A Domestic Abuse Death Related Review
Overview Report
Grace
(Died August 2023)

Independent Chair and Author: Dr Russell Wate QPM
(May 2026)

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Section One - Introduction

1.0 Introduction

The victim

Grace is described by her loved ones as the heart of their family. She lived for her children and her grandchildren, and they were always her first priority. Grace chose to care for Ethan and look after the household. This wasn't to be as a formal carer or for any monetary reason, this was through love and care for her son and her family. It was because, the family say, it was just the person she was, it was her love for them that defined her. Grace cared deeply for those important to her and would do anything for them. Grace was looking after Ethan in the best way she felt possible, she was his mother and loved him greatly.

1.1 For this report, the name to be used for the victim is Grace (71 years), which is a pseudonym. This name was chosen by the chair of the panel. The chair chose the name at the request of the family who told him that they didn't want to choose a different name rather than their loved one's real name. The name of the perpetrator Ethan (50 years), the son and brother to the family, was also chosen by the chair of the panel, as again, the family did not want to choose a different name for him. The chair of the panel did not confirm with the family that these names were suitable as they were quite clear with him that whatever name he wanted to choose would be, in their view, appropriate, and they preferred not to know.

1.2 The review chair and the panel are keen that this report has at its very beginning a picture of who Grace was. The murder of a loved one, and in this case the combined effect of the perpetrator being the loved son and brother to the family, has had an unimaginably profound effect on the family that will endure for generations to come and will continue to have an impact. This is not confined only to the family but also to their friends, associates, and the wider community who know them within where they live and work.

1.3 As stated above in the pen picture, Grace chose to care for Ethan and look after the household. The family told the review chair that this wasn't to be as a formal carer or for any monetary reason, this was through love and care for her son and her family. It was because, the family say, it was just the person she was, it was her love for them that defined her. Grace cared deeply for those important to her and would do anything for them. Grace was looking after Ethan in the best way she felt possible, she was his mother and loved him greatly.

1.4 The family were keen to stress that there were no instances of domestic abuse prior to this incident within the household. Agency records support their view with no reports of domestic abuse recorded or even alluded to.

1.5 On behalf of the Safer Lincolnshire Partnership, the panel chair wishes to acknowledge the essential involvement given to this review by the family of Grace and appreciates how hard it is for them coping with the loss of her. The chair also acknowledges the professionalism and engagement by the respective panel members, agencies and the IMR authors in their support and understanding, helping to develop the lessons to be learned and changes to practice suggested.

1.6 This review is not about apportioning blame, the criminal trial did this and found during a fact- finding hearing that Ethan had carried out the attack on his mother, Grace, which led to

her death. This fact-finding hearing did not seek to discover Ethan's 'mens rea'[1] that will occur if and when he is fit for release from his hospital order. The review though is looking at where both individual and agency professional practice can be improved or enhanced, and where changes to how agencies work together will provide further safeguards for those service users, which also includes their family members who may be at risk from the service user.

2.0 The Report - Process

2.1 This report has been commissioned by the Safer Lincolnshire Partnership (SLP). This is a statutory partnership which brings together agencies with the aim of reducing crime, disorder and anti-social behaviour across the County area of Lincolnshire. These agencies work together to improve the safety of residents and visitors by information sharing and partnership activity.

2.2 One of the key roles of the partnership is that of examining and reducing domestic abuse and supporting victims of domestic abuse. Relevant policies are enshrined in each of the statutory agencies' practices within the partnership and within the voluntary agencies who have participated in this review.

2.3 In August 2023, Lincolnshire Police received a call from a male, subsequently found to be the perpetrator (Ethan), to say that he had just attacked his mum (Grace) and doesn't think that she's OK. He stated that he had stabbed her and wanted to be shot by the police when they arrived. Ethan stated that everyone wants to kill him and that the neighbours have been heard talking about wanting to kill him which has caused his psychotic episode this morning. Officers attended the location and found Ethan on the roof of the conservatory and Grace in the house with a number of stab wounds to her neck area. East Midlands Ambulance Service (EMAS) also attended; they attempted advanced resuscitation but a doctor who was present shortly afterwards confirmed death. A knife believed to have been used in the murder was located in Ethan's room. Only Grace and Ethan were present in the home. The police commenced a homicide investigation and arrested and charged Ethan with Grace's murder. The death was also referred to HM Senior Coroner for the Lincolnshire area.

2.4 Later that month Lincolnshire Police notified the Chair of the Safer Lincolnshire Partnership of the death, as per the Lincolnshire Domestic Homicide Review (DHR)[2] Protocol. Also, in August 2023 the Chair of the Strategic Board considered the case in conjunction with other key agencies. The meeting concluded that the case met the criteria and justification for what will now be referred to for the rest of this report a Domestic Abuse Related Death Review (DARDR).

2.5 In July 2024, Judge Simon Hirst, who presided over a fact-finding trial, placed a Section 41[3] hospital order, with restriction for Ethan to stay at a secure hospital for treatment until he is deemed fit to be tried for the homicide. The previous week, a jury had accepted the facts of the incident following the four-day hearing that took place. It had been previously concluded

[1] In criminal law, mens rea is the mental state of a defendant who is accused of committing a crime.
[2] This is now called Domestic Abuse Related Death Review (DARDR)
[3] Section 41 of the Mental Health Act 1983 allows the Crown Court, when making a hospital order, to also impose a restriction order on high-risk offenders. This order restricts discharge from hospital and requires the consent of the Secretary of State for Justice for any leave or transfer. It is necessary for the protection of the public from serious harm.

that Ethan was not fit to enter a plea and to stand trial in criminal proceedings due to him having a mental disability.

2.6 The fact -finding hearing had been held to determine whether Ethan had been responsible for the injury which led to his mother's death. The jury concluded that Ethan had inflicted the injuries which led to the death of his mother Grace.

2.7 Addressing the jury, Judge Hirst said: *"What you have heard has been deeply distressing. You have heard about a much-loved grandmother, mother and wife losing her life*." *"Members of Grace family have been in court throughout and it is all the more personal for them but, nonetheless, it has been very difficult for you to have to hear it." Speaking to Grace's relatives, the judge added: "I thank the family for what you have had to go through the last few days and indeed most of the last year. It is an incredibly sad case on so many levels. Thank you for the way you have approached this and the dignity you have displayed. "I hope this is the beginning of trying to move on, to some extent."* The Senior Investigating Officer said following the hearing, *"I would like to thank the family for their patience, cooperation and for the dignity that they have shown throughout the investigation so far."* The family have shown this dignity, patience and cooperation to this review and the panel are grateful to them for their support.

2.8 The Judge also commended the attending, arresting and investigation Police Officers, *"In difficult circumstances, they treated Ethan with politeness and consideration."* How the attending officers dealt with Ethan is worthy of note for this report and how the review will endeavour to find learning from this very tragic murder. This approach is exactly what the family would want the chair and panel to do as they knew how much Grace loved her son and how much love they also have for him, while at the same time acknowledging that Ethan is the perpetrator and he unlawfully killed his mother, their mother, wife and grandmother.

2.9 Following the conclusion of this part of the criminal trial process, the Coroner has confirmed that this case has been closed without the requirement for an inquest.

2.10 The purpose of this review is to:

- Establish what lessons are to be learned regarding the way in which local professionals and organisations work individually and together to safeguard victims.
- 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; and
- Prevent domestic homicide and improve service responses for all domestic abuse victims and their children through improved intra and inter-agency working.

2.11 This overview report has been compiled with specific reference to the Individual Management Reviews (IMRs) prepared by experienced practitioners and authors from the key agencies, both statutory and non-statutory, contributing to this process. Each of the IMR authors is independent of working with Grace and Ethan and of management responsibility for practitioners and professionals involved in this case. Where IMRs have not been required, reports from agencies or professionals have been received as part of the review process and all the agencies have actively participated in this review process throughout.

2.12 Since appointment the independent overview author has fulfilled a dual role and has chaired the panel meetings, and all professional events conducted. This is recognised as good practice and has ensured a continuity of guidance and context for the review process throughout. There have been several useful professional discussions arising, the DARDR panel meetings have been narratively recorded, and minutes prepared and approved for transparency. The professionalism of the panel members and the overall quality of the responses has been of a high standard with continued dialogue along with professional observation and critique throughout. This has emphasised the resolve of the participants to this review and has embraced both the partnership approach and the transparency of purpose to learn lessons.

Terms of reference

2.13 In addition to the generic terms of reference set out in the domestic abuse related death review guidance, the additional and specified areas of examination have been agreed by the independent chair and the panel with agencies. When asked, the family of Grace had no additional terms of reference that they wanted to be examined by agencies. These additional review areas are:

- Did actions or risk management plans, in particular in relation to Ethan's mental health issues, fit with the assessment and decisions made? Were appropriate services offered or provided, in light of Ethan's reluctance to engage?
- What knowledge did your agency have of any caring responsibilities that Grace or other members of the family had, and what was the response? Was a carer's[4] assessment offered, and/or completed? If not, should it have been offered and completed.
- Were any, or should there have been any consideration to family members that reside with and care for, whether formally or voluntarily, of risks to them from the family member suffering from Paranoid Schizophrenia? Would they know any risks associated with Paranoid Schizophrenia?
- How did your agency ascertain the wishes and feelings of Ethan and his parents and were their views taken into account when providing services or support?
- How did your agency take account of any racial, cultural, linguistic, faith and neuro diversity, when completing assessments and providing services to Ethan and his parents?
- What is the knowledge within the partnership of matricide[5], in particular following the recent local DHR in relation to Ionela[6] where matricide was a key factor.
- Were there opportunities for your agency to implement safeguarding processes? If so, were these enacted/considered and what was the outcome?
- How effective was inter-agency information sharing, and was information shared with those agencies who needed it?
- In reviewing agency interaction do your current policies and procedures capture agencies expectations and responsibilities in response to your involvement on this case? Where there are identified gaps please detail how these will be addressed?
- What was the impact of Covid-19, on access information and support and agency responses to Ethan and his family?
- Were there any examples of outstanding or innovative practice?

[4] The term ‘carer’ relates to both those who are in a paid profession and those who care for relatives or friends due to circumstance.
[5] Matricide is the killing of a mother by a son or daughter.
[6] https://www.lincolnshire.gov.uk/downloads/file/6894/dhr-ionela-and-james

- What learning did your agency identify in this case?

