incident recorded for future divorce proceedings. It was decided that there was insufficient evidence to proceed with an evidence-based prosecution [6] and the crimes of assault and coercive and controlling behaviour were finalised, and that there was a suspect identified, but there were evidential difficulties. Gareth was not spoken to about the reports, as Carol had stated she did not want any further police action.[7] Children's Social Care were sent the DASH, and deemed there was no role for their involvement.

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[2] This is now called a Child and Family Assessment

[3] DASH Risk Checklist

[4] Learn more about the Marac - SafeLives

[5] Independent domestic violence adviser (IDVA) - His Majesty's Inspectorate of Constabulary and Fire & Rescue Services

[6] A legal approach that allows for the prosecution of offenders without relying on the victim's cooperation

[7] In June 2023, in compliance with new national guidelines, Lincolnshire Police changed their crime recording policy. In circumstances where crimes of assault and coercive and controlling behaviour are alleged, and both crimes originated from the same incident, then only one crime, that of coercive and controlling behaviour, would be recorded and the assault would be investigated alongside the coercive and controlling behaviour offence.

7.16. During a holiday in July 2022, Carol's hip dislocated, and she had to be flown home for treatment. As her hip had dislocated three times in six months, Carol was booked in for an implant operation. Carol told the hospital that her children and Gareth, in that order, would care for her post-op.

7.17. Gareth stated in the report submitted to the coroner that in November 2022, Carol shared suicidal thoughts with him, part of which included a trip to a local railway station to study train times.

7.18. Gareth spoke to his employer about accessing the companies' health care to support Carol, as Gareth the children were becoming increasing concerned about Carol's mental welfare and talk of suicide. Gareth updated Carol about this, and she became very agitated. Gareth wrote in his statement to the coroner that Carol injured her own face, and sent photos of this to Gareth's employer, stating that Gareth had injured her. Gareth reported to police that Carol had also lashed out at him, causing an injury to his lip, Gareth also raised a concern with police about Carol's mental health and suicidal ideation. A crime of assault was raised, and a medium risk was identified, of Gareth as the victim and Carol as the perpetrator. Children's Social Care were informed.

7.19. Later that evening, Carol also called police, to report an assault on her by Gareth. She stated she was aware that Gareth had called police and wanted to provide her version of events. Police visited Carol, and she reported herself as a victim of coercive and controlling behaviour, due to Gareth financially controlling her which she stated was causing her poor mental health. The risk was ascertained as medium, and information was shared with Children's Social Care, the LPFT Single Point of Access,[8] EDAN Lincs and an Operation Encompass[9] notification was sent to the children's respective schools.

7.20. Police visited Gareth at work the following day, Gareth told police that he was concerned about Carol's mental health, and that he did not want to make a complaint of assault, and he signed the officer's notebook to that effect. A crime of assault was raised, and a PPN (Public Protection Notice) was completed, with Gareth as the victim and Carol as the perpetrator, and a medium risk of harm identified. The PPN was shared with CSC and Mental Health Team. All offences were recorded as a suspect being identified but no victim willing to provide evidence.

7.21. Gareth moved out of the family home at this point and moved across the road to his mother's property and remained living away from the family home until Carol's death.

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[8] The first point of contact for individuals who would like to access mental health and learning disability services in Lincolnshire

[9] A scheme that ensures schools have timely information about police attended incidents of domestic abuse involving children

7.22. Children's Social Care considered the PPNs. This was the second reported domestic incident within a three-month period. Gareth was stating this was a mental health episode due to Carol's operation being delayed, and Carol was stating this was domestic abuse which had been ongoing for many years. Children's Social Care considered that as police had not raised a concern for the children, consent for an Early Help Assessment would be required as no safeguarding issue identified.

7.23. On 2nd December 2022, Gareth called the GP expressing his concerns for Carol's mental health, he told the GP about the recent incident. Gareth asked the GP for details of previous GP consultations. This was firmly declined, and Gareth was advised to contact police or social care.

7.24. On 22nd December 2022, Carol spoke with her GP and advised that Gareth had left the home and so she was feeling less anxious.

