Overview Report:

Domestic Homicide Review in respect of the death of 'Margaret' in July 2023

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COMMISSIONED BY TELFORD & WREKIN SAFEGUARDING PARTNERSHIP

DATE: 10TH JUNE 2025

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Foreword by the Chair of the Review

The Chair and Panel would like again to pass on their condolences to Margaret's devastated family.

Margaret's daughter has already paid tribute to her in a statement issued through police, part of which has been attached below.

"My mom radiated love and lit up the world around her with joy and laughter. She was a wonderful wife, sister, daughter, aunt and grandmother who surrounded her family with happiness.

She was a mother you could only dream to have, a friend to many and a tremendous role model in her nursing career. "For us, life will never be complete without her, we will continue to miss her every second of the day."

Jan Pickles OBE Chair and Author

Acronyms used and a glossary of terms.

Term	**Acronym**
Mental Health Homicide Review	MHHR
Telford & Wrekin Safeguarding Partnership	TWSP
West Mercia Police	West Mercia Police
Victim's Support Homicide Team	VSHT
MPFT Midlands Partnership University Foundation NHS Trust	MPFT
Improving Access to Psychological Therapies now known as NHS Talking Therapies	IAPT
Emergency Duty Team	EDT
Crisis Resolution and Home treatment Team	CRHT
Mental Health Act Assessment	MHAA
Approved Mental Health Professional	AMHP based in Adult Social Care
Community Treatment Order also known as a Community Treatment Plan	CTO/ CTP
Cognitive Behaviour Therapy	CBT
Support Time Recovery	STR

Early Intervention in Psychosis Team	EIPT
West Midlands Ambulance Service University NHS Foundation Trust	WMAS

1. The circumstances that led to this review

This report of a domestic homicide review examines agency responses and support given to 'Margaret', a resident of Telford and Wrekin until her death in July 2023.This review ran in parallel with a Mental Health Homicide Review (MHHR) commissioned by NHS England and which is yet to be submitted in relation to Margaret's death.

In addition to reviewing the various agencies that were involved in her life, the Review will also examine the more distant past to identify any relevant background or trail of abuse before the homicide, and whether and what support was accessed by Margaret within the community and whether there were any barriers to her in accessing that support, or perhaps other agencies whose support Margaret was unable to access. This Review intends to take a holistic approach in establishing to what degree those agencies charged with protecting Margaret did so. In addition, where the Review believes that agencies could perhaps have better protected Margaret it will seek to identify those gaps and suggest possible appropriate solutions to make the future safer for all.

Margaret was killed by Jack, her son. Margaret died from blunt force trauma after being hit by a claw hammer. Just after his manslaughter of his mother, Jack had attempted to kill his father, who sought to protect himself by locking himself in the bathroom in the house and called 999. He did, however, still sustain serious life changing injuries.

Following the attack on his parents, Jack was held in a secure unit, he was admitted on Section 2 Mental Health Act 1983[1] to a medium secure unit. He was deemed 'fit for interview' by his treating psychiatrist. In Early October 2023, Jack was arrested, and the Crown Prosecution Service authorised that Jack be charged with the manslaughter of his mother and assault on his father Jack was detained on Section 3 [2] until his arrest in October 2023. The following day Jack was remanded in custody by Stafford Crown Court. Jack had earlier refused to leave his cell in the prison and therefore was not present for his hearing. In his absence, the Judge remanded Jack into custody and a Plea Hearing' was set for the beginning of November 2023. In January 2024 a decision was made that he was fit to stand trial and a trial date for July 2024 was agreed.

However, trial was avoided when Jack pleaded guilty to the manslaughter of his mother by reason of 'diminished responsibility' and the attempted manslaughter of his father at Stafford Crown Court in March 2024. At that hearing he was sentenced to a 'Section 37

[1] Section 2 of the Mental Health Act (MHA)1983 allows for the hospital detention of someone for up to 28 days to assess and treat a mental disorder:
[2] Section 3 of the Mental Health Act allows a person to be detained in a hospital for up to six months to receive treatment for a mental disorder. It's also known as a treatment order.

Hospital Order' with a 'Section 41 Restriction Order' under the Mental Health Act [3] later attached in April 2024.

This review will consider agencies' contact and Involvement with Margaret and Jack from January 1st, 2021, to Margaret's death by manslaughter in July 2023, a period of nineteen months. This is due to the belief that although Jack did not have contact with agencies prior to late May 2021, the Panel believe that the ending of a relationship with his partner in March 2021, and his learning at some point after that he had a child from a previous relationship to have been particularly traumatic for him and may have contributed to the onset of the deterioration of his mental health. The family state that at the first incident which led to his inpatient care he presented with command hallucinations within psychosis and subsequent extreme violent and threatening behaviour.

The key purpose for undertaking a DHR is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. For these lessons to be learned as widely and as thoroughly as possible, professionals in all relevant fields need to be able to understand what happened, why, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

1.1. Timescales

Following Margaret's manslaughter, West Mercia Police immediately referred the case to the 'Telford and Wrekin Safeguarding Partnership', and it was agreed that the manslaughter met the criteria for a Domestic Homicide Review. At the beginning of September 2023, this Review was commissioned to run in parallel with a Mental Health Homicide Review (MHHR). West Mercia Police in November 2023, advised that the review process should await the outcome of the trial. An initial meeting of the Review Panel was held in January 2024, to inform all agencies of the reasons for the delay to the review process. It was agreed by the Panel that the process would be paused until the completion of the Criminal Justice process. In May 2024 following the sentencing of Jack, the DHR Panel met, and this Review commenced. The Individual Management Reviews were requested to tie in with the completion of the draft MHHR report for August 2024.

1.2 Confidentiality

The findings of each review are confidential. Information is available only to the participating officers and professionals and their line managers. In order to protect the identity of the victim the family were asked to choose pseudonyms by which they would be known within the Review.

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[3] https://www.mind.org.uk/information-support/legal-rights/courts-and-mental-health/section-37-41/
A Section 37/41 hospital order with restrictions is an indefinite order. It is given by a court when a person has a serious mental health problem and instead of going to prison, they should be in a hospital for treatment. The Section 37 is a "hospital order" and the Section 41 is a "restriction order". The restriction order means that the person cannot be discharged from the hospital unless the Secretary of State for Justice or a Tribunal says so.

Margaret was aged 58 years old at the time of her manslaughter. She was married and the mother of two adult children and identified as White British.

Jack her son, was aged 31 years old at the time of the death of his mother and identified as White British; he had received treatment for ongoing mental health problems and had presented with a range of paranoid delusions and command hallucinations. Post sentence Jack was diagnosed as suffering from paranoid schizophrenia.

1.3 Terms of Reference

The Terms of Reference in draft form were shared with the family in July 2024.

Aims and Purpose

The aim of this review is established in the Multi-agency Statutory Guidance in the Conduct of Domestic Homicide Reviews :

Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

Apply these lessons to service responses including changes to the policies and procedures as appropriate;

Prevent domestic violence and homicide (and suicide) and improve service responses for all domestic violence and abuse victims and their children by developing a coordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.

Contribute to a better understanding of the nature of domestic violence and abuse; and highlight good practice.

As well as examining agency responses, statutory guidance requires reviews to be professionally curious and find the “trail of abuse”. The narrative of each review should “articulate the life through the eyes of the victim… situating the review in the home, family and community of the victim and exploring everything with an open mind” (Home Office, 2016).

Panel Membership

Jan Pickles has been appointed as the Independent Chair and Author for this review and will be working alongside Anne Richardson who is undertaking a Mental Health Homicide Review on behalf of NHS England. The panel to include representatives from the following agencies:

1. West Mercia Police
2. Primary Care
3. Telford & Wrekin Safeguarding Partnership

4. Midlands Foundation Partnership trust
5. Telford and Wrekin Adult Social Care

Timeframe and Scope

The review will consider agency involvement with the victim from suggested from the scoping January 2021 to July 2023.

The review should also consider relevant information relating to agencies' contact with the individuals outside that time frame as it impacts on agency involvement in this case.

Agencies involved

The following agencies who have had significant contact are asked to contribute a proportionate IMR and chronology to the review:

1. Primary Care
2. West Midlands Ambulance Service
3. Adult Social Care
4. Housing Trust
5. Midlands Partnership Foundation trust
6. West Mercia Police

The following agencies are asked to provide briefer information reports to the review

- Department of Work and Pensions

Equality and Diversity

The review will consider all protected characteristics, as defined by the Equality Act 2010, as well as additional vulnerabilities from an intersectional perspective. At the outset, the panel has identified that matters of mental health, drug and alcohol misuse, sex and gender need to be considered.

