Domestic Homicide Review

Executive Summary

Deceased Ionela (51 years) and James (71 years)

Died: August 2019

Independent Panel Chair and Author: Dr Russell Wate QPM
(July 2022)

Publication Version

1. The Review Process

1.1 This summary outlines the review undertaken by the Safer Lincolnshire Partnership Domestic Homicide Review Panel into the murders of Ionela and James, who were residents in their area.

1.2 Pseudonyms are used in this executive summary (which were chosen by their families) to protect the identity of the victims and the perpetrator and those of their family members. Ionela was at the time of her death 51 years old. She was a mother of three and was a psychiatrist who also ran a care and medical business from her home address. She had been a doctor in her home country within Eastern Europe and upon moving firstly to Germany and then to the UK she was employed at various locations around the country as a speciality psychiatrist. Ionela was firstly a locum then employed as a specialty doctor in Lincolnshire for a period of approximately six years. At the time of her death Ionela was working as consultant psychiatrist in the West Midlands area.

1.3 Her partner James was 71 years old at the time of his death. James is described by his family as a very private individual. He loved to travel and was an avid photographer and reader. He had run a software enterprise and moved to the UK from America in 1986, becoming a dual citizen. He has a daughter and a large extended family.

1.4 Criminal proceedings were completed in February 2020 and the perpetrator who is Ionela's eldest son was convicted of the murders of both Ionela and James and sentenced to a minimum 32 years imprisonment.

1.5 The Domestic Homicide Review (DHR) process began with Lincolnshire Police in August 2019 notifying the Chair of the Safer Lincolnshire Partnership (SLP) that the deaths of James and Ionela were being investigated as a homicide and it was confirmed that a DHR would be undertaken. The review was commissioned and the Independent Chair and Author appointed in September 2019.Agencies that had involvement with Ionela, James and the perpetrator were identified and contacted and asked to contribute to the DHR by way of compiling an Individual Management Report (IMR) or by providing information. Twelve agencies have contributed to the DHR.

2 Contribution to the DHR Process

2.1 The following agencies have contributed to the review with in almost all cases the provision of an IMR: Each of the agency authors is independent of any involvement in the case including management or supervisory responsibility for the practitioners involved.

- Lincolnshire Police *(IMR)*
- East Midlands Special Operations Unit (EMSOU) *(IMR)*

- Lincolnshire Partnership NHS Foundation Trust (LPFT) *(IMR)*
- United Lincolnshire Hospitals NHS Trust (ULHT) *(IMR)*
- GP Medical Practice *(IMR)*
- GP Surgery *(IMR)*
- Lincolnshire Community Health Services (LCHS) (*IMR*)
- Student Wellbeing- University *(IMR)*
- East Midlands Ambulance Trust *(Report)*
- Recruitment agency in Milton Keynes. *(Report)*
- Dudley and Walsall Mental Health Trust *(Report)*
- Medical Centre (USA) (*Information)*

2.2 All the agency IMR authors are independent of any involvement in the case including management or supervisory responsibility for the practitioners involved.

3. The Review Panel Members

3.1 DHR 2019F Review Panel Members.

Independent Overview Report Author / Chair Support to Chair	Russell Wate Ian Tandy
Lincolnshire Police	Karl Whiffen Sarah Norburn
Lincolnshire Partnership NHS Foundation Trust	Liz Bainbridge
United Lincolnshire Hospitals NHS Trust	Elaine Todd
Lincolnshire CCGs Primary Care	Rebecca Pinder
Domestic Abuse Project Officer	Natalie Watkinson
Lincolnshire Community Health Services	Gemma Cross
Lincolnshire County Council Children's Services	Yvonne Shearwood
Lincolnshire County Council, Community Safety Strategy Co-ordinator-DA lead	Jade Sullivan
EDAN[1] -Independent Domestic Abuse advisor and Representative	Jane Keenlyside
Independent Mental Health Advisor	Colin Jordan
Suicide Prevention Advisor	Shabana Edinboro
Eastern European Country culture Advisor	Sian Spear

[1] EDAN Lincolnshire Domestic Abuse Service (formerly West Lincolnshire Domestic Abuse Service) is a registered charity. The service covers the county of Lincolnshire, and provides support and assistance to women, men and children suffering, or fleeing from domestic abuse.