7.25. On 18th January 2023, an EDAN Lincs support worker contacted Carol, and a DASH was completed regarding the incident in December 2022, and her current situation. This was found to be standard risk, with the possibility of escalation if Gareth came back to the home. Carol was offered two support sessions and described seeking access for legal advice around the home and financial matters – which had continued to be an issue throughout. Carol did not describe being afraid of Gareth, she stated that she had a good support network, although she stated she was depressed due to the six operations she had endured over the previous eighteen months.

7.26. Carol had a few privately funded counselling sessions during January 2023 – this was linked to the trauma of her operations.

7.27. On 6th February 2023, a domestic abuse support worker contacted Children's Social Care to discuss concerns about abuse within the home, about Carol's mental health and her ability to care for the children. Carol had also disclosed using alcohol in addition to the medication, as this made her numb. Children's Social Care assessed that there was no role for social care however advised the caller to discuss an Early Help Assessment with Carol.

7.28. On 10th February 2023, EDAN Lincs referred Carol to Adult Care and Community Wellbeing (ACCW) for an assessment for aids to support her mobility around the house, following the planned operation later in the month. The referral stated that Carol had mental health difficulties, PTSD, past suicidal thoughts, and was financially controlled by her partner. Carol received a wellbeing assessment on 15th February 2023, and she was advised that the hospital team would liaise with their occupational therapists once her surgery was completed, to ensure she had the right aids in place at that time. Carol was also provided with contact details for ambulance transport to get to and from the hospital in another county, where the operation would be taking place. This also

included support with paying for transport via her GP, and advice about relevant welfare benefits.

7.29. EDAN Lincs also completed a referral to the Early Help Front Door, although Carol had not yet consented to a referral. At this point Carol was in hospital undergoing surgery. EDAN Lincs agreed to speak to Carol to obtain consent when she was back home and would also ask the school to encourage Carol to access Early Help.[10]

7.30. Carol underwent further surgery on her hip on 23rd February 2023. The Physiotherapist saw Carol again on 28th February 2023, and she seemed positive and was being proactive in mobilising more often. Her pain was more controlled. Carol stated she would not need a package of care for personal care upon discharge home, although it is noted that she was very concerned about pain relief upon discharge.

7.31. Carol returned home from hospital on 2nd March 2023 and had an appointment with her GP for 6th March 2023 to discuss pain management. On 16th March 2023, Child A contacted LPFT Single Point of Access on behalf of Carol. Child A described how Carol was bed bound following a hip replacement, that Carol was *"going through a messy divorce".* She stated that Carol had been receiving messages from Gareth and from Carol's own mother, which had upset Carol. Child A stated that Carol, and the children were all safe, and that Carol was not aware of the call. Carol could be heard in the background telling Child A that she was not happy Child A had made the call without her permission. The call was terminated.

7.32. EDAN Lincs linked in with the children's school, and it was agreed that the children would be supported individually by allocated staff members, who would regularly check in on their wellbeing.

7.33. On 15th April 2023, Child A[11] called EMAS as Carol had slipped whist walking in the house on crutches and had hit her head. Carol had blurry vision and was slurring her words, and Child A was concerned that Carol was concussed. Child A was advised to monitor Carol until an ambulance arrived. Carol then called and cancelled the ambulance; she said she was fine and apologised for Child A overreacting. An hour later, a further call came into EMAS from Child A stating that Carol had a serious concussion and Child A was worried about her. Child A stated Carol was like a different person and could not see properly. A neighbour was downstairs with Carol, calming her down, and Child A had called without permission from Carol. A third-party provider attended on behalf of EMAS. Carol declined being attended to hospital, and there were no concerns recorded by the crew in relation to this, therefore Carol was treated at the scene.

[10] Support for children and families as soon as difficulties arise or are likely to emerge.
[11] Child A had recently turned eighteen at this time.

7.34. Carol referred herself to ACCW for support on 19th April 2023, she stated she required help completing her PIP[12] form and applying for a blue badge.[13] Carol was provided with support around the PIP until 2nd May 2023.