Key Lines of Enquiry

The review should address both the 'generic issues' set out in the Statutory Guidance, and the following specific issues identified in this particular case.

IMR authors to analyse key episodes in their service responses, including assessment of:

- Were agency actions in line with agency policy and best practice guidance.
- How effective were agencies in identifying and responding to the needs and risks faced by the victim?
- What risk assessments were used by each agency, were attempts made to triangulate this risk assessment with information from other involved agencies?
- Where attempts made to involve the family and others in the assessment of risk?
- What resources were family members offered in order to manage the risks identified?
- Did your agency have an up to date risk management plan and was this shared with other agencies and those at risk such as the family.

- How effectively did services identify and respond to disclosures of, or indicators of, domestic abuse?
- What barriers to disclosure and help-seeking were experienced and how did agencies respond to overcome these barriers?
- How effectively did services work in partnership to support and protect the individuals concerned? To include the rationale for, and effectiveness of, referrals, to other agencies.
- What good practice can be identified?
- How can agency policy and services be improved?
- What lessons can be learnt to prevent harm from domestic abuse in the future and how will the changes be achieved?
- What system-wide, multi-agency recommendations do agencies consider need to be made?

The review may adopt further lines of enquiry as further information becomes available.

Engagement with those directly affected

The review will sensitively attempt to engage with family members, in keeping with the BASPCAN Best Practice Guidance (2012) and the Statutory Guidance which states that, "Their contributions, whenever given in the review journey, must be afforded the same status as other contributions" (Home Office, 2016). The Independent Chair will be responsible for this engagement with the support of the panel.

The Chair will ensure that the family is offered advocacy services from the Victim Support Homicide Team and /or Advocacy After Fatal Domestic Abuse.

The Panel will identify which family members, friends, employers/colleagues and informal networks to be invited to participate in the review. This requires sensitivity as the both the perpetrator and one of the victims worked for the same employer.

Practitioners who were directly involved in the case should, wherever possible, have the opportunity to directly contribute to the review. The panel will consider the means by which this could happen.

Specialist and Legal Advice

The review may seek specialist and legal advice as deemed necessary by the panel.

Parallel proceedings

The coronial process is currently on hold until after the criminal trial has taken place. A Mental Health Homicide Review will also be taking place alongside the DHR and wherever possible work streams will be aligned to minimise impact upon professionals and family members.

Confidentiality

All information discussed is strictly confidential and must not be disclosed to third parties without the agreement of the responsible agency's representative and the Chair.

All agency representatives are personally responsible for the safe transfer and safe keeping of all documentation that they possess in relation to this DHR and for the secure retention and disposal of that information in a confidential manner.

Media Handling and Publication

No information will be made public until the end of the DHR process and when the report has been authorised for publication by the Home Office. All media enquiries should be directed to Safer Telford & Wrekin (Community Safety Partnership) who is responsible for the final publication of the report and for feedback to family members and the media. Affected agencies are responsible for timely feedback to staff that have been involved throughout the process of the review.

1.4 Methodology

Following the decision to undertake this DHR in September 2023, all agencies were instructed to secure any records relating to Margaret or Jack. At the time of the decision being made it was recognised that there had been limited contact and information held by services.

Following the scoping of sixteen agencies in Telford and Wrekin it was agreed that five agencies held relevant information. Independent Management Reviews were requested from agencies, once completed by a member of staff who were not involved with the case, they were authorised by a responsible officer in each organisation

Information from Margaret's family, best friend and her close colleague were included in the review as outlined below.

1.5 Involvement of Margaret's family and close friend

The chair was appointed in October 2023 and informed that a 'Family Liaison Officer' and an advocate from the 'Victim's Support Homicide Team' (VSHT) were already supporting Margaret's husband and adult daughter. The Chair wrote to Margaret's husband expressing the Panel's condolences and providing leaflets on the DHR process prior to sentencing.

Following sentencing Margaret's husband and daughter met in July 2024 with the DHR Chair, the MHHR author and the VSHT advocate that had been supporting them. The family advised the Chair that Margaret's 'close friend and confidant' would have relevant information for the reviews.

The terms of Reference were shared with Margaret's family, and they were invited to meet the Panel. After each Panel meeting the Chair updated the VSHT Advocate who in turn updated the family on the DHR process.

Prior to the submission the Review was shared with the family for a two month period for them to comment and make any necessary amendments. They stated the DHR

" reflected their thoughts and feelings and captured our and was a true reflection of the time period 2021 to 2023."

In August 2024, the Chair of the DHR and the MHHR author met virtually with Margaret's long standing best friend who had the role of 'her confidante' according to her family.

Margaret, a private person by nature had discussed her concerns about Jack's care and management with her

1.6 Involvement of Margaret's employer

Margaret qualified as a Nurse in the Army and worked in a local nursing home for the elderly and frail. In September 2024 the Chair sought permission from the family to speak with her employer and the nominated a colleague who Margaret had worked with for seven years and who were referred to in the home as the 'dream team'. Margaret was held in high regard and cared for by residents and colleagues. In the staff office they have a photograph of her and often state "Today we are going to do what Margaret would want us to do". Her colleague believed Margaret brought the best out in those she spent time with staff and residents alike. Margaret was a private person but shared the concerns she had about her sons mental health and his admission into hospital with her colleagues, they accommodated shift changes to enable her to visit Jack, noting she would start a 12 hour shift after walking with him in the hospital grounds. Margaret did share with another colleague that she was frightened of what was happening and that she did not know where to go for help. At no point did she use the term domestic abuse and did not see Jack's behaviour in that light. Margaret was described an intelligent professional who on a daily basis used risk assessment processes to manage the elderly frail. She was adept at managing risk in her professional role, and her colleague believes these skills would have been familiar to her had she seen her situation with Jack as domestic abuse.

1.7 Involvement of the Perpetrator

The MHHR Lead sought advice from the responsible clinician for Jack's care to avoid further harm it. It was agreed the Panel provide questions for those in charge of Jacks care to ask on their behalf.

1.8 Agencies which contributors to the review

The following sixteen agencies were asked to check their records in August 2023 and if they held information to ensure the records were secured. It was agreed that these five agencies would be asked to provide an IMR. All IMR authors were offered a briefing by the Chair on the purpose and content of their IMR.

1. Primary Care – GP Medical centre
2. West Midlands Ambulance Service
3. Telford & Wrekin Council: Adult Social Care
4. Midlands Partnership NHS Foundation Trust
5. West Mercia Police

The following health agencies had limited involvement, and some of their contact occurred following Margaret's death which the Panel did not believe to have been relevant to the DHR and were therefore not asked to provide a report for the Review.

1. The Jack Jones and Agnes Hunt Orthopaedic and District Hospital
2. Shropshire Community Health Trust
3. Shrewsbury and Telford Hospitals NHS Trust

The following agencies were not involved with the family and were therefore not asked to provide an IMR.

1. West Mercia Youth Justice Service
2. Telford & Wrekin Council: Housing
3. West Mercia Women's Aid
4. Shropshire Domestic Abuse Service
5. Shropshire Fire and Rescue Service
6. National Probation Service
7. Telford & Wrekin Council: Neighbourhood & Enforcement
8. Telford & Wrekin Council: Children's Social Care

NHS England shared the Mental Health Homicide Review (MHHR) with the Panel which negates the need for a IMR from MPFT.

1.9 The Review Panel Membership

The Review Panel members were independent in that they had no prior contact with the individuals involved in this DHR or line managed those that did. The exception to this is the GP Partner at the GP Medical Centre, the Safeguarding Lead for Adults and Children who as a GP in the practice had limited contact with the family. The Panel met in January 2024 and following the sentencing in May 2024, and then in September, October, November and December 2024.

