A Domestic Abuse Death Related Review
Executive Summary

Grace
Died August 2023

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(May 2026)

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1. Introduction and participating agencies:

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 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.

1.3 In July 2024, 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 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 that Ethan was not fit to enter a plea and to stand trial in criminal proceedings due to him having a mental disability.

1.4 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.

1.5The 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.

1.6 The participating agencies are:

- Lincolnshire Police
- Lincolnshire County Council Adult Social care
- Lincolnshire County Council Children Services
- Lincolnshire Community Health Services
- Lincolnshire Domestic Abuse Specialist Service (EDAN Lincs)
- East Midlands Ambulance Service
- Lincolnshire Integrated Care Board on behalf of GP Practice
- Lincolnshire Partnership NHS Foundation Trust
- Department for Works and Pension
- East Lindsey District Council

2. Purpose and terms of reference for the review

2.1 In addition to the generic terms of reference set out in the domestic homicide review guidance that describe the purpose of these reviews and this review, the additional and specified areas for examination have been agreed by the panel chair and the panel with their agencies. These 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?
- 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.
- 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?

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

3. Agency contact and information from the review process.

3.1 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.

3.2 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. The GP was notified of his discharge from services.

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

3.4 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.

3.5 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.

3.6 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 for Information and advice in relation to carer being provided to Grace.

3.7 GP referral was received by LPFT 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. 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. 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.

3.8 The outcome of the assessment was to refer Ethan for graded exposure work[1] 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.

3.9 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. 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). 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.

3.10 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. 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. 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.

3.11 On 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. 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.

3.12 A further CMHT referral was received from Ethan's GP on the 13th of October 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. The referral and triage assessment were discussed in a team meeting with

[1] 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.

the outcome being that there was not a role for CMHT and that psychology would be more appropriate.

3.13 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.*'

3.14 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).

3.15 Ethan appeared visibly well and made good eye contact. He requested some support/counselling from mental health team which the Nurse Practitioner agreed to investigate and subsequently made a referral to LPFT.

3.16 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. The assessment identified both of Ethan's parents as carers who tried to motivate him and prevent him from self-neglecting. 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.

3.17 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.

3.18 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.

3.19 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. 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.

3.20 On the 12th of March 2020, CMHT practitioner visits. 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. Agreed to let the GP know of Ethan's discharge and will send Ethan details of other services/support should he need it.

3.21 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.

3.22 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".

3.23 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.

3.24 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.

3.25 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. For both questionnaires Ethan self-scaled himself at moderate to moderately severe symptoms.

3.26 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.

3.27 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. 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).

3.28 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. Only Ethan and his mother were present in the premises. Ethan was arrested on suspicion of murder.

4. Key issues arising from the review

4.1 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.

4.2 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. Practitioners employed 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.

4.3 Grace was in essence Ethan's carer and Ethan outlined 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.

4.4 Although the 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.

4.5 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 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.

4.6 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.

4.6 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.

4.7 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.

4.8 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. 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.

4.9 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. Although Ethan was known by his family to not take all medications prescribed, he appeared to be broadly compliant with his prescription and Grace collected this for him. His prescription had not changed for two decades and did not appear to be effective at reducing his symptoms.

4.10 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.

4.11 The NICE guidance[2] 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

4.12 In the view of the review author, 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.

4.13 As already mentioned earlier in the report 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[3]), 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.

4.14 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).

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

[3] Catanesi Roberto et al (2014), 'Matricide by Mentally Disordered Sons: Gaining a Criminological Understanding Beyond Mental Illness-A Descriptive Study.'

4.15 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.

4.16 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.

4.17 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.

4.18 When a family member moved into the home with Grace, her husband and Ethan a risk assessment was carried out. However, there was a lack of clarity of who was spoken to at LPFT in relation to consideration of any mental health issues in the family home. Equally 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 for 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 the correct pathway to seek this information.

5. Learning themes

5.1 The review has identified key themes which in summary are:

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.

6. Conclusions

6.1 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.

6.2 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.

6.4 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.

6.5 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.

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

7. Recommendations

7.1 There are a number of agency specific recommendations in addition to the following key practice 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 of 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.