Domestic Homicide Review

Overview Report

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

Died: August 2019

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

Publication Version (2022)

SECTION ONE-INTRODUCTION

1 Ionela and James

1.1 The review author and panel feel it is very important that at the beginning of this report that they highlight and illuminate the lives of the murdered victims who were completely innocent people. Ionela and James are described by people who knew them locally as a lovely couple and well regarded in the village that Ionela lived in. The names Ionela and James are pseudonyms, these are the names that their families chose for them to be called within this report. The review author and panel would like to convey their sincere condolences to the family and their friends for the murders of their loved ones and for their great help in assisting the review at such a difficult time for them.

1.2 Ionela was at the time of her murder 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 murder Ionela was working as Consultant Psychiatrist in the West Midlands area.

1.3 James was 71 years old at the time of his murder. 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 was a father of one and had a large extended family.

1.4 His Honour Mr Justice Pepperall said in his sentencing remarks in February 2020 that *"Ionela and James were an accomplished couple. Ionela was a much-respected psychiatrist and James was a successful retired businessman with a love of people and travel."*

1.5 This report has been commissioned by the Safer Lincolnshire Partnership (This is Lincolnshire's name for their Community Safety Partnership). They are a statutory partnership which brings together agencies with the aim of reducing crime, disorder, and anti-social behaviour across the county. These agencies work together to improve the safety of residents and visitors by information sharing and partnership activity. One of the key safeguarding roles of the partnership is that of tackling domestic abuse.

1.6 In August 2019 Lincolnshire Police notified the Chair of the Safer Lincolnshire Partnership (SLP) that the deaths of James and Ionela were being investigated as a homicide. They had both been found deceased at an address in Lincolnshire and the perpetrator was Ionela's

eldest son who was 22 years old at the time he carried out the murders. The panel discussed using a pseudonym for him but decided that he was to be named the perpetrator in the report as that was what he was. The notification by the Police was in accordance with the Lincolnshire Domestic Homicide Review Protocol. The Chair of the Partnership Board considered the case, in conjunction with other key agencies that had had contact with the family and concluded that the case did meet the criteria and justification for a Domestic Homicide Review. The Home Office were notified accordingly. In terms of cases where the "circumstances in which the death of a person aged 16 years or over has, or appears to have, resulted from violence, abuse or neglect by –

(a) a person to whom the deceased was related to, or

(b) a member of the same household as the deceased,

Then a review will be carried out with a view to identifying the lessons learnt from the death."

1.7 The SLP held an initial scoping meeting on the 20th of September 2019 and commissioned the review appointing as the Independent Chair and author, Dr Russell Wate QPM, who has compiled this overview report.

1.8 In December 2019, the family of both Ionela and James were sent the Home Office leaflet and informed of their right to have independent advocacy if they wished, highlighting the advocacy charity 'Advocacy After Fatal Domestic Abuse' (AAFDA) to them. The panel queried this time delay and have learnt that this was an old process that has been amended and the partnership has since this time totally changed their processes and always now inform the family at its earliest opportunity and send a second letter to them once a Chair and author has been appointed informing them who this person is. The panel were pleased that this new process is now in place and during communication with the families they were not in the slightest bit effected by this as their focus and concern was with the ongoing criminal process occurring at that time.

1.9 Timescales for completion of review

In order to ensure the review into the circumstances that led to the murders of Ionela and James, was dealt with in a timely manner, the following timescales were agreed by the DHR panel:

- 14th January 2020 - Initial panel meeting with appointed Chair/Author to agree Terms of Reference
- Name of Independent Management Review (IMR) authors to be sent to DHR Administrator
- 28th February 2020 Deadline for submission of completed chronologies

March 2020 - **The** review was paused in line with Home Office guidance due to the Covid-19 Pandemic. Both families of the deceased were informed.