	Agency	**Role**	**Name**
1	Independent	Independent Chair and DHR Author	Jan Pickles
2	NHS England Mental Health	MHH Review lead	Anne Richardson
3	Shropshire and Telford Hospitals Trust (attended January and May 2024 meetings when it was agreed their agency need not be represented on the Panel)	Head of Adult Safeguarding, MCA & Prevent Lead	Kathy George
4	Community Social Work and safeguarding, Telford, and Wrekin Council	Service Delivery Manager	Tracey Holmes
5	Midlands Partnership University NHS Foundation Trust	Safeguarding Named Professional MPFT	Sarah Whenmouth
6	Shropshire Community Health Trust	Nurse Specialist, Safeguarding Adults	Anthony Archambault

7	GP Medical Practice	Primary Care Practice	GP Partner at GP Medical Centre, Safeguarding Lead for Adults and Children. Name withheld
8	West Mercia Police	Detective Inspector Statutory and Major Crime Review Team. Police Staff Investigator	Jordan Baker Hannah Clements
9	Telford & Wrekin Safeguarding Partnership	Safeguarding Adults Board Manager	Lisa Jones
10	Telford and Wrekin Domestic Abuse Services (from Panel meeting 2)	Service Manager acting as the Panel's independent Domestic Abuse adviser.	Andrea Williams

1.10 Author of the Review

Jan Pickles was appointed as author of the DHR and author of this report in December 2022. She is a qualified and registered social worker with over forty years' experience of working with perpetrators and victims of Domestic Abuse, Coercive Control and Sexual Violence, both operationally and in a strategic capacity. In 2004, she received an OBE for services to victims of domestic abuse for the development of both the Multi-Agency Risk Assessment Conference (MARAC) model and for development of the role of Independent Domestic Violence Advisers (IDVAs). In 2010, she was awarded the First Minister of Wales's Recognition Award for the establishment of services for victims of sexual violence. She has held roles as a Probation Officer, Social Worker, Social Work Manager at the NSPCC, Assistant Police and Crime Commissioner and as a Ministerial Adviser. She has undertaken Independent Board member roles on two NHS Trusts and was a member of the National Independent Safeguarding Board for Wales for eight years. She has completed the Home Office training for chairs and authors of Domestic Homicide Reviews.

Jan Pickles is not currently employed by any of the statutory agencies involved in the review (as identified in section 9 of the Act) and have had no previous involvement or contact with the family or any of the other parties involved in the events under review.

1.11 Parallel Reviews

The Panel were informed that NHS England had commissioned a Mental Health Homicide Review. The Chairs of the reviews had met together at the start of the process to ensure they worked collaboratively to reduce the demands and trauma as much as possible for

Margaret's family. The Coroner was informed immediately of the request for a DHR, and the Coronial process was adjourned until after the completion of the Criminal trial.

1.12 Equality and Diversity

The Equality Act 2010 identifies nine Protected Characteristics they are:

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

In terms of the Protected Characteristics within the Equality Act 2010 Margaret was 58 years old woman who was married at the time of her death. She identified as heterosexual, White British and had no known disabilities.

In terms of the protected characteristics within the Equality Act 2010 Jack was aged 31 years old he identified as White British, heterosexual and male. Jack had recognised mental health difficulties which at their most critical included command hallucinations within psychosis and was diagnosed with schizophrenia following these offences and subsequent mental health examination. Although not recorded it is likely Jack experienced stigma[4] and associated discrimination because of his lived experience with the mental health issues he faced.

1.13 Dissemination

Once the DHR has been agreed by the Panel and Margaret's family it will be signed off by the Community Safety Partnership and submitted to the Home Office for the quality assurance process. When published copies will be shared with Margaret's family, the organisations that make up the Community Safety Partnership, the Telford and Wrekin Police and Crime Commissioner and the UK's Domestic Abuse Commissioner.

[4] Helen Butler, Merryn Gott & Jackie Robinson (2025) Intersectionality and healthcare experience for people diagnosed with mental illness – a scoping review, International Journal of Mental Health, 54:4, 544-581, DOI: 10.1080/00207411.2025.252621

1.14 Research

There has been limited research on the phenomenon of 'parricide' - the killing of parents by their children, to date. Parricide is a relatively rare event, accounting for approximately 4% of all homicide in England and Wales[5] and 3%–4% of all homicide across the globe[6].

Research has examined different kinds of mental illnesses and their role in different parricidal contexts. For example, in an analysis of offenders that have committed parricide held in a secure hospital in Finland[7], it was found that significantly more offenders who killed their mothers were more likely to have suffered from a psychotic disorder, while those who killed their fathers from a type of Personality Disorder. Such findings suggest that there are different psychopathological contexts to matricide - the killing of mothers to those of patricide - the killing of fathers. Early research suggests that those who kill their mothers are more likely to suffer or have suffered from a range of more severe mental illnesses including delusional beliefs. However, in this case we understand from the injuries received by Jack's father that had he not acted so swiftly he may have been more seriously injured or killed.

In the 2022 research undertaken by Rachel Condry and Caroline Miles 'Who Counts? The invisibility of mothers as victims of femicide'.[8] They describe parricide:

"as a gendered form of homicide in which women, like in other forms of domestic homicide, are disproportionately represented (compared to non-domestic violence and homicide), and the vast majority of perpetrators are male. The killing of mothers (matricide) has hitherto fallen under the radar of gender-based violence and abuse research and is not readily identified as a form of femicide".

"Drawing upon analysis of Homicide Index data and fifty-seven case studies of parricide in the United Kingdom, we show that in many cases women are killed by their adult-aged mentally ill sons, within a broader context of 'parental proximity', maternal caregiving and intersectional invisibility, which ultimately renders them vulnerable to fatal violence".

Although this case does involve an adult there is data that identifies an increase in abuse of parents by children and adolescents related to Covid that may be relevant in this case, as it demonstrates the extra stress many families experienced in the Covid- 19 pandemic. The Violence Research Unit report, the 'Comprehensive needs assessment of Child/Adolescent

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[5] Bojanic et al., 2020 Parricide: A comparative study of matricide versus patricide. The Journal of the American Academy of Psychiatry and the Law 35: 306–312.
[6] Holt, 2017. Parricide in England and Wales (1977–2012): An exploration of offenders, victims, incidents and outcomes. Criminology and Criminal Justice 17: 568–587.
[7], Liettu Säävälä, H., Hakko, H., Räsänen, P., & Joukamaa, M. (2009). Mental disorders of male parricidal offenders. Social psychiatry and psychiatric epidemiology, 44(2), 96-103.
[8] Who counts? The invisibility of mothers as victims of femicide Rachel Condry et al Current Sociology Volume 71, Issue 1, January 2023, Pages 43-59 https://orcid.org/0000-0002-4527-4289 and affiliations

to Parent Violence and Abuse in London' [9] March 2022 noted an increase in rates of abuse over the period of the Covid lockdown.

"the number of reported incidences fell after 2018 but began rising slightly during the first national lockdown from March-June 2020 in response to the COVID-19 pandemic".

[9] https://www.london.gov.uk/sites/default/files/comprehensive_needs_assessment_of_child-adolescent_to_parent_violence_and_abuse_in_london.pdf

2. Background Information

2.1 At the time of her death, Margaret was an experienced qualified nurse, was working in a local nursing home and living at home with her husband and her son, Jack. She also had a close and loving relationship with her adult daughter who lived nearby and who had recently had Margaret's first and much loved grandchild. Margaret was a caring and loving mum, wife and grandmother. Margaret was described by her colleague at the nursing home where they worked as a well-respected and skilled nurse, a member of a close team where she had worked for many years caring for elderly residents many of whom were frail and required skilled nursing. Her best friend of many years described her as someone who always put others first and who was worried about Jack (her son). Both Margaret's daughter and her best friend believed that Margaret did not have her granddaughter to stay overnight at the family home due to her concern that Jack may have posed a risk to her, an indication perhaps of her underlying fear of him. Prior to the fatal attack on his mother and serious assault on his father in July 2023, Jack had experienced a similar psychotic episode in June 2021. This was his first presentation to mental health services at which he told professionals that he 'needed to kill his family and the family dog to protect them from torture and pain by others and to do so he had made a pact with the devil'. Jack was discharged from the adult acute inpatient ward in mid-July 2021 after receiving compulsory in-patient treatment and made subject to a 'Community Treatment Order (CTO)[10] due to fears of his non-compliance when discharged back into the community. These fears were based on his behaviour and attitudes evident whilst on the adult acute inpatient ward. There was also a package of support under a section 117 MHA[11] provided by community mental health and related teams put in place on his discharge.

2.2 Jack had worked as a security guard in his father's business, but his use of cocaine MDMA[12] and cannabis had led to him being unreliable to the point that his father had covered some of his shifts. He had in March 2021 returned to live in the family home after the break-up of his relationship with his girlfriend, the reasons for this break-up are not known. Jack had sometime in the last year learnt that he had a son from a relationship that had ended ten years ago and had been due to see them both the day before his threatened attack on his mother and father but had not gone to that meeting. It is not known why he did not attend that meeting as arranged. The family state that he appeared to have changed

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[10] https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983 (29:50) Code of Practice MHA 83.

[11] Under Section 117 of the Mental Health Act 1983, council social services departments and NHS Clinical Commissioning Groups (CCGs) must provide or arrange free aftercare for adults, young people and children who have been detained under certain sections of the Mental Health Act (sections 3, 37, 45A, 47 or 48) until they are satisfied the person no longer needs it. These duties and responsibilities are set out in the Mental Health Act Code of Practice (the Code of Practice).