University	Julie Spencer
Panel Support Members	
Lincolnshire County Council, DHR Business Support	Teresa Tennant
Legal Advisor to review	Toni Geraghty

3.2 A total of eight meetings were held with the review panel. The first was to consider the information received and agree that a DHR was appropriate and the second was to consider the Terms of Reference and set time frames. In March 2020, the review was paused in line with Home Office guidance due to the Covid-19 Pandemic and was recommenced in September 2020. The Third Panel meeting saw the presentation of the IMR/Summary reports and discussed the findings and the fourth Panel meeting was to present the draft Overview Report and ensure that if fairly represented the information of the agencies that had contributed. The fifth was to agree any proposed changes to the report. The additional meetings followed receipt of Home Office QA. The family of Ionela and James were contacted consistently throughout the process to establish their views.

4. Chair and Author of the Overview Report

4.1 Dr Russell Wate is a retired senior police detective. He has extensive experience in partnership working within safeguarding environments and authoring Serious Case Reviews. He also has extensive experience in conducting Domestic Homicide Reviews; having authored several such reviews across the country as well as internationally. He has no connection with the Safer Lincolnshire Partnership other than previously providing professional and Independent services in connection with two other unrelated Domestic Homicide Reviews. He has completed the Home Office DHR training, the Sequeli and NSPCC training and the Standing Together and AADFA DHR training. He himself trains widely both nationally and internationally on the carrying out of Safeguarding Reviews, including DHRs.

5. Terms of Reference for the Review

5.1 The specific Terms of Reference for this review agreed by the Chair and the panel with agencies and addressed within this report are set out as below.

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

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

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

d) Was appropriate professional curiosity exercised by those professionals and agencies working with the individuals in the case, this includes whether professionals analysed any relevant historical information and acted upon it?

e) Were the actions of agencies in contact with Ionela, James and the perpetrator appropriate, relevant, and effective to the individual and collective family needs and risks identified at the time and continually monitored and reviewed?

f) Did the agency have policies and procedures for Domestic Abuse and Safeguarding and were any assessments correctly used in the case of the subjects? Were these assessment tools, procedures and policies professionally accepted as being effective?

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

h) Were any issues of disability, diversity, culture, or identity relevant? Taking account that the female victim and the offender are of an Eastern European nationality and the male victim is of non-British nationality.

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

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

6. Background Information

6.1 It is not known by family and friends exactly when Ionela and James became a couple, but they had been together for several years (before the perpetrator and a brother came to live in the UK). They met through a dating website. James kept his own house but the two of them did reside together on a regular basis when he was not away travelling. There is nothing to indicate that their relationship was anything other than healthy, a fact which is confirmed by friends and family and also the perpetrator who lived in the household with them.

6.2 Lincolnshire Police have only four reported contacts in relation to the people who are the subject of the review. Firstly, an incident that occurred on the morning of 18th September 2015 when Ionela was involved in a road traffic collision whilst driving her car in an area near Lincoln. She received minor bruising to her knees and attended Lincoln County Hospital. The

further three reports are one of reporting a stolen cycle and the other two are when Ionela is reported missing.

6.3 On 11th September 2015 the perpetrator went to his GP stating he was about to go to university to study games computing. He was on no medications and had no allergies, was a non-smoker and reported no history of any note he requested a letter saying he was fit to study at university, but the GP advised they were not aware of this need and it was not provided. The GP advised him to re-contact the surgery if necessary. He started at University shortly after this.