- The review recommenced in September 2020 again both families were informed.
- Deadline for submission of completed IMR/Summary Reports for QA 9th of November 2020.
- Deadline for submission of completed IMR/Summary Reports to DHR Chair by 30th of November 2020.
- 3rd of December 2020 - Panel meeting to present IMR/Summary reports.
- 1st February 2021 Draft Overview Report and action plan circulated to panel members.
- 9th February 2021 Panel meeting presented draft Overview Report.
- 29th March Amended Overview Report submitted to Panel members for comment and shared with both family's the findings from the review. Extensive communication held with perpetrator and review author.
- 14th April 2021 Comments returned from panel and family, and panel meeting.
- Action plan completed by all agencies and returned to DHR administrator.
- Overview report, Executive summary and action plan signed off by all agencies and the Chair of the Community Safety Partnership.
- Report submitted to the Home Office.
- Report amended following response from Home Office QA panel.
- Family informed.

2. Confidentiality

The findings of this review are confidential. Information is available only to participating officers/professionals and their line managers. Pseudonyms are used in the report to protect the identity of the individuals involved.

3. Terms of reference:

3.1 The specific Terms of Reference for this review were agreed by the chair and the panel with agencies and addressed within this report are.

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

3.2 The critical dates for this review have been designated by the panel as 1st January 2015 to early August 2019; however, the panel chair has also asked the agencies providing IMRs to be cognisant of any issues of relevance outside of those parameters which will add context and value to the report.

3.3 These dates were felt to be the most relevant and appropriate in the lives of Ionela and James, it coincided with when they became partners as well as being the time period that the

perpetrator resided in England living with his mother. At the panel meeting in January 2020 the panel discussed the review timeframe, and all agreed the most appropriate time period.

4. Methodology

4.1 The aim of the IMRs is to:

- Allow agencies to look openly and critically at individual and organisational practice and the context within which people were working to see whether the homicide indicates that changes could and should be made.
- To identify how those changes will be brought about.
- To identify examples of good practice within agencies. (Multi- Agency Statutory Guidance for the conduct of DHR's, para 8.2)

4.2 The purpose of this Domestic Homicide Review overview report is to ensure that the review is conducted according to good practice, with effective analysis and conclusions of the information related to the case. To then establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims. To 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; prevent domestic homicide and improve service responses for all victims and their children through improved intra and inter-agency working.

4.3 This overview report has been compiled with reference to the comprehensive Individual Management Reviews (IMRs) prepared by authors from the key agencies involved in this case. Each author is independent of the victim and family and of management responsibility for practitioners and professionals involved in this case. Where IMRs have not been required, reports from other agencies or professionals have been received as part of the review process.

4.4 The overview author has fulfilled a dual role and has chaired the panel meetings in respect of this case. This is recognised as good practice and has ensured a continuity of guidance, context for the review. There have been several useful professional discussions arising and the panel meetings have been referenced and noted appropriately for transparency.

4.5 The review author has also made several requests to agencies and individuals for clarity of issues arising and is grateful for the participation of individuals and agencies throughout. The professionalism of the panel members and the overall quality of the responses has been of a high standard.

4.6 In support of the information received from agencies, the author has also on behalf of the panel engaged with the families of the deceased all of whom live abroad in two different countries. Had in depth and lengthy conversations with work colleagues of Ionela, some of whom are friends of the couple, also other friends, and neighbours. Some of the information within the report will not be, where possible, personally referenced as the author and panel have due regard for any confidentiality and sensitivities required. The author has also had conversations with the perpetrator.

4.7 The author has also sought additional information outside of the date parameters this has assisted in context to examine some background history.

5. Involvement of family, friends, work colleagues and community.

5.1 Domestic homicides are tragic not just for the family, but also for friends and work colleagues. In this case, there has been some impact to the small neighbourhood and community where Ionela had been living. James had his own home elsewhere but did regularly stay within her home, so was known in the neighbourhood. The overwhelming effect that this has had on those individuals can endure and the author is grateful for their participation, frankness, and openness. Equally, their privacy must also be respected and any willingness to assist agencies further must be of their own volition.

5.2 The Home Office leaflet has been sent to family members on at least three occasions and the letter on each occasion that accompanied it also emphasised the opportunity to access an advocate (including the assistance of AAFDA) to assist them in the DHR process in getting their views and feelings across. The review author has also had regular communication with lead members of both families opening up another communication channel if there is anything that they would wish to add, contribute further, or know about the review.

5.3 Key matters pertaining to individuals have been addressed in the respective narrative of this report, but it is acknowledged by the review panel that they are survivors of these tragic murders, not least the family of both of the deceased (including for Ionela's family the loss of the son and their son/brother to incarceration) and this review must be seen as a way forward in supporting others who may have similar needs and obtaining individual and sometimes personal views, may identify intervention opportunities for agencies in future cases.