2.14 The scope for this review is to focus on the period 1st of March 2019 to August 2023.

DHR Panel members

2.15 The following individuals are totally independent of practice in this case and form the DHR panel and represent the agencies involved in this review:

Agency	Advisor	Job Title	Panel Role
Lincolnshire County Council (LCC), Adult Social Care	Angela Copestick	Area Manager of Safeguarding	Representing Local Adult Services
Lincolnshire County Council Children Services	Laura Bonner	Head of Service	Representing Children Services.
East Lindsey District Council	Jason Oxby	Service Manager Housing & Support Solutions	Representing Housing
Lincolnshire Partnership NHS Foundation Trust (LPFT)	Tony Mansfield	Head of Safeguarding	Representing Local Mental Health services
Lincolnshire Community Health Services (LCHS)	Jennifer Parker	Named Nurse for Safeguarding Adults and MCA	Representing Local Community Health
Lincolnshire Integrated Care Board	Claire Tozer	Head of Safeguarding Adults and Primary Care	Representing Local GP Commissioning Services
Lincolnshire Police	Rachael Cox	Detective Chief Inspector	Representing Local Police Service
East Midlands Ambulance Service	Emma Wilson	Safeguarding Lead	Representing Local Ambulance Service

EDAN Lincs	Sharon Walker	MARAC Manager	Representing Local DA Services (Voluntary sector)
RJW Associates LTD	Russell Wate	Chair/Author	
Support to the Panel			
Legal Services Lincolnshire	Toni Geraghty	Legal advisor to the review	
LCC	Lara Iggulden	Domestic Abuse Operational lead	
LCC	Teresa Tennant	DHR Senior Administrator	

Overview Author

2.16 Dr Russell Wate, QPM has significant experience in partnership working within numerous safeguarding environments, conducting Child Safeguarding Practice Reviews. He also has extensive experience in conducting Domestic Homicide Reviews; having chaired and authored several such reviews across the country, as well as internationally. He has completed the Home Office DHR training, the Sequeli and NSPCC training and the Standing Together and AADFA DHR training. He presents training to agencies, both nationally and internationally, on the conduct of and carrying out of Statutory Safeguarding Reviews.

2.17 Dr Wate is entirely independent of all agencies in this process having no connection with the Safer Lincolnshire Partnership other than previously providing professional and independent services in respect of unrelated Domestic Homicide Reviews and other statutory safeguarding reviews.

Contributors to review

2.18 The following agencies have contributed to this review:

Agency	IMR	Report
Lincolnshire Police	➢	
Lincolnshire County Council Adult Social Care		➢
Lincolnshire Community Health Services		➢

East Midlands Ambulance Service		➢
Lincolnshire Integrated Care Board on behalf of GP Practice	➢	
Lincolnshire Partnership (NHS) Foundation Trust	➢	
DWP		➢
Lincolnshire County Council Children Services	➢	

Timescales

2.19 To ensure the review into the circumstances that led to the death of Grace was dealt with in a timely manner, the SLP panel have maintained momentum of the review, taking account of the criminal investigation processes. Since then, there has been clear impetus expedited to the review to accord with best practice where possible to minimise any further delays to the process, following the decision to conduct this review.

2. 20 In August 2023 the Chair of the SLP in conjunction with their partners agreed that the case met the criteria and the review was commissioned and begun, with an author and panel members and scoping identified. Due to the criminal justice priorities, the review process fully commenced in July 2024, when the first panel meeting took place. The final report was agreed by the panel on the 20th of July 2025.

Confidentiality

2.21 The findings of this review report are confidential. Information is available only to participating professionals and their line managers from the participating agencies and the Home Office, QA Panel. This matter has not been discussed other than in closed and minuted confidential meetings with appropriate representatives present, in person or remotely, or where unable to actively participate, have been informed of progress in their absence. As well as the victim, and the perpetrator, no names have been used in the report to protect the identity of other individuals and professionals involved.

Involvement of family

3.0 The review chair has maintained open communication channels for all contributions that both the family, or other relevant professionals wish to make, and has kept them updated about the progress of the review process.

3.1 The Home Office leaflet concerning the procedure of the Domestic Homicide Review process (now domestic abuse related death review) was sent to the family and the letter that accompanied it also emphasises the opportunity to access an advocate. The family have had the use of, but not really felt the need to engage with the Victim Support Homicide section support worker. They have also had the support of a local Lincolnshire Police Family Liaison officer and one of the family members that has been having contact with the panel chair, is being personally supported by an advocate.

Parallel reviews

3.2 The Criminal Investigation process concluded in July 2024, when Judge Simon Hirst, who presided over a fact- finding trial, placed a Section 41 hospital order, with restriction for Ethan to stay at a secure hospital for treatment until he is deemed fit to be tried for what his 'Mens Rea[7]' was at the time of the homicide.

3.3 A Joint Lincolnshire Partnership NHS Foundation Trust and NHS England, Independent Investigation into the Mental Health Care and Treatment received by Ethan has been commissioned alongside this DARDR. This investigation will examine the NHS care and treatment of Ethan from his first contact with specialist mental health services up until the date of the death of Grace. It will independently assess the quality of the NHS care and treatment provided to Ethan against best practice, national guidance and LPFT policy. The review will identify any opportunities for learning that may be applicable on a local, regional, or national basis. This DARDR report tries not to repeat or duplicate this mental health review but will need to comment contextually where necessary and appropriately as and when any findings from that review emerge during the process of this review.

3.4 Throughout the review process the author and the multi-agency panel have been kept informed of the NHS mental Health review. The review itself on completion was chaired with the author to assist with their report, conclusions and recommendations. The family of Grace also was given the opportunity to discuss the mental health review with the authors and commissioners of that report.

Equality and diversity

4.0 The DHR panel has scrutinised the IMR's, discussed and examined the nine protected characteristics in accordance with the Equality Act 2010. Specific comment is made accordingly within the report narrative where appropriate in respect of those characteristics which are recognised as being.

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

[7] In criminal law, mens rea is the mental state of a defendant who is accused of committing a crime.

4.1 In this case, Grace is identified as being white and British as has been determined by records held by contributors to this review process. No known disabilities are referenced or reflected within information provided by healthcare practitioners and other professionals. Grace had no known or identified religion or beliefs.

4.2 Ethan was also identified as white British and is known to have a diagnosed mental health illness and thereby has a disability which he was receiving benefits for.

4.3 Evidence has shown that domestic abuse is a gendered crime, and research supports the theory that men commit more acts of domestic abuse than women and statistically, women are more likely to be victims of domestic abuse. The Crime Survey for England and Wales in December 2023[8], estimated that 5.1% of people aged 16 to 59 years experienced domestic abuse in the previous year.

4.4 Statistically, approximately some 1.4 million victims were women and 750,000 were men, although it is a consistent picture that women were more likely to be the repeat victims of abuse and men are more likely to be repeat perpetrators. A change in the recording of harassment and stalking offences may identify part of the reduction in the recorded figures.

4.5 There were 100 domestic homicides recorded in the year ending March 2023. Women remained as being more likely to be killed by someone they knew than men, for example, of the 100 domestic homicide victims in the year ending in March 2023, 70 were women. However, those statistics do not include 'suicide' figures where the victim had a known or suspected background of domestic abuse. Those figures may be known by the Home Office and then included when the amended statutory guidance for Domestic Abuse Related Death Reviews (DARDR) to replace the current Domestic Homicide Review process, is adopted nationally during 2025.

4.6 Age and disability are key factors for this review and need to be acknowledged. Grace was over 70 years old and had health problems of her own. Ethan had a diagnosed and known disability of severe mental illness, that all agencies were aware of. There should have been more understanding of how these factors overlapped, particularly the situation of an older parent caring for an adult son with serious mental illness, by all practitioners and agencies. This is discussed later in this report at the analysis section.

Dissemination

5.0 This anonymised report and the accompanying executive summary have been prepared by the author and panel for consideration of publication in accordance with the policy of the Safer Lincolnshire Partnership, following the completion of the review process. In any event, the report will be shared with the Police and Crime Commissioner for Lincolnshire and all relevant statutory and voluntary agencies, supporting victims of domestic abuse within Lincolnshire. The report will also be shared with the Domestic Abuse Commissioners Office.

[8] The Crime Survey for England and Wales (CSEW) provides a more reliable measure of long-term trends for domestic abuse than police recorded crime data.

This report will be provided to the HM Coroner on request, given that the inquest has been completed.

5.1 The author wishes to assure all parties that any publication will be made with due regard to any potential ongoing sensitivities and recommends that any publication of the findings of this report are treated with due consideration to all those affected and those involved in this review process. Any decision made to publish this report, whether in full or in a redacted format, will be made by the Chair of the SLP in company with their strategic leaders.

Section Two – The facts

6.0 Circumstances

Chronology

6.1 Although the timeline for this review has been determined as being the 1st of March 2019 (when Ethan re-engaged with services) until August 2023, it is apparent that there is a much wider background to consider. The previous relevant background is included in this section as part of the facts.

6.2 The first evidence of contact with Ethan which is relevant to the terms of reference can be identified in LPFT paper records, where Ethan was open to Community Mental Health Team (CMHT) from October 1997 to February 1998 with the Trust's predecessor, Lincoln District Healthcare NHS Trust. He had been referred to them by his GP on the 8th of October 1997 for treatment of anxiety and lack of confidence. At this time, Ethan identified experiencing anxiety in social situations and chose to stay in his room (it is of note to this review that this room is in the home of Grace and her husband and this is the case throughout,) watching sports on the TV. Ethan was assessed by the CMHT and attended six sessions with a focus on anxiety management before he requested to be discharged in writing on the 1st of February 1998, stating "*I think you've helped me as much as you can and now it's up to me to overcome my problems".* The GP was notified of his discharge from services.

6.3 The GP records show Ethan with a documented history of Paranoid Schizophrenia since 2002.

6.4 Ethan was awarded Incapacity Benefit (IB) from 29th of May 2002, which then migrated (transferred) over to Disability Living Allowance (DLA). The IB and DLA were awarded because his health condition was recorded as, Paranoid Schizophrenia.
This meant that Ethan had a limited capability for work and work-related activity. This also meant that Ethan no longer needed to engage in work related activities and there was no direct contact with him by the DWP during the scoping period beyond payment of benefits.

6.5 LPFT have a record relating to Ethan's applications for these allowances between 2005 – 2008. Within this paperwork various Community Psychiatric Nurses (CPN) had written supporting statements as professionals of Ethan's health needs, which indicated he was engaging with mental health services at least sporadically throughout this time, although there

is no archived information available to add any detail to this beyond the DWP paperwork. An example is, on the 12th of January 2005, a CPN provided a supporting statement for the allowance stating that Ethan was diagnosed with *"depression with psychotic features, agoraphobia and panic attacks".* They also stated that Ethan had paranoid beliefs that he would be killed by others. He was being seen weekly by a CPN and a support worker at this time.

6.6 Another example is where a CPN provided a supporting statement for the allowance in December 2005 stating that Ethan was diagnosed with psychosis with features of paranoia and his delusional beliefs were preventing him from leaving the house. He was also experiencing depressed mood due to agoraphobia and social isolation. Ethan was assessed as requiring intensive support from his family and mental health services.

6.7 Grace was awarded a Carers Allowance (CA) from 24th March 2008 until early 2013 as she was caring for her son, Ethan. DWP had no contact with Grace during the period of review and payments were made automatically which is normal for carers allowance. The carers allowance ceased in early 2013 when Grace reached state pension age and was awarded the State Pension.