[12] MDMA (Ecstasy) https://www.nhsinform.scot/healthy-living/drugs-and-drug-use/common-drugs/mdma-ecstasy/
MDMA is the shortened chemical name for the synthetic psychoactive drug 3, 4-methylenedioxy-methamphetamine. MDMA is a stimulant drug that may increase feelings of empathy and is usually swallowed.
MDMA is a Class A drug under the Misuse of Drugs Act (1971).

after receiving this information, becoming more withdrawn and secretive. Jack's sister described him as a 'closed book', shy and introspective but also emotional and warm, often wanting to spend time with her and his mother, seeking intimacy with them and was not gregarious or noisy. It seems that he had always found large gatherings difficult, but that he would enjoy his own solitary pursuits and loved nature and being outdoors. Jack could be very polite and social skilled as demonstrated by the custody video of him thanking officers He was however also described by his sister as being capable of being 'nasty' to his mother and seeking to antagonise his father. His sister said that he would spend a lot of time at home in his bedroom, that he found it difficult to relax and to get to sleep. Margaret's husband and daughter both recognised that Jack could "*be really horrible to Margaret*" and believed that Margaret may have tried to protect him from the consequences of his actions. The family had at no point considered that Jack's behaviour may have had elements of 'Coercive and Controlling Behaviour'[13] within the meaning of the legislation recently enacted.[14]

2.3 Jack was admitted to an adult acute inpatient ward in June 2021 and remained there for some four weeks. His sister described Jack's time in inpatient care as 'traumatic' for him, that he witnessed disturbing things whilst there and that because he was quiet, she believed that he was probably left to manage the impact of them on him, himself. His sister did not feel that Jack benefited from being on the adult acute inpatient ward and that once discharged into the community he was not invested in the therapy and contact that had been arranged with those working with him. She suspected that he was not engaged or committed to the treatment goals set for him but was solely motivated by the need to avoid being returned to hospital. Linked to that Jack's sister and father felt the greatest error made by those working with him was the failure to drug test Jack, which was not a requirement of the CTO. His sister articulated the feelings shared by all family members, that they were left alone to manage Jack. They state that the workers that saw Jack had no contact nor shared any information nor advice about him with them. They describe feeling isolated and anxious, aware themselves that he still appeared unwell, and that many of the patterns that were evident prior to admission to the

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[13] Section 76 of the Serious Crime Act 2015 (the 2015 Act) introduced the criminal offence of controlling or coercive behaviour in an intimate or family relationship. The offence was brought into force in recognition of the severe impact of controlling or coercive behaviour which can comprise economic, emotional and psychological abuse, technology-facilitated domestic abuse, as well as threats, whether or not they are accompanied by physical and sexual violence or abuse.
The controlling or coercive behaviour offence previously only captured behaviour between current intimate partners, whether or not they lived together, and ex-partners or family members who live together. This meant that abuse by an ex-partner or family member who no longer lived with the victim could not be prosecuted for controlling or coercive behaviour.
https://www.gov.uk/government/publications/controlling-or-coercive-behaviour-statutory-guidance-framework/controlling-or-coercive-behaviour-statutory-guidance-framework-accessible

[14] This statutory guidance is issued under section 77 of the Serious Crime Act 2015 (the 2015 Act). Any persons or agency investigating offences in relation to controlling or coercive behaviour under section 76 of the 2015 Act must have regard to it.

adult acute inpatient ward were returning, heavy drinking, indications of drug use, avoiding contact with them and money problems. They felt unable to share these concerns with those working with Jack. There was in the view of the report writer, though not overtly expressed in the documents, a sense of frustration held by family members that they were unable to give and receive feedback from those services working with Jack, and of which they knew little of the methods or the goals that they were working towards. There was a sense of frustration that they were not being involved or consulted in Jack's treatment and updated on his progress. This feeling it seems continued up to the day of Margaret's manslaughter.

2.4 Prior to the fatal attack on Margaret it was reported at the beginning of April 2023 that Jack had not been taking his prescribed medication for psychosis and depression for the last six months but that he appeared well. At this time, he stated he was using cocaine and cannabis once per week. It is also recorded that he had repeatedly declined offers of support to reduce his drug use. At the beginning of July 2023, he was still taking 'recreational' drugs. Jack reported to his mental health support worker in July 2023 that he felt well, saying his mental health was 'good.' Jack's support workers reported no evident symptoms of psychosis. It was ten days after this that Jack attacked his parents killing his mother and seriously injuring his father.

3. Chronology

3.1 Covid restrictions were in place to a greater or lesser extent from the period March 2020 to December 2022. Jack's six week admission onto an adult acute inpatient ward in June 2021 was not affected by the second wave of visiting restrictions, however. The visiting arrangements were such that Jack's mother, was able to visit the ward frequently and walk in the gardens within the hospital grounds with Jack. The other Covid related impact was on professional's meetings, many of which had already moved to an online format and so continued to function through this time.

3.2 Margaret was a married woman who lived with her husband in their family home, their daughter had recently had a child and lived close by. Her son had returned home in March 2021 after the breakup of a relationship. The family was part of what appears to have been a gregarious and friendly extended family that often socialised together. Margaret was a qualified nurse who was well known locally and held in high regard by those that worked alongside her. Margaret's husband, daughter and her best friend all described her as a 'loving mother who was a private person'. Margaret was reported to be in good health and only needed to visit her GP for general screening services. Margaret was delighted to have become a grandmother to her daughter's child and was reported to have idolised Jack, her son, described as 'the apple of her eye' by her close friend. However, Margaret had become aware of Jack's deteriorating mental health over the two to three years before her death. The family knew that he used drugs – his sister stated that he would take 'anything with complete disregard to the impact on him or others'. In medical notes Jack was described by Margaret as having become increasingly socially anxious and unhappy as a teenager, he complained of health worries in response to stress or relationship problems. He had first started using cannabis as a teenager, but it was also noted that he would take other substances as well, it seems that cocaine was a drug that he would often use either in addition to or in place of cannabis.

3.3 Jack had worked as a security guard in his father's business but had proven unreliable over time, possibly due to his substance abuse, and his father had covered for some of these absences. Jack's drug use was significant, and it caused friction within the family. On one occasion his father stated he 'nearly threw Jack out' because his drug use had caused him to vomit extensively within the home. Jack had returned to live at the family home three months prior to the manslaughter of his mother and assault on his father, following the breakdown of his relationship with his then partner. The reasons for the breakdown of that relationship are not at this time known. Jack's sister stated that from his being a young child he was often 'a little withdrawn or self-conscious in some ways'. He was not in her view a very confident child and that he found it difficult to mix with others, she gave an example to illustrate this of a time when all of their family had gathered together, and Jack disappeared for several hours. He later explained to her that he had felt too 'self-conscious' that he was not in employment to remain there with everyone.

3.4 Jack had at sometime within the year prior to his attack on his parents learnt that he had a son of around eleven years of age with a previous partner whom he no longer saw. It is recounted that he had recently re- established contact with this ex-partner and had been due

to visit the child the day before the attack on his parents, but that he did not attend as arranged. At this point, the reason for this failure is not known. His ex-partner was asked to participate in this Review but declined, therefore there is no information that may have provided context to this decision. The only other indicator that was recounted by a family member that could help in understanding this event was that the family believed that "something happened to Jack that week (before his attack on his mother) as one day he was fine and then the next completely different. He became very negative and highly emotional, his cousin had seen him and said he looked like a 'different person'. At the same time, Jack's sister remembers him saying that he had lost his phone and bank card, she believes that he had hidden it in anticipation, "*knowing he would be arrested*".

3.5 In early June 2021 the overarching Safer Telford and Wrekin DHR chronology stated that Jack contacted the help line '111' concerning his mental health and particularly his anxiety after he had had penetrative sex with a woman who had then told him she was HIV positive. Jack was advised "to make contact with the GP Medical Centre within 24 hours". The GP Medical Centre state that Jack contacted them with regards to his mental health the next day. Their records state that "at this point, there were no symptoms suggestive of psychosis and the assessment includes a comment that he was receiving support from his family." They also record that he had concerns regarding possible sexually transmitted diseases following sexual intercourse with a prostitute, to which they advised he access local sexual health services. The IMR from the GP Medical centre goes on to state; "family and friends really supportive. Works as security guard, enjoys job. Sleep ok, little appetite. Used to cook and do photography, not motivated. No self-harm, no suicidal ideation. Cannot get past how stupid he has been." They record that they "referred Jack as per protocol to 'Improving Access to Psychological Therapies' (IAPT) and 'Every Mind Matters'. Antidepressants offered. Will self-refer. Follow up 2 weeks, sooner if worsening". The IMR prepared by the GP Medical Centre goes on to note that at "this point, there were no symptoms suggestive of psychosis and the assessment includes a comment that he was receiving support from his family. They also noted in their IMR that "the risk assessment covered risk to self but not others".