5.4 As already stated in this report both families have been consulted on a regular basis to ensure ongoing dialogue during the entirety of the review process. Neither of the families had any input in relation to setting of the Terms of Reference and there was also a conscious decision made by the panel, following a request from the families themselves, not to share with them the draft reports. This was in particular due to the families wanting to be left alone as much as possible for them to grieve for their loved ones. The emerging findings of the

review were though shared with the families on a regular basis, and they did provide input for the panel to consider. There have also been really extensive conversations with a large number of work colleagues some of whom although mostly Ionela's friends are equally also friends of James. The perpetrator has also had conversations with the review author and has wanted to help the review in any way possible to assist with the learning.

5.5 Ionela and James are described by people who knew them locally as a lovely couple and well regarded in the village that Ionela lived in.

5.6 James's family told the review that he was a very private individual and wanted the review panel as much as where possible to respect that. He, they said, absolutely loved to travel and was an avid photographer and prolific reader. Everyone who has shared information with the review have said what a lovely, intelligent, and gentle man he was.

5.7 Ionela was highly regarded by not only her family, but also by the many friends and colleagues who spoke to the review chair, she was a loved individual who was successful in her professional life.

5.8 The friends and family spoken to, all say how well Ionela got on with, and how highly she spoke about her three boys. Ionela did say to a couple of friends that of all of sons, she did worry most about the perpetrator being very quiet and often playing computer games. One of her friends in fact told the perpetrator, when out for dinner with him and Ionela just before the murders, how lucky he was to have a mother like Ionela.

6. Contributors to the review:

6.1 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)*

7. Review Panel members

7.1 The following individuals and agencies comprise the DHR panel:

Agency	Panel Member	Role
Lincolnshire Police	Karl Whiffen Sarah Norburn	Senior Investigating Officer DA Coordinator
Lincolnshire Partnership NHS Foundation Trust	Liz Bainbridge Tony Mansfield	Consultant Nurse, Safeguarding Head of Safeguarding
United Lincolnshire Hospitals NHS Trust	Elaine Todd	Named Nurse for Safeguarding Children and Young People
Lincolnshire CCGs Primary Care	Rebecca Pinder	Safeguarding Review Nurse
Lincolnshire County Council	Natalie Watkinson	DA Project Officer
Lincolnshire Community Health Services	Gemma Cross	Named Nurse for Safeguarding
Lincolnshire County Council Children's Services	Yvonne Shearwood	Head of Service, Children in Care
Lincolnshire County Council	Jade Thursby	DA Business Manager
EDAN[1] -Independent Domestic Abuse advisor and VAWG and all victims of DA representative	Jane Keenlyside	Consultant
Lincolnshire CCG	Colin Jordan	Senior Quality Lead Nurse
Lincolnshire County Council	Shabana Edinboro	Senior Public Health Officer

[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.

Cambridgeshire Constabulary, Eastern European Country culture Advisor	Sian Spear	Police Officer
University of Lincoln	Julie Spencer	Head of Student Wellbeing
Admin and Legal support to the Review Panel		
Lincolnshire County Council, Business Support	Teresa Tennant	DHR Administrator
Legal Services Lincolnshire	Toni Geraghty	Assistant Chief Legal Officer
DHR Chair/Author		
DHR Chair and report Author Support to Chair	Russell Wate Ian Tandy	

8. Panel Chair and author of the overview report:

8.1 Dr Russell Wate is a retired senior police detective from the Cambridgeshire Constabulary. He was the Independent Scrutineer of the Cambridgeshire and Peterborough Safeguarding Children and Safeguarding Adults Boards. He has extensive experience in partnership working within safeguarding environments and authoring Serious Case Reviews. He also has extensive experience in conducting Domestic Homicide Reviews; having authored several such reviews across the country as well as internationally. 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.

8.2 Dr Wate has authored several national publications, contributed to several specialist publications, in particular concerning the investigation of child deaths and homicide.

8.3 Dr Wate 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.

9. Details of any parallel reviews:

9.1 The murders of Ionela and James 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 EMSOU and a Senior Investigating Officer (SIO) from that unit is appointed to lead the enquiry.

