7 Point Briefing

Grace

POINTS TO CONSIDER

- Reflect on the findings and discuss the implications for your practice.
- Outline the steps you and your team will take to improve practice in line with the recommendations.

Further reading

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

BACKGROUND

Grace (71 years) and the perpetrator (Ethan 50 years) were mother and son. They lived together with the father in the family home. He had in essence, other than for a short period years earlier, always lived with them.

Ethan suffered from paranoid schizophrenia and increasingly never left the family home. Grace was his carer. He was under the care of his GP and also for long periods of time LPFT for his mental illness.

Ethan used a knife to stab his mother and murder her. Due to him being unfit to plea a fact finding hearing took place where it was found he committed the act of killing Grace.

SAFEGUARDING CONCERNS

The review found that no carers assessment took place for Grace and also that her and her husband were not advised on what risk signs to look out for in Ethans behaviour.

The review focussed on the following areas.

• missed opportunities for carers assessment.
• Understanding the risks associated with paranoid schizophrenia for family members
• Partnership knowledge of matricide
• Improved interventions with hard to engage individuals.

WHAT TO DO

- Always consider who is caring for a client who has a serious mental illness.
- Ensure you consider if a carers assessment is required.
- Share important risk and contingency plans with them.
- Identify risk and act on it in a multi-agency -holistic way.

WHY WAS THE REVIEW CARRIED OUT?

The Safer Lincolnshire Partnership carried out a statutory **Domestic Abuse Related Death Review** to identify learning for agencies and practitioners working in areas involved in this case.

WHAT NEEDS TO CHANGE

- LPFT and GP practices to check their serious mental illness register and ensure there are no family carers that require an assessment.
- Ensuring that professionals give family members advice on risks involved with changes in behaviours for example when the person with a mental health illness becomes non-compliant with their medication.
- Better knowledge of matricide across all professionals.
- Improvements to recording practices when information is being sought, who was asked and in what department do they work in.
- LPFT to provide a correct pathway to obtain information about clients that they are or have been working with.

FINDINGS & RECOMMENDATIONS

- There was no instances of DA within this family prior to the fatal stabbing.
- Ensuring that a carers assessment is considered when it is apparent that a family member takes on a carers role for an adult.
- Lincolnshire County Council Public Health department to review the carers strategy and work with the Lincolnshire Domestic Abuse Partnership to ensure that it includes domestic abuse as part of the carer's strategy.
- The need to actively encourage professionals that work within the mental health arena, in the Lincolnshire area, to make use of professional curiosity to enquire into the makeup of households for patients that they are treating.