3.6 A week later, during dinner at the family home, his sister described that Jack left the room and returned wearing gloves and holding a baseball bat. Jack then was disarmed by his mother (his father was not present) and fell to the floor sobbing saying he 'could not do it' He explained to his mother that he had intended to kill her, his father, and the dog to 'euthanize them, and to prevent them being killed in a much more brutal fashion by a satanic creature'. He then spoke of the angels and demons in his head 'that are telling him to kill his family'. Jack's sister rang 999 and explained the situation to the call handler. The call handler then assessed the situation as 'medical' because Jack's sister had said that Jack was no longer being aggressive or holding a weapon. This classification as not a threat meant that police officers were not asked to attend by the call handler. An ambulance did attend but did not offer treatment as the responders felt 'unsafe' without a police presence. The Emergency Services liaised, and West Mercia Police did then attend. Jack was assessed as 'medium risk' by the police officers attending. A mental health assessment was arranged for the following day. The paramedic attending advised the Emergency Duty Team (EDT) that Jack was presenting as experiencing a psychotic episode, and that Jack believed that an "*angel of mercy had told him if he did not kill his family someone else would do it for him*." He reported that he believed that he was

unable to be helped or protected by anyone as 'he had signed a deal with the devil'. The paramedic assessed Jack as having no capacity, though noted he was currently calm and settled with no further thoughts of harming his family.

3.7 The attending paramedic then contacted the Emergency Duty Team' advising them of the night's events and that Jack 'did not have capacity' and 'requesting advice and information' The Emergency Duty requested that the Crisis Resolution and Home treatment Team (CRHT) undertake a visit and assess Jack to establish if he could he treated in the community and whether he met the criteria for a Mental Health Act Assessment (MHAA). The CRHT attended that night and assessed Jack as needing to be treated in an adult acute inpatient ward, however Jack refused his consent for this and so remained at home overnight, pending a further mental health assessment. A Mental Health Act Assessment was undertaken at home the following day and it was identified that Jack was "exhibiting signs of psychosis, talking about making a pact with the devil and selling his soul. Feels he has to kill his mother and sister to protect them from sexual assault and torture". Margaret during the meeting disclosed that she had found a knife under his pillow; this was not explored further. There was following this assessment a delay in the ambulance transport to the adult acute inpatient ward due to other operational pressures and a planned time to transfer Jack could not be offered.

3.8 The IMR from ASC acknowledges that there was no specific risk assessment or safety plan relating to domestic abuse completed to manage this, despite Jack having made specific threats to kill his mother. At this point he was not receiving any treatment and was left in the house with his mother, despite him making specific threats to kill her whilst they waited for the ambulance. He was later that day admitted to an adult acute inpatient ward. The MHHR notes

'In *the early days of his admission, X denied that he was unwell, and he was reluctant to share very much information with the staff; they also judged that X had appeared to be relatively socially isolated on the ward, and X's mother reported that X had not been very open with her or with other family members'*.

Jack shared with staff '*he'd been feeling detached emotionally for some time (that) he'd been on a spiritual journey and regrets how he'd lived his life'*.

He attributed his voices to '*spiritual rather than mental health issues'*.

He also stated that he had not taken any of his prescribed medication for about a year. Jack was prescribed the anti-psychotic drug, 'Aripiprazole'[15]. The records note

[15] It may be relevant that the Medicines and Health products Regulatory Agency (MHRA) published a Drug Safety notice on 5th December 2023 concerning Aripiprazole to draw attention to a risk associated with gambling and gambling disorder. However, given that Jacks's risky behaviour in regard to his spending on webcam sex predated both his illness and the date of the MHRA publication, the MHHR team has judged this not to be material to the review'.

"*Jack had become increasingly socially anxious and unhappy as a teenager and complained of health worries in response to stress or relationship problems"*

3.9 Two weeks after being admitted Jack was discovered to be missing from the ward in the early evening, the staff on duty responded as per the agreed protocol and searched the grounds before contacting West Mercia Police in line with local protocol. This protocol required residential care establishments to follow specified actions to locate the missing person themselves. These included reviewing the 'trigger plan' for relevant information and actions and carrying out initial inquiries including calling the missing person's contact numbers, contacting next of kin/family, searching the immediate area and speaking to other residents or patients. When the West Mercia Police responding officer asked whether Jack posed a risk to others, ward staff replied, 'just his family'. West Mercia Police completed the relevant checks and dispatched an officer to his family home. Jack's mother later contacted the ward to say that Jack had been in touch to tell her he had gone for a walk, and she had advised him to get a taxi back to the hospital as he had access to money and bank cards. The police officer involved appropriately monitored the situation and then Jack rang the local police himself 'asking for a lift back', police officers then returned him to the hospital. The IMR from West Mercia Police state that the parents were not 'concerned' about their own safety when they learned that Jack had absconded from the adult acute inpatient ward. However, the MHHR recognised that Jack caused the family anxiety whenever he absconded.

3.10 At a team meeting held in in the hospital to discuss Jack in early July 2021 at which his mother was present, it was agreed that due to his non-compliance with oral medication Jack should be given 'depot', a medication administered by an injection by a qualified practitioner. The mental health charity 'Mind' describes Aripiprazole as being given for symptoms such as psychosis and with a range of possible side effects including sleeplessness and irritability. Risk factors were identified concerning Jack's mental health, and it was noted that that his isolation and a risk of violence to others were current risks.

3.11 In July 2021 the adult acute inpatient ward on which Jack was an inpatient requested a Mental Health Act Assessment (MHAA) to consider placing him on a 'Section 3 of the MHA 1983 as the Section 2 Order would soon lapse'. A further MHAA accordingly was undertaken, and it was agreed he remain a patient at the hospital under Section 3 of the MHA 1983. Section 3 allows that an individual can continue to be treated and provides a gateway to entitlement to funding for aftercare under Section 117 of the MHA[16] This gave the adult acute inpatient ward greater powers in managing Jack on the grounds of his "lack of insight, his unwillingness to remain in hospital and the risks that he posed". During the assessment it was discussed that Jack was not consistently taking his medication and had absconded from the

[16] Section 117 of the Mental Health Act (1983) requires clinical commissioning groups (CCGs) and local authorities to provide or arrange for the provision of aftercare services to patients who have been detained in hospital for treatment for a mental disorder. These services are provided after the patient is discharged from the hospital.

ward on two occasions. His non-compliance with the drug therapy was to be a recurring pattern in Jack's response to treatment, evident also when he was returned to the community. AMHP remained concerned about his poor mental health and felt that he was not ready for discharge.

3.12 A week and a half later at a meeting to discuss Jack's discharge it was agreed that a Section 117 of the Mental Health Act 1983 entitlement (a joint responsibility between Health and the Local Authority)[17] be made when Jack was to be discharged from the adult acute inpatient ward and that on release the Early Intervention in Psychosis Team (EIP) be engaged to monitor and administer the anti-psychotic medication (by injection). During the meeting it was recognised that whilst no social care needs were identified in this case, Jack did require support with medication management, compliance and the monitoring of his mental health. Although the day to day management of Jack's case was closed to Adult Social Care (ASC), Section 117 of the Local Authority Support Plan stated that Jack's care needs should have been reviewed, but this was not done.

3.13 Jack's inpatient consultant agreed to allow Jack to leave hospital under the S.17A of the MHA (Community Treatment Order-CTO) so that he could be monitored and managed more safely after it was determined he no longer needed inpatient care and treatment. The purpose of a CTO is stated to "allow suitable patients to be safely treated in the community rather than under detention in hospital and to provide a way to help prevent relapse and any harm to the patient or to others"[18]. On Jack's discharge, the MHHR records that a Care Coordinator (CC) was allocated to Jack, who was a qualified mental health nurse and member of the EIPT to liaise with Jack and deliver a range of mental health treatment and support which included the added support of a Cognitive Behavioural Therapist (CBT). A 'Support Time Recovery' (STR) worker whom Jack met regularly to provide help with the more practical and advice-based components of his mental health and wellbeing was also allocated. The EIP team shared information relating to Jack's risks, triggers and warning signs associated with his mental health (for instance, failure to take medication, use of illicit substances, poor sleep, paranoid thoughts, vivid dreams, or very low mood.) with the other professionals working with him, Jack was also invited to engage with the substance misuse service, which he declined (and was to continue to do throughout the period of his care) stating that he could manage without their support. This was accepted. If at any time during the life of the CTO Jack had refused his medication, he could have been recalled to hospital without the need to convene another MHAA.[19] It was acknowledged that the decision to discharge Jack after six weeks of inpatient treatment held a high risk that he may not cooperate with the treatment plan after discharge based on his attitude and behaviours observed whilst on the ward– for instance non-compliance with his medication and absconding. An area of concern was that the conditions of

[17] Ibid

[18] https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983 (29:50) Code of Practice MHA 83.