9.2 The Coroner's inquests were opened in respect of Ionela and James in September and October 2019, respectively. The Coroner Mr. Paul Smith at that time suspended both inquests awaiting the outcome of the court proceedings. Due to this being a criminal investigation and somebody charged and convicted with the murders of Ionela and James he decided that the Inquests were not being resumed into their deaths. The Coroner states that this is normal procedure when criminal charges have been brought and concluded. The Coroner has thereby concluded his functions in this case.

9.3 In February 2020, the perpetrator was convicted of both murders at Lincoln Crown Court and sentenced to 32 years imprisonment.

10. Equality and diversity

10.1 The Panel is satisfied that the IMR authors and this report have addressed, where appropriate the nine protected characteristics under the Equality Act 2010 and in accordance with the terms of reference. Specific comment is made accordingly within the report narrative where appropriate in respect of those characteristics which are.

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race
- religion or belief
- sex
- sexual orientation

10.2 Both the deceased Ionela and James came to live in the UK from other countries. The review has found nothing to evidence they were ever treated differently, unfairly or

discriminated against because of it. The review panel has taken independent advice in relation to any culture issues. This also applies to the perpetrator who himself came to England from an Eastern European country. The independent advice confirms that DA is regarded mostly the same in that country as it is in the UK. For example, DA also includes wider family members as it does in the UK. A difference to the UK, the independent advice states, although not readily applicable to this review, but worthy of note is that DA involving coercive control does not seem to feature in that country.

10.3 Evidence and research has shown that domestic abuse is in the main a crime of gender. There is evidence to support the theory that men commit more acts of domestic abuse than women. Statistically, women are more likely to be victims of domestic abuse. In the year ending March 2019, an estimated 2.4 million adults aged 16 to 74 years experienced domestic abuse in the last year, of which 1.6 million were women and 786,000 were men show that women were more likely to be repeat victims of abuse and men are more likely to be repeat perpetrators (Walby et al, 2004)[2].

10.4 The review panel fully acknowledge and understand the gender aspect in relation to domestic homicide. Later within this report the review panel discuss the issues involving parricide and matricide[3]. This review though is about the homicide of James as well and the review panel treated his murder equally to help with the learning from the case.

10.5 There is also a societal issue in this case which relates to the perpetrator as a young man's attitude to mental ill-health and his difficulty in accepting the preliminary diagnosis of depression. Practitioners need to be aware of the barriers and reluctance to accepting help by young men in general, and the perpetrator in this case, to address their mental health issues. The cultural advisor to the panel did also conclude that with the perpetrator not completing his university course, this would have created for him a cultural impact, on losing face when he returned to his home country. When the cultural advisor was asked further in relation to this point, they agreed that this would also be the case for a person in a similar situation in this country.

[2] Walby, S. (2004). The Cost of Domestic Violence. London: Women and Equality Unit (DTI).

[3] Matricide is the murder of a mother by her son or daughter. The term parricide is defined as the murder of a close relative. Some may confuse "parricide" with "patricide," but the latter term refers only to the murder of one's father. The term "parricide," on the other hand, is used to define the murder of one's parents, siblings, or another close relative.

11. Dissemination

11.1 This anonymised report and executive summary have been prepared by the author for publication in accordance with the policy of the Safer Lincolnshire Partnership at the conclusion of the review process.

SECTION TWO- THE FACTS

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12. Background Information:

12.1 Ionela and her eldest son (the perpetrator) lived together in a village in Lincolnshire. James had his own home elsewhere but did regularly stay within her home, so was known in the neighbourhood.

12.2 At the end of July 2019, Ionela was reported as being missing when she failed to attend work. Lincolnshire Police as part of their missing enquiries circulated across the UK the details of the vehicles that both Ionela and James owned.

12.3 Police officers in Scotland spotted one of these vehicles and spoke to the perpetrator who was 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 when he came to the home the next day. He said that their bodies were at the Lincolnshire address that he and his mother shared 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.

12.4 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.

12.5 Lincolnshire Police commenced a murder enquiry into the deaths of Ionela and James. The perpetrator was arrested, subsequently charged with the murders of his mother Ionela and her partner James. He was convicted of both the murders and received 32 years imprisonment following a Crown Court trial.