6.4 On 16th April 2018 the perpetrator contacted a Wellbeing Advisor at the University and explained that he had attempted suicide a few days earlier whilst at home. He said that he had a knife and was going to stab himself, but he could not do it as he was too frightened. He said that he had had other thoughts of suicide and had not completed his last two assignments as 'he did not intend to be alive'. This conversation was discussed with the Clinical Lead Counsellor and it was decided to put the perpetrator "at risk" (At risk was a definition that the university used to mean he was a risk to himself and others) and put him through drop in counselling for a second opinion and to identify what other support he needed. This conversation was a 5-minute appointment, and all procedures were followed, as students who are seen in triage and who discuss risk to themself or others are then offered a drop-in appointment. The perpetrator did not mention that he was going to harm others only himself.

6.5 That afternoon the perpetrator was seen through the 'drop-in' and repeated to the counsellor what he had earlier said about wanting to stab himself. He said he had tried twice on 13th April 2018 and was disappointed with himself that he could not bring himself to do it. He displayed low esteem and hatred for himself. He talked about his family and his parents being divorced when he was young. He discussed his mother Ionela and that she was a psychiatrist and was aware of this suicide attempt and her advice to him was to go off and do something he liked and to get some fresh air. The mental health liaison team was explained to him and he agreed to return for a counselling drop-in the next day. These appointments are 15-minute slots whereby concerns which are raised can be explored in more depth and further.

6.6 Following the recent self-harm/suicide attempt the perpetrator was seen whilst accompanied with his mother Ionela by his GP on 17th April 2018. It is documented that they had a long chat with the GP and a referral was made to the mental health trust crisis centre. Blood tests were also arranged, and he commenced on Mirtazapine (an anti-depressant) which was to be reviewed after 2-3 weeks. Following this `attempt` he had informed Ionela and his mentor at university. The University had advised him to go and see his GP and to see

the Mental Health team. It was documented that he appeared shy and sad throughout the consultation. He told the GP that he had been feeling very sad for quite a significant length of time, but lately things had come to a head and that was what had led to the self-harm attempt, but there was no specific trigger. He also mentioned that he had always felt sad and had little pleasure doing things, he was not sleeping and felt there was nothing positive in his life. The referral letter stated that "*he had a protective factor of his mother, family and friends and the University are supporting probably arranging counselling"*. The GP documented that there was a worry as the perpetrator could be at risk of further deterioration of his mental health and could do with support as soon as possible. The GP also advised him what to do and how to seek help if he had any further self-harm thoughts.

6.7 On the 19th of April 2018 the LPFT Crisis Resolution and Home Treatment Team called the perpetrator as he had been referred by his GP. They were offering him 72-hour support, but he denied any risk to himself and did not want too many services involved at once. The perpetrator was happy with the University support and the counselling support he was receiving. A clinical risk assessment was made which assessed him as no risk to himself or others. At this time perpetrator had decided to interrupt his studies and he would continue with counselling, but not use the rest of the services.

6.8 On the 24th of April 2018 the perpetrator, at a counselling session, stated that he had spoken to the Crisis Team and how 'shocked' he was at them using the word 'depression' about him, saying that he did not like to hear this said about himself. The Anti-Depressants seemed to be taking some pressure off him, although he was concerned about how he will tell his family when he goes to his home country in the summer. He told the counsellor of about two memories that were difficult for him, one being a negative childhood memory and the other a previous romantic relationship. The childhood one was of his mother asking for him to give her money that he had received as Christmas gifts from his grandparents. He was confused about why he had to look after her and why she did not ask her parents for herself. He was concerned about what the counsellor would think about his mother in telling them this. The other memory was summer of 2017 when he 'fell in love' with a girl and how shocked he was that this had happened as he thought 'it never would'. He was then left confused and was convinced that he was not good enough and it was 'terrible as I have had the feelings, but I am still alone'.

6.9 The perpetrator saw a counsellor again on 1st May 2018 and his mood had improved and he had been recently reviewed by his GP. He was working out how 'to live' rather than thinking he should die. He had spoken with his mother who was being very supportive, and he was planning to go to his home country in the summer to see some family and his friends. He did become tearful when thinking about his childhood and the times he felt happy and was wishing for those times again. He was removed from being "at risk". His thoughts for the future included working on cruise ships, which was his dream job, and having a simple life.