[19] ASC IMR

the CTO had not been recorded within the Social Care assessment nor on Jack's digital records, only on mental health notes. Margaret, as the Nearest Relative (NR) was consulted during the examination of Jack, and her feelings about his discharge were recorded. There is however no record of the conditions of the CTO being explained to her. Margaret believed that the CTO meant that should Jack stop taking his medication he would have to be returned to hospital. This was not to be the case.

3.14 At the time of Jack's discharge from hospital in July 2021 Margaret shared with her best friend that she was more afraid that Jack would do something to himself rather than to others. As time went on, she became aware that Jack was using 'street drugs' again, she believed these to be cannabis and 'MDMA'. Margaret stated that she was surprised that Jack had not been required to provide blood tests or urine samples to ensure his compliance with his medication regime. Margaret later disclosed that her daughter had told her that since discharge Jack had indeed not been taking his medication but had been 'stockpiling' it.

3.15 After his discharge in July 2021, Jack returned to work as a security guard working long shifts with a local company. In December of that year, following a review, his consultant summarised Jack's current mental health and noted "that Jack has largely recovered from the psychosis, but not from the trauma with which the experience was associated". Jack said he valued the CBT, was still working nights and taking his 'depot[20]' The consultant added that 'He says he's taken no illicit drugs for six months'. Jack's mood was then described as "showing mild/moderate subjective depression. Jack appeared insightful and he was agreeable to taking his meds and cooperating with the treatment plan. The plan was to continue with psychological therapies, discharge the CTO and consider reducing his meds, then gradually reduce until discontinued." Discharging the CTO would remove the likelihood that any concerns held by those treating him in terms of his mental health could be met by a speedy recall to hospital. A return to hospital in hindsight was one of Jack's greatest fears and potentially also a brake on his return to detectable risky behaviours- his drug use in particular.

3.16 Margaret's best friend had told the report author that following Jack's threats to kill Margaret and her husband and his subsequent hospitalisation, she initially felt that the intervention of mental health services to have been helpful for Jack. However, over the course of his inpatient care, Margaret's confidence in the help he was receiving had steadily declined. Margaret's friend told the DHR author that it was at the point Jack had absconded and was taken back by the police that she believed the treatment he was receiving was not effective. She went on to say that Margaret believed that Jack was 'released' on the proviso that he receives a monthly 'depot' injection and that if he did not comply, he would be 'sectioned' and returned to hospital. Margaret later shared that she believed Jack had "*duped them, (the community mental health*

[20] https://www.mind.org.uk/information-support/drugs-and-treatments/antipsychotics/depot-injections/ A depot injection is a slow-release form of medication. The injection uses a liquid that releases the medication slowly, so it lasts a lot longer. Depot injections can be used for various types of drugs, including some antipsychotics. The medication used in depot injections is the same as other forms of the drug, such as tablets or liquid.

workers) he had sweet talked them into (his) being responsible for his own medication." Margaret told her friend that she had contacted mental health services and challenged the decision to hand over to Jack the responsibility for his 'depot' injections, and that she had been reassured by them that Jack was well enough to be in charge of his own drug regime. At this point Margaret told her friend that she had received no guidance from mental health services on how to help Jack, and that she felt 'abandoned' by them. Her friend reported that Margaret 'felt bereft and abandoned by the system', did not know how to help her son, and worried for the safety of her husband and daughter.

3.17 In January 2022 a Mental Health Review Tribunal (MHRT) was undertaken, together with a statement of Jack's mental state and social circumstances. Jack's CTO was rescinded. According to the MHHR "Jack's CTO was removed when it appeared that he was compliant with his medical treatment regime, and he appeared to be well, contact with the EIP team then continued during 2022. He was supported and reviewed as an outpatient by the consultant, in face-to-face meetings and home visits with his Care Coordinator who administered his medication, and he saw the STR worker for support and discussion about relapse prevention". During 2021 and part of 2022, restrictions in association with managing the Covid epidemic were also present. Despite this, as records show services felt there was a sense of improvement regarding Jack since discharge from the Acute Ward. The MHHR states that Jack "was reviewed regularly by the consultant and in the multidisciplinary team (MDT) meetings, as well as over the telephone. Apart from an episode of low mood in the summer of 2022, Jack remained well, managing to sustain work as a security guard in his father's business – albeit, with support from his father and mother". This sense of optimism does not seem to have been shared by the family. As the chronology notes during a home visit to Jack in early July 2022, (almost a year since discharge from the adult acute inpatient ward) at which Jack's mother was a present, recorded as saying that "Jack seems to be deteriorating; he seems depressed, is finding it hard to concentrate, sleeping a lot, pacing, agitated. (Jack's mother) is finding it v upsetting. Some concerns expressed over what Jack is spending his money on". It seems that the concern expressed by the family on the day of the first incident leading to Jack's hospitalisation that "when Jack is better there will be a high risk presented to his mental health if/when he takes illicit substances and/or decides that he would prefer to be medication-free, as he did before" were not being considered during this review in July 2022.

3.18 Later that month, during a home visit it was suggested that Jack's medication be changed from a depot injection to oral Aripiprazole to reduce the unpleasant side-effects that Jack reported to be having with the injections- such as "pacing and significant weigh gain". The MHHR acknowledges that there was concern expressed by members of the family at that time in doing this due to their fears of Jack's "continuing to take illicit substances and his reluctance to take medication". However, the MHHR concludes that the family were persuaded of the value of the decision when informed of the reasons for it and given Jack's assurances that he would cooperate with the drug regime as instructed. With the value of hindsight, it is known that as there was to be no drug testing conducted on Jack, his compliance with the drug therapy was unknown. It is also noteworthy that Jack had some months before this decision been assessed by mental health workers as at 'high risk' using the approved 'FACE' risk assessment tool. Jack's reported behaviours - excessive gambling, drug and alcohol use, online sexual behaviour, high spending and debts and other impulse control symptoms, have

all now been recognised as a side -effect of Aripiprazole, although these behaviours evident in Jack were not known at the time of Jack's supervision as being risk factors linked to the oral use of 'Aripiprazole '

3.19 In September 2022, Jack's records indicated that his risk level using the approved risk tool 'FACE' was designated as a 'low', this assessment was set to be reviewed six months later. The notes in the MHHR chronology state "the form makes it clear that Jack's family knew who to call if there were concerns for their safety, which they had expressed before. It notes that Jack had been experiencing command hallucinations to kill his family. It also mentions his reckless (financial) behaviour was partly due to online gambling and spending on webcam sex sessions. This may have been linked to the effect of his medication as noted above". By October 2022, it was reported that Jack had broken up with his girlfriend although this event does not appear to have triggered any significant deterioration in his mental ill health. In January 2023 he was seen by his consultant who did not observe any signs of psychosis or suicidal thinking. He was believed to have been taking his anti-psychotic medication, but later in March 2023 CC informed the consultant that Jack has stopped his Aripiprazole, against advice - following discussion with his consultant he agreed to restart them. In hindsight it is known he did not do this. He had completed a second course of CBT sessions, and his therapist assessed his mood as 'normal', he stated he was not using other substances and that he had met an old girlfriend. He reported that he had found the CBT sessions useful.

3.20 In March 2023 when seen at home by his Care Coordinator, (CC), the CC discovered that Jack had still not re-commenced the anti-psychotic medication, despite agreeing to so before discharge from the adult acute inpatient ward and in January 2023 to his consultant. He did apologise to the CC for his deception explaining that he did not disclose his non-compliance due to his fear of being re-admitted to the ward. The CC assessed Jack and saw no signs of psychosis or anxiety. The CC did discuss the worries that Jack had disclosed including those concerned with poor sleep, paranoid thoughts, and dreams about angels and demons and suggested to Jack that they may indicate a deterioration in his mental health, Jack then admitted to using cocaine. The Support Time Recovery (STR) worker who was also present in the interview suggested a referral to substance misuse services which Jack declined. A few weeks later, in early April 2023, the STR worker met with Jack's mother and disclosed to her Jack's non-compliance with his anti-psychotic medication. Jack's mother described him as 'unsettled', but 'OK' and believed those feelings to have been due to his girlfriend leaving the area to find work.