7.35. On 15th May 2023, the children's school received a call from Gareth, following an incident over the weekend where Carol had left the home unexpectedly. Gareth told the school that the children had experienced *"an upsetting number of days".* He did not want to raise this as a safeguarding issue but wanted the school to *"keep an eye on the children".*

7.36. Gareth also contacted Carol's GP on 15th May 2023, raising a concern about the pain medication being prescribed to Carol. The receptionist asked Gareth to put his concerns into writing. He subsequently sent the practice a letter on 17th May 2023. Gareth submitted a letter detailing his concerns, and summarised that "*I am not making accusations, or asking for any judgement, I am merely trying to demonstrate the adverse impact I believe this medication is having on my wife's behaviour and my concern for the potential impact on my children's emotional wellbeing. Ultimately, I am hoping that you will recognise some of these symptoms, in connection with this medication and act accordingly to review the situation."*

7.37. Medication continued to be prescribed. On 9th June 2023, Carol approached the GP as she was concerned that she had reduced her Oxycodone intake too quickly and was no longer able to weight bare and could not stand the pain. The medication was increased back to the previous level.

7.38. During this time, Carol developed hives, which she told her GP on 12th June 2023, she believed was due to stress, and which she stated appeared when she had to speak to Gareth. Carol requested that her medication continued at the same level to ensure she could mobilise to take Child A away on a short break, she stated she also had an appointment booked to see her consultant regarding the ongoing pain.

7.39. Carol spoke to her GP on 19th June 2023 to discuss her medication. She told the GP she had experienced a panic attack the night before when she found out Gareth was starting divorce proceedings. Carol took Child A away for a mini break in Europe and returned on 26th June 2023.

7.40. Carol died by suicide in June 2023.

8. Conclusion

[12] Personal Independence Payment

[13] A permit for people with mobility problems, to park in disabled bays.

8.1. It is not possible to say with certainty why Carol took her own life. What is clear is that she was living with chronic pain, that there had been indicators of coercively controlling behaviours, violence and aggression within Carol's and Gareth's relationship over the years, and both Carol and Gareth had struggled with mental ill health and suicidal ideations/threats.

8.2. The use of hindsight, and the ability to put all of the agency information together allowed the panel to identify patterns of controlling behaviour on Gareth's part. LPFT identified Gareth's possible need to control the narrative during their engagement with the couple, however this did not develop into any conversations with Carol and was not taken any further. It is considered that practice has developed since this period, and practitioners would be more alert to this behaviour if faced with it now.

8.3. A main area of learning is around the consistent and regular asking about domestic abuse, by all practitioners, not taking matters on face value and assuming that all is well, when presented with apparent affluence.

8.4. A further area of learning is around the effects of domestic abuse, coercive control, or even acrimonious separation on children. In addition to this, and exacerbating matters is the effects on children living with parents who are struggling with mental health issues, suicidal ideation, and particularly pertinent to this case – living with chronic pain.

8.5. Carol clearly felt hopeless and helpless against the pain she was experiencing. She missed the person she used to be, in her own words, "bubbly" and in her family's words "gregarious" and may have felt like a prisoner in her own body.

8.6. It is important that practitioners can understand how a person's personal characteristics, social environment and relational ties, all intersect to create their experiences of the world. With the benefit of hindsight, it is clear to see that Carol was a high risk of suicide, and this case should be used for future learning regarding the impact of various vulnerabilities and complexities intersecting.

8.7. There was a lack of overarching analysis of the individual incidents, involving police and Children's Social Care, with no identification of emerging patterns and themes.

8.8. Although Gareth was very visible to practitioners, he was never approached about his behaviour, or indeed his wellbeing. It is important that practitioners can challenge and question the behaviours of partners, as well as feel able to suggest carers assessments for partners who are providing informal care.

9 Lessons to be Learnt

9.1. Agencies should be reminded that incidents and risks should always be considered in context and not focused on individually. The patterns of behaviour identified back in 2017, were being raised by Carol again in 2019 through to when she passed away.