6.8 In January 2011 whilst Ethan was under the care of the LPFT Assertive Outreach Team, a carers assessment was completed with his mother, Grace. This was the only evidence of a carers assessment having been completed by the LPFT. An analysis of this assessment is detailed further in this report in the relevant section.

6.9 Also in January 2011 Adult Care and Community Wellbeing (ACCW) have a record of Grace providing care to Ethan. The outcome of the contact (there is limited information available electronically regarding this contact, given the historic date,) was that information and advice in relation to being a carer was provided to Grace. This is proportionate to this period of time, given the Care Act 2014 was not implemented until 2015.

6.10 Ethan must have stopped accessing services around a similar time that this carers assessment was completed as a further GP referral was received on the 20th of June 2014, which advised that he had not been seen by any professionals for *"at least 3-4 years",* (he is still throughout this period on his prescribed medication) This referral states that Ethan was diagnosed with Paranoid Schizophrenia in 2002. It stated that, "*He had recently attended his brother's wedding and niece's birthday but had felt anxious and would like to re-engage with CMHT support."* Ethan was assessed at home by the CMHT on the 15th of July 2014, where a detailed history was taken. This assessment provided some context of Ethan's presentation to mental health services in 2002 which had led to his diagnosis of Paranoid Schizophrenia. He had developed delusional ideation for his own safety, believing work colleagues were planning to torture and kill him. These delusions had been somehow related to the American September 11th attacks where two aeroplanes were hijacked by terrorists and flown into the World Trade Centre. These persecutory ideas had then expanded to a general anxiety for his own safety. The CMHT records stated that the local team had spent "several years" working with Ethan between 2002 - 2010, and that "psychotropic treatment has been limited with Ethan as he has been reluctant to engage.'' Safeguarding screening tools and risk assessments completed at this time did not identify any other person at risk. Ethan maintained throughout the assessment that his life was in danger.

6.11 Ethan had managed his anxieties by withdrawing from the community and spending most of his life within the confines of his home (Grace and her husband's home). Ethan was reluctant to accept psychotropic medication beyond what he was already taking and did not want to consider altering his medication or dosage. The outcome of the assessment was to refer Ethan for graded exposure work[9] with an Occupational Therapist (OT) within his local CMHT and he was added to the waiting list for allocation. Ethan declined to have a review with a psychiatrist.

6.12 On the 25th of June 2015, Ethan made contact with a Lincolnshire Police Community Support Officer (PCSO) to say that he has overheard someone saying that they were going to kill him soon and there was nothing he could do about it. There was no indication from Ethan where he heard this or who said it. Ethan said that he has had fears about threats to his life since an assault on him in his local town in 2001, (there are no police records of this assault). It was established that the mental health team have not been involved with him since July 2014 and the PCSO was unsure as to whether he has been taking his medication, Ethan said he had. Ethan told them that he does not go out of his house and does not like to use the telephone, his mum and dad live at the address, so he is rarely alone. The GP surgery when contacted, a nurse practitioner there said she would contact the mental health crisis team. The PCSO offered Ethan contact with the crisis team, but he didn't want it. The PCSO had no concerns about Ethan wishing to harm himself but followed up with a Stop Abuse form. The surgery then contacted the PCSO saying the crisis team were unhelpful stating that the police should have contacted them directly. So, the officer called them but there was no reply, and it went to answer machine. The PCSO thinks that Ethan believes the threats are real, but they are actually to do with his mental health issues, Ethan said the only way the officer could help was by getting him police protection – the officer told him that wasn't possible.

6.13 On the 25th of June 2015, Adult Care and Community Wellbeing (ACCW) received the Stop Abuse Form shared by the Police noting some of Ethan's Mental Health needs. The referral notes Ethan believed his life to be in danger and that he had received many threats against his life since an assault in his local town in 2001. He is noted to take medication and said he was classed as 'delusional' by a previous Psychologist. There were attempts to contact Ethan, however, he did not answer the phone. Ethan's GP and his local Crisis Mental Health Team were spoken to. The CMHT confirmed they had contact with Ethan on the 26th of June. They further advised that Ethan does not currently access Mental Health Services, and he had a good relationship with his GP. Ethan was offered assessments for Wellbeing Services, Adult Social Care and Safeguarding (with descriptions given to him of the services). Ethan declined them but was provided with contact details to re-refer. Leaflets were sent to Ethan's home address providing further information about the Wellbeing Team and the Carers Team. There is no recorded information during this contact regarding any caring roles. However, the Carers information shared was standard practice at this time. Once Ethan had received the leaflets in the post he called ACCW in July 2015 to discuss the support available. Ethan was

[9] Graded exposure is a Cognitive Behaviour Therapy (CBT) based treatment used for anxieties and phobias. https://www.nhs.uk/mental-health/conditions/phobias/treatment/#:~:text=The%20final%20step%20would%20be,less%20anxious%20about%20your%20phobia.

advised to seek support via his GP for his Mental Health and low mood. Ethan was again advised about the support that can be offered via Wellbeing Services and the Carers Team.

6.14 Also on this date, the 26th of June 2015, Ethan was referred to the LPFT Crisis Resolution and Home Treatment Team (CRHTT) by his GP due to a deterioration in his mental state. This was due to his beliefs that he was being threatened by others, saying he could see people outside his window and hear them. He was again unwilling to take medication to alleviate his symptoms but was not distressed. His parents, including Grace, were spoken to as part of this referral and it was documented that they were not concerned about his mental state. Due to no risk issues being identified there was no role identified for CRHTT, and he was discharged.

6.15 Ethan was allocated to an Occupational Therapist (OT), who saw him for the first time (he hadn't been seen before when a previous referral had been made) on the 3rd of September 2015, where an OCAIRS (Occupational Circumstances Assessment – Interview Rating Scale) was completed. The OCAIRS is used by Occupational Therapists to assess how well a person is able to engage in everyday activities (occupations) and what factors support or hinder their participation. Ethan was assessed to have moderate difficulties with occupational participation and functioning meaning that targeted intervention was required to support him to overcome some of these barriers. Ethan did not want to complete graded exposure work due to believing he would be in danger if he left the house (hence why he wasn't seen before) but agreed to consider ways to increase structure and meaningful activity within his home.

6.16 In a telephone contact on the 29th of September 2015, Ethan advised the OT that he had been able to go out in the car with his father without feeling any anxiety at the time but then became emotional that evening about having left the house. Ethan expressed motivation to investigate new ways to decrease his social isolation. However, in subsequent contacts, Ethan returned to his previous reluctance to attempt to leave the house due to his fear of being harmed and very little progress was made around this. The CMHT professional was able to encourage Ethan to engage in some online courses as a way of building meaningful activity within the confines of his home. As a result, Ethan successfully completed an Open University Course in bookkeeping and started another course on internet security. Ethan had nine contacts with the professional over an 11-week period but was discharged from OT on 20th November 2015 due to the professional leaving the team and no one else available in the team to take over.

6.17 A further CMHT referral was received from Ethan's GP on the 13th of October 2017, and he was triaged by a practitioner via telephone on the 17th of November 2017. The same delusional beliefs were present, and he did not believe mental health services could help him due to this being a police matter. Ethan said that he could manage his personal care and nutrition with prompting throughout the day by his parents, in particular Grace who ensured he did not self-neglect. At this time a carers assessment for Ethan's parents was offered, but he refused this (see for further analysis of the appropriateness of this later within this report). The referral and triage assessment were discussed in a team meeting with the outcome being that there was not a role for CMHT and that psychology would be more appropriate. It is not clear how this conclusion was reached, given that Ethan had stated that his issues were of a policing/public protection nature rather than mental health so his likelihood of engaging with

psychology was low. CMHT also made a request for a psychiatrist to review Ethan's medication.

6.18 The onward referral to psychology was declined. The referral to psychiatry for a medication review was also declined. A consultant psychiatrist who knew Ethan well and was aware of him from previous involvement in 2003, responded to the CMHT request advising them that Ethan was presenting with similar complaints as he had fourteen years earlier, with no improvement in his presentation since then. The psychiatrist advised that they considered the most appropriate course of action would be for CMHT to engage with Ethan first and gently persuade him to see a doctor. The psychiatrist also suggested that if his condition had deteriorated to the extent that he was presenting a risk, his GP could request an assessment under the Mental Health Act (MHA). There is no CMHT documentation of any response or consideration of the advice from the psychiatrist when they declined the referral, so Ethan was fully discharged from the Trust with no ongoing support from the 7th of December 2017.

6.19 On the 20th of February 2018 Ethan phones Lincolnshire Police to report that he is being filmed. Ethan was visited by an officer. *'I have spoken with the caller who is clearly paranoid, there is no reason as to why he thinks he is being watched. He has not seen anything; he does not know who is watching him or why, as he has not seen him. He has seen the doctor who has said it is in his head and referred him to his local mental health team.*'

6.20 On the 8th of March 2019, Ethan, who was on his GP Practice severe mental illness register, had a Mental Health Review conducted at home by a nurse practitioner from the Practice. It should be highlighted here that Ethan had been on the Practice's severe mental illness register since 2006. (Patients on the severe Mental Illness Register are eligible for annual health checks from their clinician, such as a GP or a Practice nurse). Prior to this visit in March 2019, Mental Health Review entries were recorded on the GP's IT system to have taken place on the 27th of June 2006, 8th of January 2009, 6th of February 2014, 4th of July 2014, and the 16th of March 2018, and there were no concerns highlighted in any of the records. This visit in 2019 was expected practice in line with current guidance for the Practice's annual review for Severe Mental Illness patients. The nurse practitioner also did a set of observations (Blood Pressure (BP), Height and Weight) for Ethan all of which were within normal parameters.

6.21 Ethan greeted the nurse practitioner at the door; he appeared visibly well and made good eye contact. He had been struggling to exercise due to generalised joint pain. They agreed that Ethan would try analgesia more regularly to enable exercise. He requested some support/counselling from mental health team which the Nurse Practitioner agreed to investigate and subsequently made a referral to LPFT.

6.22 On the 15th of March 2019 following the GP referral. Ethan was accepted for assessment by the local CMHT, which took place on the 14th of May 2019 with a CPN. Ethan said that he continued to feel isolated and was anxious about going out. The assessment identified both of Ethan's parents as carers who tried to motivate him and prevent him from self-neglecting. Ethan's delusional beliefs about being at risk from others appeared to have changed. He was now saying that he was being filmed within his own home (previously this was only a perceived risk outside the home) although he had *"got used to it now*". He denied any thoughts to harm himself or others. Ethan stated he would like some support in managing his anxiety and paranoia but was ambivalent about whether he would engage with support from CMHT. The outcome of the assessment was that Ethan was accepted for short term support for anxiety management. This was commenced with an assistant practitioner on the 26th of June 2019. Ethan reported a good relationship with his parents and no risks were identified. Ethan was

again reluctant to engage in behavioural activation work but felt that he would benefit from learning some motivational techniques. Further contact and visits did take place.