3.21 A reassessment of Jack using the accredited risk assessment tool was due to have been completed at the end of March 2023 but had not yet been done by the end of April 2023, due to the planned absence of Jack's Key Worker for several months. The decision was taken not to re-allocate Jack's supervision to a qualified worker during this time. It appears that the decision not to re-allocate was based on the on the progress he seemed to have been making and the

"positive relationship he had with the STR worker allocated to him and through that worker access to the wider mental health support team"[21].

3.22 Jack had had no contact with mental health workers over a five week period in March to May 2023 despite several unsuccessful attempts that had been made by them to contact him by phone. In early May 2023, telephone contact was made with Jack at which it was recorded that 'no concerns' were raised. A week later Jack met for a face to face meeting with a STR worker from EIP at which he disclosed that his relationship with his girlfriend has ended and stated that he was using a 'small amount of substances'. There then followed two more successful contacts with Jack in June 2023, and in a home visit in mid-July 2023 at which he disclosed spending substantial amounts of money weekly on cannabis and cocaine and on digital sex platforms. He stated that he remained in employment working six days a week, completing an 'art project' and described himself as being close to 'euphoric' in mood. The MHHR notes "Jack was discussed each week, and a qualified member of the staff team contacted him regularly. Once again, Jack declined a referral to substance misuse services. The STR worker also asked Jack to confirm that Jack's mother had their contact details if she was concerned"[22].

3.23 Paradoxically, in the weeks and months up to Margaret's manslaughter by Jack, and until the week before that Jack killed his mother, Jack's sister felt that there had been no signs evident to anyone in the family of his poor and deteriorating mental health. The Mental Health Homicide Reviewer notes " The onset of psychosis can be extremely fast; there are not necessarily any warning signs. Jack's sister stated that he had told them that he had stopped taking drugs- which they believed, and that he had also stopped talking about 'angels and demons'. In retrospect she believed that he still had these thoughts but had simply stopped sharing them with his family.

3.24 The family believe that about a week before Jack killed his mother that something happened to him, they describe him as being fine and then he suddenly and completely changed. The family do not know the reason for this -whether there had been a sudden triggering event for him or whether it was a deterioration that they had failed to notice over a period of time. Jack's sister described them all becoming unnerved by Jack in this period, and that in response to that her mother hid Jack's crossbows in a locked cupboard- something she had never felt necessary before. Jack's sister describes him as becoming 'very negative and highly emotional' and that Jack's cousin on seeing him said 'he looked like a different person'. Jack told his sister that he had lost his phone and bank card, but his sister believes that he had hidden these in anticipation of his intention to kill his parents and knowing that he would be arrested. The night before Margaret's manslaughter Jack's sister noted that Jack was feeling 'teary and overwhelmed', and he was talking about this. She saw this this to be 'a good thing',

[21] MHHR para 27 page 9
[22] MHHR para 28 page 9

that this might indicate that he was again beginning to include others in the thoughts and feelings he was having.

3.25 Ten days later Jack killed his mother in her bed with a hammer and attacked his father who was able to lock himself into the bathroom and called '999'. Jack's father received serious head injuries in the attack despite this. The family dog which lay on the bed by Margaret was untouched, despite it having been named as an earlier target by Jack.

3.26 During the family's review of the final draft of the DHR prepared following Margaret's manslaughter, her husband shared that he himself had held a shotgun license for many years storing securely six shotguns and an air rifle in the home. He also stated that his son Jack knew how to shoot and where these were stored. The Panel can confirm following investigations carried out in the course of this tragedy, that Jack held four crossbows in his room, along with an assortment of knives. Two of the four crossbows Jack held were powerful in that they had the capacity to shoot a crossbow bolt through a solid wooden door, which had previously happened. Prior to the Police call out in 2021 no checks were required to be made by Officers a Domestic Incident. (This position was changed in 2023 following the Plymouth mass shooting incident)[23].

[23] All applicants for a firearms licence must now provide relevant medical information to the police with their application - supported by a new digital firearms marker on medical records. The digital markers would alert GPs to patients that have a firearms licence and enable them to alert police if the patient begins to suffer from a relevant medical condition so police could assess whether it was safe for the individual to continue to have access to firearms.

4. Overview

4.1 Mid -June 2021. Jack made threats to kill his parents at home. He was disarmed by his sister and the police and ambulance services called. On arrival, Jack told attending officers that he 'needed to kill his family and the family dog to protect them from torture and pain by others and that to do so he had made a pact with the devil'. The next day after remaining at home overnight with his family, Jack was examined and detained under the MHA to a mental health hospital.

4.2 June – mid July 2021 Jack remained as an in-patient. He had absconded from the adult acute inpatient ward three times during this period. He was known to be a reluctant patient. His sister reported him to have been' traumatised' by his stay on the ward. His mother and sister did not feel that his hospitalisation had resolved his condition. Despite the severe threats he made toward his family, the hospital failed to implement any additional safety precautions. He was not regarded by either staff on the adult acute inpatient ward or his family as being an imminent threat to them. He was seen as non-compliant with treatment. MHA Section (S2) was changed to S3, and the relevant form (A7 joint application under the MHA) was completed by the inpatient consultant and the GP, and it describes Jack's lack of compliance with his medication and absconding. A letter to Margaret detailed Jack's legal status and the reasons for the Section, the circumstances of his detention and the fact that he would not be allowed to leave without permission.

4.3 Late July 2021, Jack was discharged to his family home subject to a CTO. The CTO included conditions to comply, engage with the community mental health team working with him, engage with treatment, allow home visits and allow a second opinion doctors' assessment if required. A follow -up visit to Jack at home found all to be well. Jack stated that he intended to visit his girlfriend and to return to work.

4.4 Mid-August 2021 Notice was given of the intention to remove the CTO due to Jack's compliance with his treatment requirements, and a copy was sent to Jack's GP.

4.5 September 2021 depot injection carried out at Jack's home - mother was present.

4.6 October 2021 Cognitive Behavioural Therapy sessions with Jack started and all sessions completed by December 2021.

4.7 End of December 2021 - Notice from Jack's consultant that the CTO would be removed due to Jack's recovery from the psychosis, Jack's employment and compliance with his medication. This removed the option of a more rapid return to the adult acute inpatient ward in the event of concerns about Jack being raised. The reasons for the discharge given was that there had been no reported drug use, and that Jack was reported to be cooperating with his treatment plan. The Report stated that 'Jack reported no drug use for the last six months. Jack was reported to appear insightful, and he was agreeable to taking his meds

and cooperating with the treatment plan. The plan was to continue with psychological therapies, aim to gradually reduce medication and then discontinue the medication at some future point'.

4.8 Early January 2022 CTO removed.

4.9 Mid -January 2022 CBT sessions ended at Jack's request.

4.10 Four days later in January 2022 Jack had a CPA review and a depot injection at home from Jack's allocated mental health nurse. He reported that his mood was low although he didn't want anti-depressants. At that time, Jack was complying with his medication. Jack disclosed to the nurse that he was using cocaine weekly.

4.11 Late March 2022 Home Visit by Jack's Key Worker. Depot injection administered.

4.12 Late April 2022 Home visit by Jack's Key Worker. It was recorded that Jack "appeared tearful and his mood was low and sleeping a lot. He was not engaged with activities. He had not seen his son. Some restlessness was noted".

4.13 The next day in April 2022 a medical review with his consultant was undertaken. Jack reported weight gain and that he was spending a lot of time in bed, and that his mood was low. Agreed that Anti- depressants had been prescribed, and he needed to wait for them to take effect. It was suggested that he discuss his feelings with his family and continue with his anti-psychotic medication to which he agreed.

4.14 Two days later in April 2022 a Joint visit by Community Mental Health Nurse and Key Worker was undertaken Jack's weight gain was again noted.

4.15 Late April and mid-May 2022 Home visit to Jack, nothing significant was noted.

4.16 Late May 2022- home visit undertaken by Key Worker. Jack spoke about his wanting to move into a flat. Help was offered by the key worker regarding this but there is no evidence of discussion or professional curiosity evident about the reasons for this- i.e. circumstances at home, difficulties or problems within the family that might have prompted this wish.

4.17 Two days later in May 2022, a meeting undertaken with Jack's Key Worker and Consultant and weight gain reported. It was noted that there had been no improvement in Jack's mood, and he reported to spend a lot of time in bed. Jack was advised to continue with his medication, use CBT techniques and wait for the anti-depressants to work. The Key Worker agreed to discuss Jack's circumstances with his parents- this did not happen.