12.6 Lincolnshire Police notified the Chair of the Safer Lincolnshire Partnership that the incident was being investigated as a homicide, in accordance with the Lincolnshire Domestic Homicide Review Protocol. The Chair of the Safer Lincolnshire Partnership Board considered the case. In conjunction with other key agencies that had contact with Ionela, James and the

perpetrator it concluded that the case met the criteria and justification for a Domestic Homicide Review in accordance with the Domestic Violence, Crime and Victims Act 2004. The Home Office was notified accordingly. The panel appointed an independent chair and author to conduct the review into the circumstances leading to the murders of Ionela and James.

12.7 On the 20th of September 2019 the Safer Lincolnshire Partnership held a scoping meeting to discuss the case and agree terms of reference, for the review. In accordance with the 2016 Home Office Statutory Guidance for conducting domestic homicide reviews, the circumstances surrounding the murders of Ionela and James, led the Safer Lincolnshire Partnership to conclude that a domestic homicide review would be commissioned.

A "domestic homicide review" means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse, or neglect by.

(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or

(b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death.

12.8 Subsequently Dr Russell Wate of RJW Associates was appointed as the Independent DHR chair and overview author. Further panel meetings have taken place in the interim to structure and agree the terms of reference and a presentation day was held on the 3rd of December 2020, where the respective agencies discussed the findings of their IMR's with the DHR panel. The panel and the quality of the IMRs were greatly assisted by the legal advisor to the panel carrying out a quality assurance exercise before the presentation day.

13. Chronology

13.1 James as already stated earlier in this report arrived in the UK in 1986. With respect to his families wishes asking that a lot of his personal details are kept private, it is fair to say he came to the UK to work, and he was very successful in various occupations and businesses. This included travelling worldwide on occasions for months at a time. Everyone who has shared information with the review have said what a lovely, intelligent, and gentle man he was.

13.2 Prior to coming to the UK, Ionela when she first left her home country, went to work in Germany. The family have told the review panel that they all supported her leaving her home country to progress her career as a doctor. Ionela left her three children in her home country with her mother being the person to primarily look after her three sons. Ionela worked on arriving in the UK, firstly in Birmingham and then in Lincolnshire. The eldest two sons joined

her in Lincolnshire after a few years to pursue higher education. Ionela and her ex-husband although divorced remained good friends.

13.3 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 his 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.

13.4 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.

13.5 Lincolnshire Police have 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 minor abrasions noted required no treatment and therefore she was discharged home. The further three reports are one of reporting a stolen cycle and the other two are when Ionela is reported missing.

13.6 Ionela registered at the GP Medical practice in December 2016 when her previous practice closed. At the time of her murder, she had changed practices and registered at a local surgery because this was where she was living on 1st July 2019 but was never seen by them.

13.7 The perpetrator registered at the GP Medical Practice also in December 2016 as his previous surgery where he had originally registered in September 2015 had closed. At the time of the murder of Ionela and James he had changed practices and registered at the same local surgery as Ionela because this was in the area where he was living but was also never seen by them.

13.8 On the 16th of 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 at the University, 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.

13.9 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.

13.10 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.

13.11 On the 19th of April 2018 the LPFT (mental health provider) 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.

13.12 On 24th 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 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'.*

13.13 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.

13.14 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 asked 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.

13.15 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.

13.16 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'*.

13.17 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.

13.18 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.

13.19 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 antibiotics for her ongoing respiratory infection.

13.20 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.

13.21 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 from 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.

13.22 The perpetrator on one occasion, spoke to Ionela on the phone which was overheard by a social worker at the medical centre. They did not speak 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'.*

13.23 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, telling them 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 could help him.

13.24 On the same day, 5th April 2019 Ionela contacted the GP practice to make a same day appointment. She stated that she was feeling well but had decided to reduce her working hours and she was now part time and was feeling very positive about this. She also informed the GP that she was just about to go on a family holiday.

13.25 At the end of July 2019, an Operations Director for a recruitment agency based in Milton Keynes, contacted Lincolnshire Police to report their concern for one of their agency doctors, Ionela.