6.10 On 4th May 2018 the perpetrator saw his GP and was feeling better and said that the counselling was helping him but did not feel that the mirtazapine was working for him. He was advised to continue the counselling but told to return to his GP if he felt his mood was dropping again. An appointment was also scheduled for early July to check his bloods again.

6.11 He saw a counsellor on 8th May 2018 and was annoyed with himself as he had done nothing in the week to look for his dream job. The counsellor explored why he had such high expectations of himself and then why he procrastinates. The perpetrator revealed his feelings towards his mother to the counsellor and stated she had been both 'intrusive and neglecting' of him and how this had contributed to how he felt about himself.

6.12 Another counselling session on 15th May 2018 saw the perpetrator saying that 'he was having a good day; he did not know why, but it was good!' He reflected on the positive aspects of his life and how 'lucky he was'. The counsellor explored why the perpetrator often puts himself in the place where he is 'either bad, wrong and not good enough or where he should feel lucky and grateful for his life'.

6.13 The perpetrator had his final counselling session on 22nd May 2018 and reflected on all the counselling meetings and he talked about a dream he had which included the girl he fell in love with. He talked about the 'power' the women in his family have had and how the men 'make themselves irrelevant'. The counsellor linked these two ideas and looked at how the perpetrator finds it hard to look after himself or put himself forward in life. He talked again about the work he wanted to do and that he was thinking about doing some voluntary work overseas.

6.14 On 19th November 2018 Ionela had an appointment with her GP. She stated that she worked as a psychiatrist and “everything had come to a head”. She informed the GP that she had three grown up boys and the youngest had just left home to go to university. She said that her partner was working away for three weeks and she was finding her work too much and very stressful and that she was struggling with deadlines. Ionela recognised that she needed to take better care of herself and she was learning to delegate more. She said she was often tearful but had no thoughts of self-harm and she was eating and still getting things done. She realised that she needed some time off work and that her partner was back home at the beginning of December and if her mood did not pick up, she would need more intervention. Time off was agreed as she was not fit for work until 2nd December 2018. She was also diagnosed with a viral upper respiratory tract infection.

6.15 On 3rd December 2018 Ionela had a follow up appointment with her GP and was given more time off work. She said that her exhaustion had improved, and she was feeling better. She was prescribed further anti biotics for her ongoing respiratory infection

6.16 James had organised for the perpetrator to fly to America in September 2018 and obtained for him a work placement at a software company there and he was due to return to the UK on 1st April 2019.

6.17 Whilst in America the perpetrator was admitted to a Medical Centre in March 2019 for one week, this was due to a suicide attempt and depression. He said that he had been depressed for two years but the problem had got worse in January 2019. He cited stresses at university and said he felt that there was no point in life, and he did not like himself very much. He stated that whilst in education he got overwhelmed with everything and revealed that in 2018 he had attempted suicide by coming close to stabbing himself in the heart and neck. After being admitted and assessed he was given medication which seemed to improve his mood.

6.18 The perpetrator on one occasion, spoke to Ionela on the phone which was overheard by a social worker at the medical centre. They were not speaking in English, so the social worker was unable to understand the content of the call but afterwards he said that his mother was not happy with him and she was thinking of flying to America and returning to the UK with him, but he had told her not to. She spoke to him about his education and that she would help him get back on track and finish his course and spoke about the possibility of returning to their home country. He later said that the call with Ionela did not go well, saying that 'it is just annoying dealing with my mother' and 'I don't want her to get so involved with me'.

6.19 On 5th April 2019 the perpetrator was back in the UK and contacted his GP practice for a same day appointment. He saw a GP saying he was home from America where he had been studying for a few months. He stated he was feeling better than he did, but not back to normal. He said that he still had fleeting thoughts of self-harm but managed to distract himself. The GP gave advice to continue taking Venlafaxine (this was not a new drug, but one he had been prescribed for somewhile) and to contact the Single Point of Access for talking therapies that would help him.