6.23 On the 1st of August 2019, a CMHT practitioner made a home visit. They completed care plans with Ethan who spoke about feeling sad most of the time and ruminating over thoughts of when he was attacked. Suggested review with psychiatrist as Ethan takes medication he was prescribed years ago. He refused to see Psychiatrist.

6.24 On the 9th of August 2019, CMHT has a home visit, Ethan had thought about previous suggestions, he declined an appointment with a Psychiatrist. Declined graded exposure work. Ethan agreed that talking therapy would be his best option. The practitioner supported Ethan to complete a self-referral to Lincolnshire Talking Therapies (LTT) to address this.

6.25 That same day Lincolnshire Talking Therapies declined the referral as Ethan was already in receipt of CMHT support. On the 23rd of August 2020, Ethan was advised that the LTT referral was declined. He states he is happy to look into other forms of Cognitive Behaviour Therapy (CBT). Ethan declined graded exposure work. The practitioner stated that they will seek advice from Multi-Disciplinary Team about what other support could be offered and look into peer support.

6.26 On the 26th of September 2019, a CMHT practitioner speaks to Ethan, he has been watching some self-help videos on 'You Tube' and thinks these have been useful but struggles to put any of it into practice. Spoke about how anxiety has stopped him from having "a normal life". Gave an example of going to the pub before he was assaulted in a pub twenty years earlier. He described himself as a "loner" and didn't have many friends at school. Now tries to avoid others. The local CMHT practitioner will liaise with a CBT Psychotherapist about formulating a plan for him.

6.27 On the 6th of November 2019, the CMHT practitioner visits Ethan. His mother Grace was sat in the next room but did not speak with the practitioner. Ethan's main difficulty is anxiety, and he spoke about his fear of being harmed if he goes outside alone. Ethan has refused to engage with graded exposure work offered, he says he has declined due to fear of being made to look paranoid. He just wants someone to tell him the truth as he knows he is being watched. Ethan declined any interventions around his anxiety, schizophrenia or previous trauma from the assault. Ethan stated that he had experienced high levels of anxiety before his assault, therefore it is likely that there was a pre-existent sense of vulnerability. Since the attack, he has developed 'paranoid schizophrenia'. His records show a limited ability to regulate emotions in an adaptive manner prior to the assault. No current risks identified.

6.28 On the 20th of December 2019, during a home visit with a CMHT practitioner, Ethan stated that he was worrying about some family issues that are upsetting him. Ethan also advised the practitioner that he would like to stop his medication. Advised against this until he can be seen by Psychiatrist. Ethan is reluctant around this but hopeful that an improvement in his motivation may lead to other improvements in his life

6.29 On the 5th of February 2020, a home visit by a CMHT practitioner identifies Ethan is at risk of harming himself. His depression can magnify his withdrawal from daily activities. Family support and his relationship with them are his protective factors. Severity and frequency of risk deemed to be low.

6.30 In February 2020 a relative of the family comes to live with them. A social worker from Lincolnshire County Council children services is involved and completed appropriate checks, including health, along with a police check on all members of the household. The social worker also contacted the Adult Mental Health Team to request information regarding Ethan's mental ill health. Disclosures that were returned noted one entry of a concern for Ethan's mental health from the Police in February 2018, where he called the police convinced that he was being filmed. There is no record on file of a response from LPFT to the request for information regarding Ethan. There is no evidence within LPFT records of receiving this contact from Children Services either. It is unclear where this request was directed or if it went through any formal channels including via records department. Equally there is also no evidence this request was followed up by the Social Work team.

6.31 On the 27th of February 2020, CMHT visit Ethan who reports to be well and advised that a family member was now living with them, and social services are involved. Ethan reported that he was doing a little more around the house since this family member arrived.

6.32 An assessment was completed at the beginning of March whilst the family member was staying in the household. There are no worries noted in the assessment regarding the individual staying at the address.

6.33 On the 10th of March 2020, from the GP Practice an Advance Nurse Practitioner carried out a home visit for the annual mental health review. Grace is present in the house but not in the room during review. Ethan currently seeing the mental health team every 2-3 weeks. Soon to be transferred to a peer support group. Ethan wants people to help him and feels no one is. Advised that he has the support but that he needs to engage with the service and build the confidence himself to start going out and socialising. Advised this has to start coming from him.

6.34 On the 12th of March 2020, CMHT practitioner visits, Ethan was welcoming. Reports little change in his mood and way of thinking. Discussed whether Ethan wanted to continue with CMHT support or to be discharged. Ethan was advised that he could access the service if he felt ready and wants to move on from past trauma. Also advised about online support via Lincolnshire Talking Therapies. Ethan reported that a family member was still living with them. Agreed to let the GP know of Ethan's discharge and will send Ethan details of other services/support should he need it.

6.35 On the 9th of March 2021, GP Practice (advanced nurse practitioner) visits for the annual mental health review. Ethan states he has occasional palpitations. Advised and taught to take own pulse and red flags discussed with regard to very fast irregular pulse and chest pain. Possibly anxiety induced. Still not going out of the house because he states he is worried he will be harmed if he ventures outside.

6.36 On the 11th of March 2021 the GP Practice make a referral to LPFT, due to Ethan reporting to be fearful to leave the house. On this occasion Ethan's referral was passed to an Integrated Place Based Team (IPBT) to complete an initial assessment, which took place on 21st April 2021 with the IPBT. Ethan's mother was also spoken to as part of this assessment. Ethan declined all options of support around leaving the house but did agree to a CMHT Peer

Support referral. Ethan gave consent for the assessing practitioner to speak to his mother, and she joined the appointment. Grace was noted by the practitioner to be softly spoken and could not suggest anything that might help Ethan. There is no evidence that carers support was discussed at this time with her. One thing Grace confirmed was that Ethan had not changed because of the assault (2001) as he preferred not to go out even before this.

6.37 On the 22nd of July 2021, an LPFT peer support worker contacted Ethan to introduce themselves and talk about an online peer support group.

6.38 On the 28th of July 2021 an LPFT worker visits Ethan at home, he was welcoming and quiet, only answering "yes, no, don't know". Poor eye contact. Explained peer support contact and this being via a peer support worker, but the CMHT practitioner will remain as lead professional and will visit once a month to review how things are going. Ethan reported no risks, "just anxiety".

6.39 On the 3rd of August 2021 the peer support worker calls Ethan to arrange face to face appointment for the next week. Ethan advised that he did not think he could engage with peer support at this time. The peer support worker spoke of understanding his anxiety in relation to meeting new people. Reassured Ethan that he would remain open to Peer Support.

6.40 On the 16th of September 2021, the CMHT practitioner visited Ethan who reported feeling anxious, worried and depressed. He didn't know why this was. Discussed why Ethan had cancelled peer support, he stated it was due to anxiety of meeting someone new. The practitioner spoke about how peer support had been identified as the best option of support for him to help with his engagement and if he did not want this, then he would be discharged from the team. Ethan was quite guarded about this and more difficult to engage. He declined the offer of psychiatric review again.

6.41 On the 24th of September 2021, the CMHT practitioner spoke to Ethan as planned to ascertain what support he was wanting – CMHT or peer support. Ethan said he had thought about it and is "too anxious" to meet anyone new, so agreed to be discharged from the team.

6.42 On the 28th of January 2022, The GP Practice advanced nurse practitioner visited Ethan for the annual mental health review. On examination all observations satisfactory. Ethan reports no illness and showing no concerns. Ethan says he feels quite fit and well and spends his day on his computer and is at present enjoying reading self-help books for his mental health.

6.43 On the 26th of August 2022, Grace visits the GP practice, complaining of shortness of breath on exertion for the previous two months. Further tests are requested. Further consultations following concerns, firstly with the clinical assessment service. Grace reported that she had been to a family party, felt very tired when she returned home and fell asleep, awoke feeling really dizzy.

6.44 On the 13th of September 2022 a Clinical Assessment Service (CAS) worker from the 101 service spoke to the husband of Grace who was advocating on the patient's behalf. The caller reported that Grace is suffering from dizzy episodes which are becoming more frequent.

CAS made an appointment for Grace at a nearby Urgent Treatment Centre (UTC) for further assessment.

6.45 Later that day Grace was seen at the UTC by a Clinical Practitioner, who documented Grace was accompanied by her husband. Grace presented with worsening dizziness and loss of balance. Grace reports that she has had more than five episodes of dizziness lasting more than 10 minutes with associated persistent frontal headaches. Grace was referred to A&E and at this point Grace's care was transferred to the A&E Department where further tests were performed.

6.46 On the 9th of January 2023, Ethan self-referred to Lincolnshire Talking Therapies. He cited that the reason for the referral was to seek help for traumatic events that have led to agoraphobia. Ethan stated that he had been assaulted over twenty times in his life. Although Ethan had cited the assault in 2001, he stated he had felt these experiences before that though. This is the first documented time that he has made reference to multiple assaults.

6.47 Ethan's initial assessment took place via telephone with LTT on the 27th of January 2023. During this he completed two routine standardised assessments, the Patient Health Questionnaire and the General Anxiety Disorder. These assessments are utilised to identify a baseline and gauge the recovery from symptoms of depression and anxiety. For both questionnaires Ethan self-scaled himself at moderate to moderately severe symptoms.

6.48 During the assessment, Ethan stated that he had experienced a lot of mild mental health symptoms but did not mention a paranoid schizophrenia diagnosis, he also queried whether he had Autism as it *"sounded like my life".* There was little mention of his parents except for confirming that he lived with them and that they *"aren't the most chatty people in the world".* He did say that his mother collected his medication for him, but he did not identify her as his carer. The LTT practitioner tried to explore Ethan's statement in his referral about being the victim of multiple assaults, however, found it difficult to establish specific details from him around this. He said things would happen when he was "out and about" by people that he did not know, and he had not reported this to the Police. When asked for more detail about the assaults, he said that he could not recall when they happened because he would have been under the influence of alcohol at the time. The LTT practitioner gave signposting advice. The outcome of the assessment was that Ethan was eligible for treatment, although he was reluctant to engage in any intervention to address his agoraphobia (which would have taken a graded exposure approach), so it was agreed that they would work to address his low mood and motivation first as this was felt to be more realistic.

6.49 On the 20th of February 2023, Ethan had a telephone consultation with a psychological wellbeing practitioner at his GP Practice to conduct his annual Mental Health Review. Reviews for housebound patients are either by telephone or face to face. In previous years Ethan had always had these face to face. Ethan reported feeling low and was awaiting therapy through LTT through a self-referral but thinks he may have autism/ADHD and wanted to be referred for this. (A form was sent over to Ethan for him to complete).

6.50 On the 17th of March 2023, Ethan had another telephone consultation with the same nurse from the GP Practice following him making a request on Ask my GP (an online consultation and workflow system that helps GPs manage patient caseload). He was worried

about everyone from an abuse angle. He reported that no-one in particular was causing abuse and that nothing was going on at the moment, but he fears for the future. Ethan was due to be speaking to mental health through LTT in the near future and was advised to discuss these feelings with them.