13.26 They outlined what their concern was; Ionela was a Consultant Psychiatrist who had been working in the West Midlands and she had left there on the Friday, wishing a colleague a good weekend, and said that she would see her again after the weekend. She did not turn up for work on the Monday morning which was deemed very out of character and the caller said that they were concerned because Ionela was not answering any calls or emails.

13.27 They gave her address as one in Lincoln and a police officer attended the address later that day and reported that the house was empty. The neighbours confirmed that Ionela had moved out a few weeks beforehand and had left no forwarding address. The caller was updated about this address check and advised to call again if she found out anything else.

13.28 Lincolnshire Police were then contacted again in early August 2019 by West Midlands Police (WMP) as Ionela had also been reported as missing to them by the recruitment agency. WMP requested that Lincolnshire Police re-attend the home address in Lincoln. The details for Ionela's vehicle, a Dacia car were passed over, although the vehicle was shown as being registered to the Lincoln address, it was shown as insured to an address in a different area of Lincolnshire and revealed James as being a named driver.

13.29 Later that day a police officer attended and checked the address on the insurance details but got no response. A Police National Computer (PNC) marker was then placed on the vehicles that Ionela had access to, which included her partner, James's car, a Toyota car. The Automated Number Plate Recognition (ANPR) checks showed that this vehicle had been travelling around the country since the beginning of August 2019. Over the next few days Lincolnshire Police and West Midlands Police conducted several different address checks for Ionela and James, but to no avail.

13.30 At 10:05 am on the following Monday two police officers saw the Toyota car parked in a car park at Aberdeen Airport with one male occupant reclined back on the driver's seat. The officers spoke to the man, who turned out to be the perpetrator of the homicides. He was asked and provided them with his name, date and place of birth, nationality, and address. He also provided his mother Ionela's name and address as well as that of her partner James.

13.31 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 when he came to the home the next day. He said that their bodies were at the Lincolnshire address 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.

13.32 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.

13.33 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.

SECTION THREE – OVERVIEW AND ANALYSIS

14 Overview:

14.1 There is nothing in agency information to suggest that domestic abuse existed within this relationship or household prior to the perpetrator killing his mother and her partner.

14.2 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.

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

15. Analysis:

15.1 This analysis seeks to explore the terms of reference in general terms as opposed to referencing each of them specifically, other than where this has relevance to learning.

15.2 A mandatory referral was made by the Lincolnshire Police Professional Standards Department (PSD) to the Independent Office for Police Complaints (IOPC) in relation to the visit to the home within which the murders took place. The IOPC directed that there should be a local investigation. This was completed in June 2020 and the report sent to the IOPC. In July, the IOPC confirmed that there would be no resultant criminal or disciplinary proceedings. It is clear to this review that the murders had occurred prior to Ionela being reported missing to the police.

15.3 There have been no reported previous domestic incidents involving the subjects of this review until the domestic homicides. 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.

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

15.5 There were though at least four instances when the perpetrator made a negative comment in relation to his mother. Including this information in this report might be seen as the perpetrator victim blaming. This is not the view of the panel and not corroborated by their findings from their analysis of the case or conclusions in this report, but they are facts relating to comments that agencies recorded that he made. In fact, the perpetrator himself told the review author he had no negative feelings towards his mother.

- The first instance was when talking to the counsellor in university it is recorded that he said, '*A childhood memory was of his mother asking for him to give her money that he had received as Christmas gifts from his grandparents as a child. 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 second time in counselling *'the perpetrator revealed his feelings towards his mother and where she had been both 'intrusive and neglecting' of him and how this had contributed to how he felt about himself*.
- The third was time was when he said in counselling *'He talked about the 'power' the women in his family have had and how the men 'make themselves irrelevant'*.
- The fourth time whilst in America he said following a telephone conversation with his mother, *'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.'*

15.6 Ionela told her friends and colleagues that her own mother was a very strong character. The grandma looked after the boys when Ionela went to live firstly in Germany and then in the UK. The review author and panel feel 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.

15.7 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, for example when the perpetrator was first 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 her sons she did worry most about the perpetrator being very quiet and often playing computer games.

15.8 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.

15.9 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.

15.10 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.

15.11 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.