6.20 At the end of July 2019 concerns were raised as Ionela had not arrived at her workplace as expected. The police were informed and the known home address was checked for Ionela and found to be empty and it was confirmed by neighbours that she had moved out. After further enquiries and address checks, in August 2019, James' car was located in Aberdeen by the police and the perpetrator was found to be driving it. He then revealed to the officers that he had killed his mother Ionela by strangling her and that he had also killed her partner, James. He said that their bodies were at an address in Lincolnshire and that he had committed the murders overnight a week previously. He gave no explanation at this time as to why he had committed the murders.

6.21 Lincolnshire Police were then contacted to request an address check at the given address and when officers entered the house, they discovered the bodies of Ionela and James. Ionela was lying in the bedroom wrapped up in a duvet and James was lying face down in the kitchen with head injuries.

6.22 The deaths were reported to HM Coroner. The incident in August 2019 was attended and dealt with in the initial stages by Lincolnshire police officers but once the circumstances indicated that it was a potential homicide, the investigation was handed over to East Midlands Special Operations Unit, Major Crime (EMSOU MC) Under collaborative arrangements with other forces in the East Midlands, all homicide investigations are undertaken by the EMSOU MC and a Senior Investigating Officer (SIO) from that unit is appointed to lead the enquiry.

7. Summary Chronology

7.1 The chronology of contact and services provided covers a 6-year period and is detailed for the relevant timescales between 1st January 2015 and 5th August 2019.There was no contact with any Domestic Abuse agencies.

8. Key Issues Arising from the Review / Lessons Learned

8.1 There is nothing in any agency information to suggest that Domestic Abuse existed within this relationship or household. There have been no reported previous domestic incidents involving the subjects of this review. Not one member of their family, friends and colleagues raises any issues of domestic abuse. There have also been no previous police incidents which gave any cause for concern regarding any of the subjects of this review. A line of enquiry that the review author and panel made was to see if there was any unseen financial abuse that the perpetrator may have used on his mother. The review can confirm from enquiries with family and friends that this was not the case. Ionela was keen to be affluent but was under no financial pressure from anyone.

8.2 There was also an absence of recording the name of the individual accompanying the patient regarding the attendances James and Ionela each made at Lincoln Urgent Care Centre or whether in the case of James he had attended unaccompanied. The recording of these details is required by all LCHS practitioners.

8.3 The perpetrator had some recognised mental health issues and suffered from depression but there are no indicators or pre-cursors from his contact with any agency mentioned within this review that he would display violence towards other people. He received ongoing support with his mental health and medication. Neither Ionela nor James ever indicated to anyone to the review panel's knowledge that they feared or were ever in danger from the perpetrator.

His brother described him as having few friends and only ever left the house to go the gym or university.

8.4 In the reports from agencies the perpetrator mentions to professionals attempts he had made to take his own life by suicide. These actions should be regarded by professionals as high-risk behaviour, and threats to suicide should also be considered as not only threats to kill themselves but that this might also involve others.

8.5 Examples of this are when the perpetrator contacted a Wellbeing Advisor at the University and explained that he had attempted suicide a few days earlier whilst at home. He said that he had a knife and was going to stab himself, but he could not do it as he was too frightened. He also attempted suicide whilst in America. As of 2020 the processes at Student Wellbeing have changed since their involvement in 2018 and the service now is very different, as the counsellors do not now amend the Risk Status of a student and this is only done by a qualified Mental Health Advisor. The review author and panel have seen that these changes are in place.

8.6 Research published in 2017[2] supports the review author and panel's finding that professionals need to be aware of the risks to others from individuals who have suicide ideation.