6.51 In August 2023, Lincolnshire Police received a call from a male, subsequently found to be Ethan, to say he had just attacked his mum and doesn't think she's ok. He stated that he had stabbed her and wanted to be shot by the police when they arrived. He stated that everyone wants to kill him and that the neighbours have been heard talking about wanting to kill him which has caused his psychotic episode this morning. Officers attended the location and found Grace deceased, with a number of stab wounds to her neck area. A knife believed used in the murder was located in Ethan's room. Only Ethan and his mother were present in the premises. Ethan was arrested on suspicion of murder.

6.52 EMAS also attended the same incident. On entering the property, a female was laid on her back on the lounge floor. The patient appeared to have wounds to her neck. Advanced resuscitation was commenced. The attempts to revive the patient were futile and the patient's death was confirmed by the doctor at 13.08.

Section Three – Overview and analysis

7.0 Overview

7.1 Over a number of years there are numerous contacts with health agencies in respect of Ethan. There is very little information recorded that relates to Grace. The review author has extracted what are the key events of relevance to the terms of reference, presented for review in this case. The review author would like to thank those agencies which have been asked to provide clarity or additional information.

7.2 The relationship between Grace and Ethan is biological Mother and Son. There is also present in the household the biological Father, there are other siblings who do not reside at the address but are all part of a close family.

7.3 The date parameters were agreed by the panel. It has been important that this review can see the real situation that Grace had to contend with in her household with her son Ethan and his mental health illness. This is intrinsic to understanding and illuminating the life within that household. This is seen as key to gaining an understanding of how and where services were, or were not directed, and the wider consideration of her experiences over a more substantial timeframe. It is quite clear from the chronology that Grace and her family were private people and Grace to large extent carried out caring responsibilities for her son that was seen by herself and her family as therefore professionals as a mother caring for her son with mental health issues so appropriate risks assessments were not carried out as might have been expected.

7.4 It is clear from the records that there are no instances of domestic abuse, which has been confirmed by the family to the chair of the panel. The death itself, of course, was an act of domestic abuse from Ethan to his mother Grace.

7.5 Statistically, the greatest risk to victims of domestic abuse is from an intimate, as opposed to a non-intimate relationship. Familial domestic abuse is not often considered to be the most symptomatic cause of serious injury or death, either directly, by homicide, or where the victim self-harms or takes their own life. It is a hidden dimension that may not lead to professionals exploring the full perspective of a non-intimate relationship against that of an intimate relationship. This case has highlighted that on innumerable occasions, that perspective was not considered.

7.6 A recent study by Jennifer Storey et al (2024)[10] focussing on Old Age Homicide (OAH) demonstrates that the case of Grace fits with her research, it stated: *'The perpetrator model demonstrated better fit than the victim model and more predictors with higher odds ratios. The same two conclusions as for victims can be drawn, OAH is different to AH (Adult Homicide) and risk factors for older adult abuse may provide good direction for the ongoing examination of OAH. For instance, across the two models, living with the perpetrator and links between the homicide and the perpetrator's mental state were both significant predictors. This is an older adult abuse dynamic commonly reported in other studies where an adult-child is living with their parents (often dependent on parents for housing) and has mental health problems (Pillemer and Finkelhor, 1989; Lachs and Pillemer, 2015). Thus, knowledge can be drawn from our understanding of older adult abuse to guide future OAH research.'*

8.0 Analysis

8.1 The key terms of reference for this review are:

- Did actions or risk management plans, in particular in relation to Ethan's mental health issues, fit with the assessment and decisions made? Were appropriate services offered or provided in light of Ethan's reluctance to engage?
- What knowledge did your agency have of any caring responsibilities that Grace or other members of the family had, and what was the response? Was a carer's assessment offered and/or completed? If not, should it have been offered and completed?
- Were any, or should there have been any consideration to family members that reside with and care for, whether formally or voluntarily, of risks to them from the family member suffering from Paranoid Schizophrenia? Would they know any risks associated with Paranoid Schizophrenia?
- How did your agency ascertain the wishes and feelings of Ethan and his parents and were their views taken into account when providing services or support?
- How did your agency take account of any racial, cultural, linguistic, faith and neuro diversity, when completing assessments and providing services to Ethan and his parents?

[10] The British Journal of Social Work, Volume 54, Issue 7, October 2024, Pages 2880–2898, https://doi.org/10.1093/bjsw/bcae067

- What is the knowledge within the partnership of matricide, in particular following the recent local DHR in relation to Ionela[11] where matricide was a key factor.
- Were there opportunities for your agency to implement safeguarding processes? If so, were these enacted/considered and what was the outcome?
- How effective was inter-agency information sharing, and was information shared with those agencies who needed it?
- In reviewing agency interaction do your current policies and procedures capture agencies expectations and responsibilities in response to your involvement on this case? Where there are identified gaps please detail how these will be addressed?
- What was the impact of Covid-19, on access information and support and agency responses to Ethan and his family?
- Were there any examples of outstanding or innovative practice?
- What learning did your agency identify in this case?

8.2 This analysis seeks to explore holistically all of the questions raised within the terms of reference and will at times answer each individually. This is to help the reader to understand the analysis better and to be able to focus on the learning. The key learning, as raised by the IMRs and the Panel discussions, relate to what was done for Grace in relation to her as a carer and knowledge and involvement of professionals and agencies in relation to Ethan's mental health illness and any risks associated with this.

8.3 Did actions or risk management plans in particular in relation to Ethan's mental health issues fit with the assessment and decisions made? Were appropriate services offered or provided, in particular light of Ethan's reluctance to engage.

8.4 There were primarily two agencies involved in working with Ethan during this substantial period of well over twenty years of Ethan suffering a mental health illness. This was his GP Practice who had a more consistent staffing allocation to him. The other was LPFT, who, during this time tried to deliver a whole series of different interventions but Ethan was consistently reluctant to engage with active treatment that could have helped to address or manage his anxiety, schizophrenia. The rationale Ethan always told them included a fear that he could end up in hospital or on a mental health unit as a result, but mostly he did not consider these interventions necessary due to him not having a mental illness and that his reluctance to leave the house was proportionate to the perceived risk of being harmed by others if he did. But because as one of the CMHT professionals described to the LPFT IMR practitioner that Ethan was *"very, very mild, very softly spoken, very quiet wouldn't hurt a fly type human being",* this meant that any urgency to address risk or furthermore assertive treatment was deemed by practitioners not necessary. In Ethan's case, based on his presentation as documented, even though his delusional beliefs were persistent and prevented him from living a full and meaningful life, they were not at any stage of a severity that would meet the threshold for consideration of a Mental Health Act 1983 (MHA) intervention. The MHA Act makes provision for people to be detained in hospital for assessment and treatment if their mental disorder is of a nature or degree that warrants this for the safety of self or others.

[11] https://www.lincolnshire.gov.uk/downloads/file/6894/dhr-ionela-and-james

8.5 This is not to say that practitioners from the local CMHT were not persistent in their efforts to try to build a relationship with Ethan because they were, they always tried to encourage him to engage in meaningful intervention to try to improve his quality of life. They also tried to understand why he had this reluctance and two CMHT practitioners attended together to explore the reasons for Ethan's refusal to engage in interventions using a CBT for psychosis approach to focus on his concern about harm, Ethan refused to consider any theories other than that he was genuinely at risk from others and was not willing to consider this any further. When Ethan was asked what he felt he needed from mental health services, he replied, "*regular visits for a chat*". It was reflected to Ethan that although this may help him feel better that day, it does not create long term changes and that the CMHT can only facilitate this if an intervention is being provided alongside it, but Ethan disagreed and said, "*they won't work*". When it was explained to Ethan that the CMHT may need to consider discharging him if he is not willing to engage with any interventions towards longer term change, he became visibly agitated but continued in his resistance to accept intervention beyond superficial 'chats'.

8.6 An area that has required some consideration is the decision-making and commissioning regarding Ethan being able to access support from Lincolnshire Talking Therapies (LTT), which is a service designed to offer CBT based talking therapy interventions for lower-level mental health concerns around anxiety and depression. Therefore, if a person presents to LTT with an identified SMI, this is an exclusionary criteria for accessing the service. Although Ethan's referral was declined in 2019, he was able to access treatment with LTT from January – May 2023, which was his last period of contact with the LPFT prior to the homicide. Ethan submitted a self-referral in January 2023, requesting help for past traumatic events leading to agoraphobia. There appears to be a change in Ethan's presentation at this point, with him now reporting he had experienced over 20 assaults.

8.7 Accepting that there are internal complexities within LPFT of Ethan with psychosis and an SMI so not being able to access LTT, if we look at it from the patient's perspective, in this case Ethan working with LTT seems to be a good and positive outcome. Ethan was accepted for assessment by LTT and appeared "*really keen to access the service…and he wanted to make changes*". He came to the top of the waiting list for treatment and was first seen in March 2023. When the practitioner spoke to the LPFT IMR author they stated that "*he engaged well with what we were doing, he did his homework, he seemed fine. He never gave me the impression that he was violent or aggressive…he was never angry with me*". The practitioner did, however, have some concerns about Ethan's statements relating to hearing voices through the walls of people wanting to kill him and being assaulted twenty times by twenty different perpetrators, and whether these may be indicative of delusions or auditory hallucinations. The practitioner appropriately raised their concerns with their supervisor in management supervision and queried psychosis. The agreed plan was to continue with treatment but monitor the voices and review after four sessions. However, Ethan was then discharged after four sessions when he did not wish to engage in treatment for agoraphobia.

8.8 The decision to discharge Ethan from LTT was deemed appropriate by the LPFT IMR author on the basis that he did not wish to engage in the treatment for agoraphobia. Although Ethan's Severe Mental Illness was not identified by LTT staff, if it had been then the likely outcome would have been that his referral to LTT would have been declined and

forwarded to the LPFT's Interface Meeting to consider which service was most appropriate to accept the referral, which would most likely have been his local CMHT.

8.9 The reluctance of the patients to engage with professionals and how they could try and get families to engage with them, in this case, Grace and her husband, is a clear learning feature to arise from this case and can be seen as a reason why things happened as they did and how this added to the complexity and challenge of trying to work with Ethan. This non-engagement with suggested treatments was a feature throughout and invariably led to Ethan being discharged from LPFT. Practitioners did though employ a number of strategies to engage with Ethan, including phone calls, texts, and planned visits to promote engagement. The lack of engaging Grace and her husband to assist practitioners is a major learning point for professionals and agencies.