15.12 In the case of the perpetrator one of his adverse childhood experiences is parental separation and this happened in his life when his mother Ionela divorced his father and left the family to move firstly to Germany and then the UK. This adverse childhood experience is further evidenced by an article in the BMJ 2017; 357:1334 which states *'Established risk factors for suicide attempts and suicidal ideation during adolescence and young adulthood include childhood adversities, such as abuse and neglect and growing up in a dysfunctional household. Childhood adversity is usually denoted by a range of indicators, such as parental separation or divorce.'*[4] This fits the experience of the perpetrator in this case.

15.13 In this case the perpetrator committed acts of extreme violence, and research in relation to ACEs carried out in Wales states that: *'research has explored the impact of ACEs in more vulnerable groups (e.g., the homeless population, the offender population and refugee population). This provided a strong evidential link between early childhood experiences, vulnerability and crime, which highlighted that ACEs could increase the risk of individuals being exposed to violence, either as a victim or a perpetrator, or engaging in behaviours associated with violence*.'[5]

15.14 The review author and the panel believe that increasing professionals' knowledge of ACEs will be useful to them in understanding this as a risk factor in cases of domestic abuse.

[4] https://www.bmj.com/content/357/bmj.j1334 (accessed January 2022)

[5] https://www.violencepreventionwales.co.uk/research-evidence/adverse-childhood-experiences-aces

15.15 Research published in 2017[6] 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.

> *'This study provides the most precise comparisons yet between the presence of early warnings of suicide or self-harm in a person's record and the likelihood of their committing an act of deadly domestic violence. By dating the entry of a suicidal behaviour warning, the study shows that such warnings are three times more likely to have been made prior to cases of any deadly violence than among offenders not charged with such crimes, and five times more likely for those charged specifically with murder, manslaughter or attempted homicide.'*

15.16 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.

15.17 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.

15.18 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.

15.19 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:[7]

[6] 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

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

10 common themes in suicide by children & young people
Family factors such as mental illness
Abuse & neglect
Bereavement & experience of suicide
Bullying
Suicide-related internet use
Academic pressures, especially related to exams
Social isolation or withdrawal
Physical conditions that may have social impact
Alcohol & illicit drugs
Mental ill health, self-harm & suicidal ideas

15.20 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 and her partner.

15.21 As already mentioned earlier in the report, this domestic homicide is a case of matricide. A study by Roberto Catanesi et al (2014), 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', 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. However, mental illness is not the only variable related to matricide and taken alone, is not enough to explain the crime. Several factors in the history of the mother and son need to be probed, especially how their relationship developed over the years. The peculiar dynamics of the mother-son relationship and the* unique *personalities and life experiences of both subjects are the real key to cases of matricide.'*

15.22 In the study by S Singhal, A Dutta (1992). 'Who commits matricide? It states: *'The matricidal groups' mothers were found to be more over-involved, tolerant, affectionate.'* The perpetrator describes his mother to professionals in this manner.

15.23 In an article by Holt, A. (2017). *Parricide in England and Wales (1977–2012): An exploration of offenders, victims, incidents and outcomes*. It states: *'that parricide refers to*

the killing of one's mother or father, whether through a single violent incident or a culmination of abuse and/or neglect.' This article presents the first national analysis of parricide in England and Wales. It draws on data from the Home Office Homicide Index to examine all recorded cases of parricide over a 36-year period and examines the characteristics of offenders, victims, incidents and court outcomes. '*the most frequently-used code in parricides is 'Irrational act (carried out by insane or disturbed individual)', which is used in almost a quarter of parricides (24%). This code is used to denote a homicide presumed to be the product of mental disturbance and its usage in parricides is almost six times higher than its use in homicide generally (ONS, 2014).'* The report author and the panel fully accept the findings in the criminal court that the perpetrator committed the offence of murder rather than his manslaughter defence of having a disturbed mind at the time of the killings. This analysis though helps professionals to understand irrational acts in domestic abuse and homicide cases.

15.24 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 fits with what the perpetrator has stated to professionals treating him for his mental illness.

15.25 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.

15.26 There are conflicting opinions amongst academics, psychologists, and psychiatrists in relation to the correlation of watching violence and committing violence. However, the Media Violence Commission of the International Society for Research on Aggression (ISRA) in its 2012 report on media violence said, *"Over the past 50 years, a large number of studies conducted around the world have shown that watching violent television, watching violent films, or playing violent video games increases the likelihood for aggressive behaviour[8].'*

15.27 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. The perpetrator in discussion with the author states that for him, the watching of extreme violence did not influence him to carry out the murders.