9.2. All agencies should be considering whether a culture of routine enquiry exists within their organisation, and whether it is necessary and/or appropriate for a specific policy and training to be introduced into their service in order to progress the need for widespread enquiry into domestic abuse. However, it should be noted that GPs in Lincolnshire are required to follow SafeLives guidance regarding clinical enquiry. [14]

9.3. There is an ongoing need to enhance all practitioners' understanding of the link between domestic abuse and suicide risk. This has been identified in two previous local reviews, and it would be beneficial to develop a thematic study of these cases, alongside Carol's case, to support training and development in this area.

9.4. All agencies should be confident in their identification of children as victims of domestic abuse, in their own right. Practitioners should be aware of the support available for children who are living in a household where coercive control is suspected or identified.

9.5. GP practices should be reminded of the availability of the pain clinic. There were multiple opportunities to involve Carol with the pain clinic. Early involvement of the pain clinic in troublesome pain can improve prescribing practices.

9.6. All agencies should be encouraged to improve their responses to children who are caring for their parents' physical and mental wellbeing. This review will be used to highlight the opportunity to refer young people and children to Young Carers, and how this not only provides the young person with respite from care but also allows an insight into families who may usually be invisible to agencies and professionals.

9.7. Where a partner is identified, either by the patient or by themselves as a carer, they should be offered the opportunity for a carers assessment. This should be revisited with them whenever appropriate and practitioners should be pro-active in this approach, for example offering to make the referral for them.

9.8. All agencies should consider including a question about menopause within their needs assessments, and practitioners should be empowered to both ask about menopause and know where to refer people presenting with menopausal symptoms and issues.

9.9. The panel support the following recommendation from a recently completed DARDR in Lincolnshire; *"For Public health to establish a Suicide Prevention Toolkit accessible to all agencies for reference and for LDAP to develop a toolkit that complements this but*

[14] Pathfinder Profile: General Practitioners | Guidance for General Practitioners responding to domestic abuse

is specific to Domestic Abuse and Suicide prevention, to support understanding and recognition of the links between DA and Suicide".

10. Recommendations

Multi-agency recommendations

a) A webinar will be hosted by the Safer Lincolnshire Partnership and the Lincolnshire Safeguarding Children's Partnership, to raise awareness about Young Carers.

b) A learning bulletin will be produced to highlight resources and local offers for young carers amongst the partners and partnership board.

c) A learning bulletin will be produced to raise awareness of the impact of menopause on mental health.

d) Awareness will be raised with the Domestic Abuse Commissioner's Office, of the national lack of refuge provision for victims with serious mental ill health.

LPFT

e) Safeguarding Team's hub model will include a standard check on the MARAC system, MODUS for all highlighted domestic abuse cases for evidence of previous concerns and incidents.

f) All LPFT staff be encouraged to consider domestic abuse as a causative factor within personally connected relationships as an alternative rationale for symptoms of mental illness. This should be done via mandatory safeguarding training, supervision, and Trust wide communications and include a reminder to adopt appropriate, factual and non-judgemental language when recording clinical entries.

GP Practice

i) Practice A to include documentation of alcohol and/or substance use during mental health review.

j) Practice A to ensure consideration is given to children who are providing care to their parents, or adult relations.

k) Practice A to consider ways of formalising any informal discussions that take place about complex patients.

l) Practice A to ensure a MARAC flag is placed on a victim's record for 12 months following a MARAC.

ACCW

n) Review and refresh (if required) current guidance regarding carers assessment duties for S75 LPFT & ACCW Social Care and embed in practice through current training, guidance circulation and a 7 min briefing.

o) Feedback on the identified area of good practice during a reflective session with the Wellbeing Advisor and student Social Worker involved.

Lincolnshire Community Health Service

p) LCHS's Domestic Abuse policy will be updated to raise awareness of bi-directional abuse and 'typologies' to support practitioners in identifying and responding appropriately to mutual couple violence.

SWLEOC

q) SWLEOC to consider adding a prompt to their assessment documentation regarding children / young people and exploring home/family life.