8.10 Although not implemented as a direct result of this case, LPFT would like to highlight a recent change that was introduced in December 2024, that will enable the LPFT to take a more assertive approach for patients with SMI where engagement presents a challenge, which goes some away to addressing the gap. A new 'assertive/intensive support' alert has been added to the clinical IT system, Rio, to enable adult mental health services to identify people with SMI who require a more assertive approach to treatment. This alert is designed for individuals within a defined criteria, including those who have a SMI (such as schizophrenia or bipolar disorder) impacting significantly on daily life (e.g. persistent psychosis, diminished insight, non or partial concordance with medication, disengagement, repeated admissions or high-risk depots), and also a history of problems with agreeing to work with mental health services. When the criteria is met, staff are expected to add the assertive/intensive support label to their record and detail the specific requirements and care needs in the clinical notes and care/support plan. This then triggers a multi-disciplinary review of that patient's care and support needs and, where appropriate, a more assertive response to engagement. This is seen by the review chair as extremely encouraging.

8.11 What knowledge did your agency have of any caring responsibilities that Grace or other members of the family had, and what was the response? Was a carer's assessment offered and/or completed? If not, should it have been offered and completed?

8.12 Grace was in receipt of carers allowance from 2008 until 2013. To receive a carers, allowance a carers assessment is not required. A carers allowance is awarded on the basis that the carer is providing 35 hours per week care, and the disabled person is in receipt of a qualifying benefit.

8.13 Even before this in paper records held by LPFT dating from 2007, the paperwork which was completed by Ethan outlines the type of support his mum provided, including making daily meals, washing his clothes, cleaning, and prompting Ethan to shower and change his clothes. The first, and only time that LPFT completed work with Grace regarding her role as a carer for Ethan was when she completed a carer self-assessment form in January 2011. This assessment stated that, Grace provided over fifty hours of care per week to Ethan which largely came in the form of actions to collect and ensure he was reminded to take his medication and to prevent him from self-neglecting, a common negative symptom of paranoid schizophrenia. This included doing his washing, cleaning and cooking his meals.

Grace was claiming carers allowance at the time. Grace stated that she would worry about Ethan if she went out and would need to get someone to check on him if she did, which she often requested of his LPFT worker. Grace documented in the carer self-assessment that *"my role as a carer has a lot of impact on my ability to have a life of my own"* However, she did indicate that she felt confident she could continue with the caring role with regular support from LPFT. Unfortunately, this regular support from the LPFT, Assertive Outreach Team (AOT) did not continue due to the service being dissolved in 2012.

8.14 Although there was no evidence in archived records that the LPFT considered the impact on Grace's caring role when the AOT ceased to exist, this predates the Care Act 2014 (Care Act), where the rights of carers caring for adults was first placed on a statutory footing. The Care Act and accompanying Care and Support Statutory Guidance (DHSC, 2024) gives carers a number of rights, including the legal right to a carers assessment, control over their caring role and the right to choose whether to care, protection from discrimination and flexible working. The legislation and guidance outline the duties and powers of the local authority to meet a carer's identified needs for support.

8.15 Although, as outlined above, that statutory responsibilities regarding carers came into force in 2014, the LPFT first specific role to embed this fully was the Head of Carer and Relative Experience (HoCRE), who was appointed in 2018. The LPFT IMR author has liaised with HoCRE for the completion of their IMR and they advised that support for carers is much more robust within teams than it would have been when Ethan became open to CMHT during the scoping period. LPFT now has a carer's charter, and a carers strategy is embedded within LPFT's overarching strategy. There is a network of carers champions in each team throughout the Trust, and it has maintained Triangle of Care (Carers Trust) two-star accreditation since 2020. LPFT responsibilities to carers are embedded throughout the Clinical Care Policy, which includes a self-contained Carer Policy at section 14 (pp.98 – 104), and carers of patients have access to a carers education support group and an informal WhatsApp group.

8.16 It is fair to say that the LPFT response to carers is more robust today than when Grace completed a carers assessment in 2011, there were opportunities post Care Act 2014 to recognise her caring role and engage with her about the impact of caring for Ethan. In 2017, a carers assessment for his parents was offered by a local CMHT practitioner, but Ethan refused this. This is a misinterpretation by that practitioner of confidentiality. Whilst a patient can make decisions about whether information can be shared with family members about their care and treatment, a patient cannot decline a carers assessment on behalf of their carer(s) as this is not the patient's decision to make. The current Clinical Care Policy is clear about this at pp.103 – 104: "*whether the service user has given consent for information to be shared with the carer or not, the carer must be given the opportunity to discuss any difficulties or concerns they may have about their caring role, ensuring they feel supported and valued. The service user does not have the right to prohibit a professional from engaging with a carer or from the carer being given information, advice and support, nor from talking to the carer about the patient, provided that no confidential information is divulged."*

8.17 At no point during Ethan's time being open to his local CMHT, within the scoping period, were Grace or her husband contacted and offered support as carers. The last two episodes of care with them being after the HoCRE was in post and processes around carers became more embedded across the Trust. There is a care plan on Ethan's record dated 1st August 2019, which states *"I need support to make sure I eat properly, take my medication, wash clothes, look after my home, socialise, not let my mental health deteriorate, exercise, meditate, budget my money, prepare meals, study and aim for some work"*. Therefore, the local CMHT should have reasonably been able to identify that a level of care was being provided by Grace to him, which is surprising as the CMHT assessments identify Grace and her husband as carers, so this should have been considered, and more professional curiosity could have been utilised rather than relying on Ethan's perspective. This should have meant contacting Grace directly to explore this from her, and her husband's point of view. This is in accordance with the expectations outlined in the legislation, statutory guidance and in fact LPFT's own policy. The LPFT IMR has recommended that: The Trust to offer support and training to local CMHT's regarding their statutory duties towards carers, and for the Head of Safeguarding to raise this case with the Legislative Committee, alongside HoCRE, for discussion so that any wider Trust actions can be considered.

8.18 The GP Practice were fully aware that Ethan was living with his parents. Grace and her husband were not listed on the GP Practice Carers Register. Therefore, a carers assessment was not offered or completed. When someone is identified as a Carer to the practice, they are then placed on a Carers Register. This helps them to get certain support from the GP Surgery for example support with physical, mental health and/or referral to helpful services for the carer, vaccinations etc. On reflection the GP IMR states that the practice could have categorically asked, and if identified as carers, completed a referral for a carers assessment for them. This would have given an opportunity for the practice to support them with their caring roles and put risk assessments and training into place, including being able to address mental health emergencies.

8.19 Grace presented at an urgent treatment centre (UTC) with acute illness, practitioners focused on and prioritised their response to her illness. There was though a lack of professional curiosity as to whom was in the household. Maybe because Grace presented as an older adult in UTC, staff may have presumed there were no children living in the family home and did not appear to consider Grace may have had a caring role for another adult. In an ideal situation, best practice is to gather information about family history and social circumstances during the initial consultation. However, on the day that Grace attended UTC, the need for urgency in response to her clinical presentation meant that she was transferred from the department before further assessment of her home circumstances could happen. This prioritisation of her clinical need at the time was appropriate so no learning was identified from this LCHS contact.

8.20 A guide published by the Local Government Association and The Association of Directors of Adult Social Care identifies that '*In general, families and carers make an invaluable contribution to society and the support of carers is integral to the Care Act (2014). However, practitioners should be aware of and vigilant against the potential of 'the rule of optimism', when professionals may place undue confidence in the capacity of families to care effectively and safely, affecting professional perceptions and recognition of risk of harm, abuse or neglect.'* It may be that it was this rule of optimism which prevented professionals undertaking a carer assessment, but it was more likely that it was not even fully acknowledged by practitioners of the carer role that Grace and her husband performed for Ethan.

8.21 Many carers simply do not realise they are a carer – they may simply think of themselves as someone's family, as is the case here for Grace. However, unless carers are identified, it is difficult to get support for them until they reach crisis point. It is a point of learning in the case of Grace, that those working in a wide range of community-based services, including mental health services and in primary care, are equipped to recognise people who are carers and refer them for a carers assessment and then help them to access appropriate information, advice and support. Referring carers to local carers organisations can also help someone to realise they are a carer and begin to get the support they need. Parents may be more reluctant to ask for or accept help and less likely to identify themselves as a carer. It is incumbent on professionals that they need a particularly skilled and sensitive approach to older carers to address their concerns, and this may be a process rather than a one-off intervention. Health and care staff undertaking home visits are also in a key position to identify carers.

8.22 Were any or should there have been any consideration to family members that reside with and care for, whether formally or voluntarily, of risks to them from the family member suffering from Paranoid Schizophrenia. Would they know any risks associated with Paranoid Schizophrenia.

8.23 Although this section of the analysis tries not to duplicate what has been said in the previous section, it is of note that if Grace in particular, but also the father, were formally recognised as carers, some of this section should have been dealt with by professionals at that stage of the carers assessment.

8.24 While the terms of reference specifically mention the term Paranoid Schizophrenia, it would be more helpful to this analysis and provide a more comprehensive learning if this was a wider definition and covered severe mental illness[12].

8.25 Whilst Ethan was open to the local CMHT, there were no specific triggers such as significant events or serious incidents that should have prompted a review of the risk assessment. However, the reviews of his clinical risk were not at the minimum six-monthly frequency or even to support the decision to discharge Ethan from the service, as required by LPFT policy.

8.26 Regarding Ethan's risk to others, he was not deemed a risk to others by any agency, including at the point of his initial clinical risk assessment being completed. He was reported to have a good relationship with his parents and close family. The reviews of Ethan's risk continually do not identify him as a risk to others, although these reviews did identify that he can pose a risk to himself when he starts to ruminate about the past and what happened to him when he was attacked, although this risk was also deemed to be low due to the support from his family, who were viewed as a protective factor relating to Ethan's risk to himself. However, the family, and Grace in particular, were never informed of what to look out for and what, if any, were signs that the risk to himself or others maybe increasing.

[12] The phrase severe mental illness (SMI) refers to people with psychological problems that are often so debilitating that their ability to engage in functional and occupational activities is severely impaired. Schizophrenia and bipolar disorder are often referred to as an SMI.

8.27 Ultimately, Ethan's risk was formally assessed by LPFT on five occasions during the scoping period. His risk to others throughout this time was consistently identified as low/no risk in this area, with nothing documented within the records to indicate that these assessments were not accurate or failed to consider any relevant information. There is evidence that practitioners from LPFT are experienced and demonstrate clinical risk assessment and management processes as outlined in the Trust's Clinical Care Policy. The policy states that "*clinical risks presented by patients will be assessed and reviewed as often as deemed necessary in order that the risks identified can be managed effectively, safely and progressively over time"* (p.35). The LPFT IMR does suggest some further internal learning as symptoms of SMI are not part of the curriculum for trainee Psychological Wellbeing Practitioners (PWP) within the LTT service. They have already begun the learning with a Head of Service having implemented a routine SMI awareness session on signs and indicators that will run six-monthly in line with each new cohort of PWP trainees.