8.7 The University of Manchester's (2017) report on 'Suicide by Children and Young People' carried out a study to 'find common themes in the lives of young people who die by suicide'. They looked at 922 cases of suicides of young people under the age of 25 years. This would have covered the age of the perpetrator. From their research and analysis, they came up with ten common themes:[3] Academic pressure is one of these themes. The report goes on further to define what they mean by academic pressures. *'Difficulties with schoolwork, (perceived) failure to meet own, teacher or parental expectations, current exams, impending exams or exam results, other non-exam academic related stresses (i.e., struggling with assignments, unhappy with course), and any other student-related problem.'* The perpetrator whilst in counselling and in discussion with his GP talks about his academic pressures which fits entirely with this definition. The learning for practitioners is that whilst the perpetrator was under this pressure, he was at high risk of not only harming himself but possibly others, in this case as it turned out to be his mother.

[2] Button, I.M.D., Angel, C. & Sherman, L.W. Predicting Domestic Homicide and Serious Violence in Leicestershire with Intelligence Records of Suicidal Ideation or Self-Harm Warnings: A Retrospective Analysis. Camb J Evid Based Police 1, 105–115 (2017). https://doi.org/10.1007/s41887-017-0009-8

[3] Suicide by Children and Young People. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH). Manchester: University of Manchester (2017)

8.8 The respective GPs are aware that they should record the names of all those who attend with a patient, however although the name of the perpetrator's mother, Ionela, is not documented by the GP when Ionela visited with the perpetrator, the GP had had a lot of previous contact with her and knew that she was the perpetrator's mother, so presumably did not feel the need to record her name.

8.09 No referrals have been made to the Domestic Abuse Multi-Agency Risk Assessment Conference (MARAC) in respect of Ionela and James.

8.10 There are five learning themes arising from this review:

- Professional Curiosity to be used when a client with mental health issues mentions negative comments about a family member. Think Domestic Abuse!
- Professionals to be made aware of the risks of violence to others associated with Adverse Childhood Experiences. The learning in relation to Matricide, with perpetrators who exhibit mental health issues.
- Professionals when dealing with a client who has suicidal ideation and wish to self-harm to ensure they explore risks of physical harm to others from the client.
- Professionals to be aware that the risks of academic pressures have on clients that may self-harm or take their life by suicide. Taking account of the above bullet point that they may also harm others.
- Professionals to be made aware that the watching of very violent media content may lead to increased aggression in individuals.

9. Conclusions

9.1 Ionela told her friends and colleagues that her own mother was a very strong character. The grandma looked after the boys when Ionela came to live firstly in Germany and then in the UK. The review author and panel felt that knowing about what happened in the relationships within this family is an important learning point as it highlights the need for professionals to enquire more around wider familial relationships, as these enquiries tend to be rare. This learning suggests that a greater level of professional curiosity could have been used in this case in order for professionals to have been able to understand what underlies these comments.

9.2 On balance and fairness to the recordings made by the professionals involved there was much more evidence of positive comments made by the perpetrator about Ionela. This is demonstrated by her actions alone for example when he first was considering suicide, the first person he shared this with was his mother, who showed sincere concern, gave him advice and went with him to the first GP appointment. Ionela offered to fly to America to be with him. The perpetrator often mentioned his family were his protective factor. The perpetrator

said to the counsellor *'He had spoken with his mother who was being very supportive,'* The friends and family spoken to all state how well Ionela got on with and how highly she spoke about her three boys. Ionela did state that of all of them she did worry most about the perpetrator being very quiet and often playing computer games.

9.3 The perpetrator was asked by the review author about these negative and positive comments. He said their relationship was good and only the occasional bickering on matters like for example whose turn it was to take the bins out. The perpetrator also agrees there was no conflict between his mother and James. He only had one disagreement with James which was trivial and related to how quick you should smoke a cigar.

9.4 The perpetrator had some identified mental health issues that several agencies were aware of. There are no indicators from his contact with any agency mentioned within this review that he would display violence towards other people. He received ongoing support with his mental health and medication.