[8] Media Violence Commission, International Society for Research on Aggression (ISRA). Report of the media violence commission. Aggress Behav. 2012; 38:335-341

15.28 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.)

15.29 Ionela visited her GP on a couple of occasions towards the end of 2018 telling them of the stress she felt from the workplace. Although Ionela was quite clear what she felt her problems were, the question of DA was not asked. The son was in America at this time and James was abroad for a period as well and this may have meant that the GP did not think it was necessary.

15.30 The terms of reference for this review asks the question seen at 3.1 page 5 in this report, "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?" This was covered by responses to the IMRs, and the panel were assured by the agency replies that professionals involved in this case had the appropriate level of knowledge and training to fulfil the obligations in relation to preventing domestic abuse.

SECTION FOUR – CONCLUSION

16. Conclusions:

16.1 As already described in this report Ionela was a highly regarded and loved individual who was successful in her professional life. James was described by everyone as a very amiable, intelligent, and likeable individual.

16.2 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 nor 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.

16.3 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 murders These professional friends have all received extensive continuous and consistent training and awareness of DA.

16.4 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.

16.5 As recorded in Mr Justice Pepperell's sentencing remarks, it is unclear why the perpetrator chose to murder his mother Ionela and her partner James. The defence that he committed the murders in the grip of a psychotic delusion were rejected. He had minor grievances with Ionela but not sufficient to explain his actions and he had no reason to harm James. It was accepted he had become depressed over the preceding 18 months before the end of July 2019 and things had gone wrong for him at university. The perpetrator is clear with the report author that the reason he committed the murders is because of his mental health issues. He stressed to the author that his enduring low mental health wasn't due to any agency or individual, but himself, because he refused to fully accept the help and treatment offered.

16.6 The decision by the Safer Lincolnshire Partnership to conduct a domestic homicide review under the circumstances as presented by this case was a mature and robust decision and made in accordance with the 2016 Home Office Guidance. The robust application of the guidance is a particularly positive aspect of the manner with which the Safer Lincolnshire Partnership examines the multi-agency statutory roles, responsibilities, and its overall safeguarding principles.

16.7 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.

16.8 One of the family members after reviewing a draft of this report, which they were supportive of, asked if the panel consider an additional learning theme. '*That professionals provide general family awareness raising, of the risks of physical harm where family members are self-harming and have suicide ideation. This could be specific to a particular family if confidentiality by the individual is waived.'*

16.9 The panel discussed this point and concluded that dealing with the circumstances of this particular DHR, Ionela was a forensic psychiatrist and would have a high level of knowledge and experience of the harm risks associated with mental health issues. The review panel confirmed with the Mental Health Trust that she had worked for, that Ionela had an extensive knowledge and up to date training in DA and that she would recognise it in her own personal circumstance. The review author and panel following further discussion, felt that being able to recognise DA in one's own personal situation, is very different to acknowledging it and equally acting on it. Although the review author and panel have no real idea of knowing how Ionela would have reacted in her personal circumstance, this would have been the situation for Ionela, despite her high level of knowledge and training.

16.10 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, are part of a national university UK scheme of 'Nominated Person Consent.' The university, student wellbeing information for parents and guardians, contains the following information:

> *'**Nominated Person Consent:** At enrolment, all students are given the opportunity to opt-in to a 'Nominated Person Consent'. This will give the Student Wellbeing Service consent to contact their nominated person, this can be their parent, guardian, or a friend in situations which are not an emergency, but where they have serious concerns about a student's wellbeing. It is important to recognise that this opt-in does not allow parents, guardians or a nominated person to seek information about a student's academic studies, or their day-to-day activities and will only be used in relation to concerns about a student's wellbeing'*
>
> ***If a student chooses to opt in**: If a student has opted-in to the Nominated Person Consent and is the subject of a wellbeing concern, the Student Wellbeing Team will*

undertake an assessment of the situation and will then have the option to make contact with a student's Nominated Person to discuss any concerns and a plan of action to support the student.

16.11 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 students nominated person the risk of harm to themselves and others.

SECTION FIVE –RECOMMENDATIONS

17. Recommendations:

17.1 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.

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.)