8.28 There is evidence that Ethan's parents knew how to contact the Trust as they had done so historically to request venue changes for appointments from clinic to home based. However, during the scoping period, none of Ethan's family members contacted LPFT to raise any concerns about his mental state or presentation that would have prompted a review or change to his risk assessment. Although Ethan was known by his family to not take all medications prescribed, he appeared to be broadly compliant with his prescription Stelazine (anti-psychotic medication), and Grace collected this for him. There is also evidence in the records of a reluctance for his medication to be reviewed by a psychiatrist. His prescription had not changed for two decades and did not appear to be effective at reducing his symptoms. Ethan's rationale for declining review often linked to a lack of his personal insight into his delusional beliefs as he did not consider himself to have a psychotic illness but rather that he was genuinely at risk of harm from others, which medication does not address. The LPFT IMR author discussed the implications of a patient remaining on the same prescription for over twenty years with a clinical pharmacist who explained *'that responsibility for physical health checks can be a "grey area", but NICE guidelines on the monitoring of psychosis and schizophrenia (NICE, 2024) state that when antipsychotics are initiated, responsibility for monitoring remains with the secondary care team for the first twelve months, or until their condition has stabilised (whichever is longer), then regular monitoring may be done in primary care.'* The pharmacist also highlighted that if a medication review had taken place, there is a need to balance the benefits of antipsychotics with the side-effects of long-term use, which at times can actually lead to de-prescribing, rather than increasing or changing medication.

8.29 The LPFT IMR states that there does not appear to be pertinent information relating to Ethan's risk to others that Trust staff should have been expected to expressly communicate or liaise with Ethan's parents about. However, what didn't happen, whether by LPFT or the GP Practice, is them providing adequate proactive advice, guidance and education to Ethan's family to recognise early warning signs of deteriorating mental health which could prevent him from reaching a crisis point. This should include pathways and signposts for who to contact. Known now from the family, but not until after the death, was that Ethan's behaviour had changed in the preceding days. He had stopped taking his medication, they estimate for possibly two weeks. They had no idea what this meant and whether they should contact anyone, for example the GP Practice. Ethan had not been doing his charitable walk that he was doing at home. On the night before the murder, he told his mother that he

needed to say goodbye to her as someone was coming to kill him. When his father returned from work that day, he repeated this to him as well.

8.30 The LPFT IMR highlights that this sharing of relevant information with patients and their families should already be addressed by their Clinical Care policy, which outlines on p.42 that, '*where a clinical risk is identified, crisis, relapse and contingency plans are an essential element of risk management and should contain actions to be taken by patients or their family (where appropriate) if the patient's mental health deteriorates'*. However, a crisis, relapse and contingency plan was not completed for Ethan by his local CMHT, which could have then been shared with Ethan and his parents. The LPFT IMR makes a recommendation that they seek assurance that community teams working with patients with SMI are completing crisis, relapse and contingency plans routinely and sharing these with family and carers where appropriate to educate and empower them to recognise warning signs of deterioration/relapse indicators. The chair suggests that this should be widened to include GP Practices sharing advice, knowledge and guidance with families of their patients on their SMI register, on what risks and changes of behaviour should be shared back to them.

8.31 The NICE guidance[13] for treatment of psychosis might have been useful in this case as it provides evidence-based guidance on the following best practice elements of treatment:

- Service user experience
- Physical health
- Support for carers
- Peer support and self-management
- First episode psychosis
- Subsequent acute episodes of psychosis or schizophrenia and referral in crisis, and behaviour that challenges
- Psychological interventions
- Pharmacological interventions
- Using depot/long-acting injectable antipsychotic medication

8. 32 These NICE Guidelines further advises that carers, relatives, and friends of people with psychosis and schizophrenia are important, both in the process of assessment and engagement, and in the long-term successful delivery of effective treatments. The guidance recommends that carers should be given written and verbal information in an accessible format about:

- Diagnosis and management of psychosis and schizophrenia
- Positive outcomes and recovery
- Types of support for carers
- Role of teams and services
- Getting help in a crisis

[13] NICE CG178: Psychosis and schizophrenia in adults: prevention and management (2014). https://www.nice.org.uk/guidance/cg178/chapter/1-Recommendations

8.33 In our view, advice should have been provided for Grace and her husband in understanding the nature of Ethan's diagnosis, how Grace and his family could support him, and how the not taking of medication may affect him.

8.34 What is the knowledge within the partnership of matricide in particular following the recent local DHR in relation to Ionela where matricide was a key factor?

8.35 Although the recent DHR (Ionela and James) and this review both feature matricide, the circumstances around these cases do differ to the extent that some of the learning from Ionela's case is not directly applicable to Grace's life with her son. The cases do share the similarity that that there was no reported previous domestic abuse prior to the domestic homicide occurring in either case. However, Ethan did not present as suicidal and there was no recorded clear evidence of him having experienced significant adverse childhood experience (ACEs[14]), as was the case for the perpetrator in Ionela. Ethan also did not have any known drug or alcohol issues and there were no known concerns about him viewing violent media, although he was noted to spend a lot of his time on his computer. Ethan, also in contrast, is never known to have made negative comments about his mother prior to her death, and his parents and wider family were repeatedly noted to be a positive/protective factor in his life.

8.36 As already mentioned earlier in the report and the last paragraph, there are no instances of domestic abuse within this family, however, the actual murder itself is a case of matricide. A study by Roberto Catanesi et al (2014[15]), is relevant to the analysis and learning in this case. 'Matricide by Mentally Disordered Sons: Gaining a Criminological Understanding Beyond Mental Illness-A Descriptive Study', which states that: *'Matricide is one of the rarest of reported murders and has always been considered one of the most abhorrent crimes. Psychiatric investigations as to why a son might murder his mother yield indications of a high rate of mental illness, primarily psychotic disorders, in perpetrators. Several factors in the history of the mother and son need to be probed, especially how their relationship developed over the years.'* In the case of Grace and Ethan all of the accounts, both from the family and professionals, is that their relationship was one of mutual love and kindness.

8.37 A further study helps further in this case: A Comparative Study of Matricide Versus Patricide (2007) by Dominique Bourget et al in the Journal of the American Academy of Psychiatry and the Law Online, states: '*Almost all of the matricides occurred in the family home (91.7%). A majority (70.8%) of perpetrators were living with the parents at the time of the offence. Seventy percent of perpetrators who committed matricide had a psychotic motive (i.e., delusional thinking).'* This again absolutely fits with what Ethan stated to professionals treating him for his mental illness, his delusional thinking.

8.38 Some of the literature referenced above is also highlighted in the Ionela DHR but also relates to this review in terms of the location of the matricide, in the family home, and that

[14] The term 'Adverse Childhood Experiences ' (ACEs)is credited to Dr Vincent Filletti who carried out a study in the United States of over 17,000 people in the 1980's. His study was the first to identify the relationship between experiences in childhood and problems with health and social integration throughout a lifetime.
[15] Catanesi Roberto et al (2014), 'Matricide by Mentally Disordered Sons: Gaining a Criminological Understanding Beyond Mental Illness-A Descriptive Study.'

Ethan was living with his mother at the time (Bourget et al, 2007[16]). Further research by Bojanić et al (2020[17]), outlines that the main characteristics of people who kill either of their parents (parricide) are that they are mostly male, white, middle-aged, unemployed, unmarried, and living with their parents (all of which applied to Ethan). There are links between delusional disorders and parricide offenders', and research has shown that they are likely to have been in in contact with mental health services in the year prior to the offence. LPFT have made a helpful recommendation in their IMR that: The Trust Safeguarding Team to engage with the CMHT's to raise awareness of the circumstances of this case and research/risk factors around parricide that practitioners should be aware of and factor into their risk assessments, and crisis, relapse and contingency plans.

8.39 A literature review of the use of kitchen knives in homicides (Hughes et al. 2012) by mentally disordered offenders showed that the most frequent method of causing death in parricides is use of a sharp or blunt instrument (60%), a method that is more frequently used than in general homicides (43%) (ONS, 2014).

8.40 The study showed that kitchen knives are used more often than other types of knives amongst perpetrators of homicide in England who have had contact with mental health services. While this study did not show any significant relationship between having schizophrenia and the use of kitchen knives, it was shown that most homicides in this study where kitchen knives were used were unplanned.

8.41 LPFT did provide assurance to the review that there was knowledge within the Trust of issues relating to matricide following the previous Lincolnshire DHR relating to Ionela. There were no Trust specific actions for the Trust as a result of this review, although there were some general actions for Safer Lincolnshire Partnership regarding the production of briefings relating to matricide. The Ionela review, which is of note to the learning in this review and is covered in the previous section, also emphasised the importance of professionals considering risks within family dynamics from the person they are treating, and recognising risk to others, in particular family members, from individuals with a mental health illness. The briefings that were produced as a result of this review were disseminated throughout the Trust via it's Safeguarding and Mental Capacity Champions Network and was also included in the Trust's mandatory safeguarding training for a period of time to promote and embed this learning. If they also progress the recommendation made above, they will be able to show good progress and learning.

8.42 How did your agency take account of any racial, cultural, linguistic, faith and neuro diversity, when completing assessments and providing services to Ethan and his parents?

8.43 As mentioned earlier in this report there are protected characteristics relevant to Ethan's case under the Equality Act 2010. This was a disability on the grounds of his mental illness. He was in receipt of benefits for this disability including in his incapacity to work.

[16] Bourget, D., Gagné, P. and Labelle, M. (2007) Parricide: a comparative study of matricide versus patricide. Journal of the American Academy of Psychiatry and the Law, 35(3) 306 – 312.
[17] Bojanić, L., Flynn, S., Gianatsi, M., Kapur, N., Appleby, L., & Shaw, J. (2020). The typology of parricide and the role of mental illness: data-driven approach. Aggressive Behaviour, 46(6) 516 – 522. Available from The typology of parricide and the role of mental illness: Data-driven approach.

8.44 It can be seen that reasonable adjustments were made for him by both his GP Practice and LPFT. As an example, from the LPFT, initial assessment appointments were arranged as home visits instead of at a clinical base, recognising that Ethan struggled significantly to leave the house. Another example, when Ethan failed to attend his first session with Lincolnshire Talking Therapies (LTT) they recognised that Ethan struggled to answer the telephone due to his anxiety, so knowing that he used his computer utilised an alternative communication method by emailing him to enquire about the non-attendance. This adjustment was successful as Ethan was able to reply and was therefore offered a re-booked appointment rather than being sent an opt-in letter and placed on a discharge pathway.

8.45 Regarding neurodiversity, when Ethan was assessed by LTT in 2023, he queried whether he had autism, this was not something that the practitioners who worked with Ethan in the past had identified any signs of autism. In any event, the diagnostic criteria for autism spectrum disorder (ASD) contained in the ICD-11 (World Health Organisation, 2019b) does not recommend an official ASD diagnosis when psychosis is also present as this is difficult to assess due to the cross over of symptoms creating an overlapping boundary.