9.5 It was revealed at the perpetrator's trial that he was fascinated with extremely violent internet footage of accidents, suicides, and terrorist beheadings. He said on arrest to the officers he wanted to see if he could do it. The murders of his mother and James were pre-meditated and planned by him.

9.6 The watching of extreme violence in individuals like the perpetrator whose feelings of low self-worth which is known by agencies is an area of further exploration with them as a violence preventative measure

9.7 The agency IMRs only raise one recommendation this is for GP practice to ensure they have in place a domestic abuse policy. The GP practice have already actioned this and have confirmed to the review panel that this policy is now in place and operational. This DHR has identified learning and during the analysis and research that the panel carried out, additional learning flowed from this case and makes the recommendations, as detailed below. The implementation of these will assist the Safer Lincolnshire Partnership to deal with similar circumstances in the future, resulting in the improved safety and welfare of victims of domestic abuse.

9.8 Several of Ionela's professional friends have collectively reviewed their conversations and interactions with her to see if they missed any opportunities to consider domestic abuse. They do not believe there was, so they are completely shocked by the deaths. These professional friends have all received extensive continuous and consistent training and awareness of DA.

9.9 The panel did feel that the University was one of the places that could if confidentiality is waivered provide family with information of mental issues of their family member and any

risks to themselves and other associated with it. The university in this case take part in the national University UK scheme of Nominated Person Consent. The panel felt that this is a very good initiative and suggested that the university encourage all students to opt in and when sharing information do share with the nominated person the risk of harm to themselves and others.

9.10 The facts are that Ionela, and James were murdered by the perpetrator. It was pre-meditated murder. Ionela was his mother and James the mother's partner. It is clear to the review author and the panel from the information shared by the families, friends, and colleagues, that Ionela loved and was very proud of the perpetrator and all her sons. Her family have told the review that they all got on well with no problems. The perpetrator has told the review author that although he had a generally good relationship with his mother, and he knew she loved him but, his regard of her was neutral, he did care for her but he neither loved her or hated her. A friend of Ionela went for a meal with her and the perpetrator approximately one week before the murders, although she found no conflict between the two of them, when she said to the perpetrator how lucky he was to have a mum like he had, he just shrugged his shoulders and went outside for a cigarette.

9.11 Further investigations revealed that Ionela and James were likely already deceased, when Lincolnshire Police were undertaking enquiries to locate them at the beginning of August 2019, including attending at the address where they were later discovered deceased, as the perpetrator stated the murders occurred overnight at the end of July 2019.

9.12 There were no issues of disability, diversity, culture, or identity revealed. This is after consideration that Ionela and her son are of an Eastern European nationality and that James is of originally non-British nationality (at time of death he was a dual citizen.)

10. Recommendations

Recommendation 1:
The Safer Lincolnshire Partnership should actively encourage professionals that work within the emotional and mental health arena, in the Lincolnshire area, to make use of professional curiosity. They should also provide a briefing in relation to the vulnerabilities of ACEs and risk of matricide.
a) This is important to ensure that professionals consider risks within family dynamics to individuals from the person they are treating or counselling.
b) This will also help when considering emotional neglect and trauma in individuals.

Recommendation 2:
The Safer Lincolnshire Partnership should ask the Lincolnshire Suicide Prevention Partnership to promote messages in relation to risks to others in particular family members from those individuals who are expressing self-harm and suicide ideation.

Recommendation 3:
a) The Safer Lincolnshire Partnership should ensure that those working with students are fully aware of the risks that academic pressure brings in relation to research highlighting this as one of the key risk factors in suicide and homicide.
b) The Safer Lincolnshire Partnership should ensure that the University encourages all students to 'opt in' and when sharing information do share with the 'nominated person' the risk of harm to themselves and others.

Recommendation 4:
The Safer Lincolnshire Partnership should ensure that the risks of increased aggression involved with watching violent films is communicated in learning bulletins. (Although fully acknowledged that the perpetrator watching violent films wasn't known by professionals until the criminal trial, it is good learning from practitioners to be aware of this risk and vulnerability.)