8.46 The GP Practice used to conduct Annual Mental Health reviews regularly, they were all conducted in the first quarter of every year. Even in the toughest of Covid lockdown, covered in the next section with restrictions in place, the GP Practice made sure that Ethan's Mental Health Reviews were regularly done as safely as possible. Also, to make reasonable adjustments for this, the Practice tried to facilitate Ethan as much as possible by assigning a member of staff to go to his house and do a Mental Health review in the comfort, and for him, the safety of his home.

8.47 What was the impact of Covid-19, on access information and support and agency responses to Ethan and his family?

8.48 Ethan was understandably worried about Covid-19 and before the first lockdown in the UK in March 2020, Ethan spoke of his concerns about Covid and being worried about this and therefore felt it would be best to be discharged due to potential risk of practitioners introducing the virus into his home when completing home visits. This conversation took place when a practitioner from his local CMHT visited the home on the 12th of March 2020, which was eleven days prior to this first national Covid-19 lockdown, and as a result Ethan was discharged from the CMHT.

8.49 Ethan's GP Practice did, however, keep in touch with him and supported him, Grace, and the family throughout the height of the virus and the various lockdowns.

8.50 In relation to some of the other sections of the Terms of Reference, regarding information sharing and of relevance to mental health is that Lincolnshire Police entered a formal information sharing agreement with the LPFT in 2020, where the details of submitted mental health PPN forms are shared with them. There is now an information sharing agreement with the LPFT where they are provided with incident details from submitted Mental Health PPN's. When available, a mental health practitioner is based within the Police Force Control Room and can provide instant information on a person's health record, the

police also employ a person in the role of Mental Health Liaison Officer who provides a link to partners.

8.51 At the entry 6.30 in this report it can be seen that there was a lack of clarity as to who was spoken to at LPFT in relation to consideration of any mental health issues in the family home. Likewise, there is no record found by LPFT of any call being made to them to seek this information. This lack of clarity of course leads to gaps in information seeking and sharing. This leads to two conclusions and need for actions, 1) Record keeping – this needs to ensure that whoever is spoken to when seeking information their name and department is recorded in the records. 2) In order to ensure that requests for information from LPFT are sent through the most appropriate channels, there needs to be a communication to all agencies as to the correct pathway to seek this information.

8.52 The lessons learned part of the terms of reference is picked up in the learning themes and agency recommendations and the overview report recommendations.

Section four – Conclusions, Learning Themes and Recommendations

9.0 Conclusions

9.1 There were no reported cases of domestic abuse within this household and this fact was confirmed by the family of Grace. The homicide was the first act of violence known to be committed by Ethan.

9.2 Ethan had a Severe Mental Illness for over twenty years at the time he killed Grace. He had been diagnosed and treated mainly with medication; other treatments were attempted but with limited success due to Ethan not being willing to engage with this He was on the same medication for all of this time. These numerous interventions were tried by LPFT but to no avail in reducing his symptoms of anxiety, paranoid schizophrenia and delusions. Ethan often declined more assertive interventions, which meant he was discharged from services.

9.3 More work has been done since this homicide, not entirely related to it, but fits the case to ensure that people, such as Ethan that are hard to engage with, are considered in a multi-disciplinary environment to keep them engaged with services.

9.4 There are numerous occasions that Grace was known by agencies to be a carer for Ethan but only once, many years earlier, did a carers assessment take place. This should have happened, and work should have been done, for not only practitioners but also for Grace and her family, to acknowledge and understand that caring responsibility was happening. If this had happened some statutory support as carer would have been, and should have been, provided to Grace and her husband.

9.5 Despite a number of high profile cases of homicide (including this case) where the offender was diagnosed with paranoid schizophrenia, it is relatively rare for a non-violent patient to suddenly commit extreme acts of violence. There was though, for Grace and her husband, no advice or engagement as to when Ethan could become more of a risk to others, and of course himself. This should have happened, and it is presumed would have done if they had been

formally recognised as carers. Grace and her husband did notice that Ethan had not exercised, he had stopped taking his medication and he had said goodbye to them both as he was sure that someone was coming to kill him the following day (the day of the murder.) Due to not being given any advice on who to contact, or any signposting to agencies, this information was understandably not shared. Grace and her family were on their own.

9.6 The murder of Grace by her son is a case of matricide and increased knowledge is required across the partnership in relation to this.

9.7 Learning Themes

- There are missed instances when Grace and her husband would have met the criteria for a Carer's Assessment and consideration of this should have taken place.
- Further advice and guidance are required to help carers to acknowledge that they are actually a carer and not just looking after a family member.
- Understanding the risks associated with paranoid schizophrenia and when these risks might have increased.
- Improved interventions required with hard to engage individuals.
- Improved knowledge of matricide across the partnership.

10.0 Recommendations.

10.1 Individual Agency recommendations:

Lincolnshire County Council Children Services.

i) June 2024 Family Justice Board Conference held with the focus of Domestic Abuse and with the permission of the family this included using Bethany & Darren (Local CSPR & DHR, published April 24) as a case study example. This includes the importance of adult services agencies checks during Children's Services interventions being obtained to inform assessments.

ii) Consideration to Lincolnshire Domestic Abuse Partnership (LDAP) for a partnership learning exercise to be shared to promote a learning bulletin of matricide and in LDAP training.

Lincolnshire County Council Adult Social Care - Adult Care and Community Wellbeing. No Recommendations made.

Lincolnshire Partnership (NHS) Foundation Trust.

i) The Trust to offer support and training to location CMHT regarding their statutory duties towards carers, and for the Head of Safeguarding to raise this case with the Legislative Committee, alongside Head of Carer and Relative Experience (HoCRE), for discussion so that any wider Trust actions can be considered.

ii) The Trust to seek assurance that community teams working with patients with Severe Mental Illness are completing crisis, relapse and contingency plans routinely and sharing these with family and carers where appropriate to educate and empower them to recognise warning signs of deterioration/relapse indicators.

iii) The Trust Safeguarding Team to engage with the CMHT's to raise awareness of this case and research/risk factors around parricide that practitioners should be aware of and factor into their risk assessments, and crisis, relapse and contingency plans, which links in with recommendation ii above.

Lincolnshire Police - No recommendations were made.

East Midlands Ambulance Service - No recommendations made.

DWP - No recommendations were made.

GP Practice - Practice and Partners to:
i) Create a strategy for staff to identify patients on the Severe Mental Illness Register and adequately code their carers on the system. The Practice will then create strategies around providing support to these carers for risk assessment and anticipating impending harm and how/who to look out for support. This will be done as a Quality Improvement Project for the Practice, and the senior Partner will himself monitor this project.
ii) For patients with Severe Mental Illness not attending face-to-face appointments, the Practice will encourage them and their carers to schedule video consultations that would help clinicians understand the holistic picture (patient/carers' moods, overall house situation, engagement with services etc)
iii) Discuss this case (and case of Ionela and James) as a learning opportunity with all staff and take feedback from all staff about how to improve services.
LCHS - No recommendations were made.

10.2 A mental health review is being completed in parallel to this DARDR and the panel for the review felt that a recommendation for a multi-agency strategy aimed specifically to understand the reasons for, and the consequences of, patient non-engagement or the patient declining of services, fitted more suitably with the mental health review. Also sitting more appropriately with the mental health review would be one to actively encourage professionals that work within the mental health arena, in the Lincolnshire area, to make use of professional curiosity to enquire into the makeup of households for patients that they are treating. They should also provide a briefing to professionals in relation to the vulnerabilities of the risk of matricide that could occur in relevant and identified households. This report and recommendations have been shared with the mental health review for their consideration.

10.3 Overview Report Recommendations.

Recommendation 1
(i)The Safer Lincolnshire Partnership to seek assurance from Lincolnshire Partnership Foundation Trust (LPFT) and the Lincolnshire Integrated Care Board that following a small scale dip sample of GP Practices operating in the Lincolnshire area that GP Practices are identifying patients that they are treating for severe mental health illness and are on their Severe Mental Illness register within which there may be hidden carers that need to have a carers assessment.
(ii) Lincolnshire Safeguarding Adult Board (LSAB) to implement a communication strategy to inform and remind statutory agencies and professionals to:
• Increase their awareness of carers to refer them on to specialist services and to help them identify themselves as carers
• Re-affirm that there is a choice regarding being a carer and not to assume family members will automatically take on this role.
• Increase their understanding of the 'whole family' rather than solely focussing on the patient and their needs.
• Inform a carer that they can undergo a carers needs assessment for the purpose of their own wellbeing.

Recommendation 2

Lincolnshire County Council delivers its statutory duty to support unpaid carers through the commissioned Lincolnshire Carers Service. The leads within the council will work with the providers and Lincolnshire Domestic Abuse Partnership to ensure understanding of domestic abuse is effectively integrated into service delivery and their activity. This commitment includes incorporating domestic abuse into the carers strategy to provide a framework for addressing the specific challenges carers face as a result of domestic abuse.

Recommendation 3

(i)The Lincolnshire Partnership Foundation Trust should seek assurance that their community teams working with patients with Severe Mental Illness are completing crisis, relapse and contingency plans routinely and sharing these with family and carers where appropriate to educate and empower them to recognise warning signs of deterioration/relapse indicators.

(ii) This assurance should be widened to include the Integrated Care Board carrying out a dip sample a number of GP Practices to ensure that they are sharing advice, knowledge and guidance with families of their patients on their Severe Mental Illness register, on what risks and changes of behaviour should be shared back to them.

Recommendation 4

(i) The SLP should provide a communication to all agencies and professionals the importance that when they are seeking information to assist in risk assessments that they ensure that they make a record of who they spoke to and what department they are working from.

(ii) LPFT should provide a communication to partners and practitioners to ensure that requests for information from LPFT are sent through to them using the correct pathway to seek this information.

GRACE- Glossary

ACCW	Adult Care and Community Wellbeing
ACE	Adverse Childhood Experience
AOT	Assertive Outreach Team
CA	Carers Allowance
CBT	Cognitive Behaviour Therapy
CMHT	Community Mental Health Team
CPN	Community Psychiatric Nurses
CRHTT	Crisis Resolution and Home Treatment Team
CSPR	Child Safeguarding Practice Review
DARDR	Domestic Abuse Related Death Review
DHR	Domestic Homicide Review
DWP	Department Works and Pensions
EMAS	East Midlands Ambulance Service
ESA	Employment Support Allowance
HOCRE	Head of Carer and Relative Experience
IB	Incapacity Benefit
ICB	Integrated Care Board
IMR	Individual Management Review
IPBT	Integrated Place Based Team
LDAP	Lincolnshire Domestic Abuse Partnership
LPFT	Lincolnshire Partnership Foundation Trust
LTT	Lincolnshire Talking Therapies
MHA	Mental Health Act
OCAIRS	Occupational Circumstances Assessment – Interview Rating Scale
OT	Occupational Therapist
PPN	Public Protection Notice
PWP	Psychological Wellbeing Practitioners
SARC	Sexual Assault Referral Centre
SLP	Safer Lincolnshire Partnership
SMI	Severe Mental Illness
UTC	Urgent Treatment Centre