4.18 Late June 2022- Jack met with his Key Worker- depot injection was not administered, the reason for this is not clear. It meant a gap of over a month in administering the drug. No evidence of a contingency plan being considered, or discussion of likely impact on behaviours either in terms of risks to Jack or to others.

4.19 Later that day in late June 2022 depot injection was administered. Suggestion made by the Key Worker that Jack discusses with his family a date to meet with Jack's Key Worker to discuss his progress.

4.20 In early July 2022 home visit to family by Key Worker. Mother present during home visit. Mother reports her sense of Jack deteriorating, that he seems depressed, sleeping a lot of the time, that he finds it hard to concentrate and the concerns his mother had about what he is spending his money on- similar to concerns reported by Jack himself two months earlier. There is no evidence in the records suggesting whether or how these concerns were responded to.

4.21 Mid-July 2022- it was first mooted to move Jack to oral delivery of depot medication to help moderate the effect on his moods and behaviour.

4.22 Beginning of September 2022, the move to oral administration from injection of depot was approved. There is no evidence of consultation with Jack's family regarding this decision.

4.23 The next day in September 2022 Jack's 'FACE' Risk profile was updated to 'Low Risk'. The MHHR records that the family knew who to call if there were concerns for their safety- this was not the case according to Jack's sister though records note that Margaret had been given that information. Risk indicators were also noted in the assessment- Jack 'experiencing command hallucinations to kill his family', and the evidence of 'reckless' behaviour in relation to sex workers- one of the triggers identified prior to the first event.

4.24 Late September – to early November 2022 four home visits made to Jack by the Key Worker. No contact with other family members evident. Disclosures of significant high risk behaviour-on line gambling, use of sex lines and money problems. No evidence of escalation of ratings of risk of harm or relapse being considered as a result of this information.

4.25 February 2023 one home visit in January and a review with consultant, and one home visit in February.

4.26 Early March 2023 Home Visit made- Jack disclosed that he had stopped taking all medication about a month ago and was using cocaine weekly and cannabis. Relapse signs were identified (dreaming about angels and demons, poor sleep, paranoid thoughts) Concerns that workers had about these developments were discussed with Jack.

4.27 Mid-March 2023 Home Visit by STR worker Jack was reported to appear stable. He stated he was planning to visit Germany with his girlfriend.

4.28 Late March April 2023 Risk assessment due and was noted not to have been completed.

4.29 Early April 2023 Home visit undertaken by Jack's Case Manager. The Key Worker spoke to Jack's mother who expressed concerns that Jack was not taking his medication due to fears of his being returned to hospital. Jack's mother told the Key Worker that Jack had been 'less content' since his girlfriend had gone to Germany for work but that he 'seemed OK'.

4.30 Late April 2023 Jack's Care Co-Ordinator took unplanned leave and was absent until mid - July. The decision was made not to replace him with another qualified worker but to allow the STR worker who was felt to have a good relationship with Jack to continue contact until the Care Co-Ordinator's return.

4.31 Mid-May 2023 Phone contact was made with Jack by a qualified nurse from the EI Team all reported to be "OK".

4.32 Six days later in May 2023 a face to face meeting with Jack was undertaken. Jack was reported to 'seem well' He disclosed that his relationship had ended with his girlfriend. Jack's relapse plan was discussed with him as he admitted to using illicit drugs.

4.33 Beginning of June 2023, Face to Face meeting with the STR worker was undertaken and all was reported to be well.

4.34 Mid-June 2023 a phone call from the STR worker was made to Jack as he had not responded to previous calls from them. He reported himself to be well. An arrangement was made to meet with Jack but had to be cancelled by the STR Worker. No further contact established however, until three weeks later in early July 2023.

4.35 Early July 2023 – A home visit was made by the STR Worker to Jack. An increase in his use of drugs was reported by Jack- both cocaine and cannabis, Jack reported that he was spending more money on internet sex channels- 'web cams and lap dances 'etc. Jack reported that he was trying to cut down and that he was feeling 'close to euphoric'.

4.36 Mid- July 2023 Home visit made to Jack in which he told the STR that his mood was `buoyant' and reported having no symptoms of psychosis. He also stated that he had been working 'six shifts' per week and was completing an art project. STR worker discussed with Jack the risk to Jack's mental health by using substances, but Jack maintained that he was managing well and discounted the risk of relapse.

4.37 Late July 2023 Margaret's manslaughter by Jack and serious injuries sustained by his father.

5 Analysis

5.1 The manslaughter of Margaret by her son at the end of July 2023 was a shocking event, and one which had been preceded by a 'near- miss incident when Jack had threatened to kill his mother and father two years earlier. That Jack's father and sisters actions to support him and encourage disclosure about his thoughts and take possession of the weapons Jack had were potentially lifesaving for them all at that point. After being called to the incident by Jack's sister the attending police officers found three crossbows (though the family note he possessed four) in Jack's bedroom. Jack's sister stated that the family knew of these weapons, but it seems that that they had become accustomed to Jack using them on camping trips and were not concerned about them as 'weapons' as such. Records indicate that there had been a building sense of concern about Jack since his return to them after a relationship breakdown some months earlier. The family's concerns about Jack had heightened just prior to the incident in 2021 and in particular the week before. The family believed that 'something happened to Jack that week as one day he was fine and then the next day completely different'. Jack's sister has stated that the week before the incident he had become 'negative' and 'highly emotional, and that a cousin had said that he looked like 'a different person'.

5.2 The June 2021 incident at which Jack made these serious threats to his family could have alerted appropriate services to the very real and imminent risk that Jack at that time potentially posed to his parents. Importantly, had his behaviour been recognised as domestic abuse and a domestic abuse risk assessment completed it would have alerted the family and services to the threat he posed to them. His pattern of behaviour in retrospect indicated evidence of coercive and controlling behaviour, but this was seen by the family "as Jack being nasty to his mother." It seems that none of the services involved with Jack either at the time of the incident, immediately after nor during his hospitalisation and then supervised care within the community seem to have considered the family to have been at risk of domestic abuse.

5.3 In the first incident Jack was reasoned with and disarmed by his mother and sister. Jack's sister then contacted 999 requesting that police and ambulance services be called. The call handler did not request police attendance because Jack's sister told the call handler that he had been disarmed by this point. This appears to the panel a rather blunt measure in which to judge the imminence or seriousness of a threat. Police officers did attend however as the ambulance crew on their attendance felt it to be too dangerous to do so without them being there. The West Mercia Police IMR notes that police officers not being requested to attend by the call handler was and presumably remains, the correct procedure. When police officers did attend, they did not assess the event as one of domestic abuse, but one of a mental health crisis and completed risk assessments relating to that. This then set the agenda for the future. There were mental health responses, assessments and referrals but no domestic abuse assessments and referrals which, the Panel believe had they been completed may have triggered a multi-agency process geared to protecting the family. The attention of the attending services from that point on was focussed on medical assessments and decisions concerning the management of Jack's mental health. As a result, Jack's family- the intended targets were left overnight and into the following morning alone with him until a mental health assessment could be completed, and then again until a bed was found in an adult acute inpatient ward. This, despite Jack's mother disclosing to those attending that she had found two knives under

his pillow. The safety plan for the family was that they stay awake through the night, as Jack appeared calm at the time. The Adult Social Care (ASC) IMR regarding this notes that there was

"*a lack of professional curiosity evidenced in the report and case notes. When considering detention under the MHA the doctors are required to consult with each other. The reports states that, yes, they did consult but no elaboration. The recorded risks were the same as identified in the original assessment that in my opinion fell short of the expected recordings. There is nothing recorded about the risks Jack posed whilst on the ward, not taking medication and absconding."*

5.4 The ASC IMR recognises that 'Margaret's voice' was not heard by professionals assessing Jack at his home, there is no evidence of the fear and trauma that the family had experienced within the assessments of Jack the day after the event. The professionals assessing him focussed only on his presentation and symptoms, and not the impact on those he had threatened to kill. There is no sense of the build up to the 2021 admission that it was an integral part of the threat generated by Jack's behaviour to his family. There is little evidence of an understanding of the presence and risks of domestic abuse or of robust professional curiosity by any of those attending either in the evening or the following day's mental health examinations and later in-patient care. Certainly, the number of domestic abuse related risk factors present at that time should, had they had been recognised have given cause for more reflection in terms of the family's wellbeing and safety than appears to have been the case.

5.5 The handover between ASC and MPFT appears to have been a critical moment for information to have been shared. However, in this case as the initial crisis was not seen as one of domestic abuse then the following mental health assessments continued to focus on Jack's mental health. This is to a degree understandable as the family were not presenting as in a crisis. This lack of concern from the family was due to their normalisation to Jack's controlling and threatening behaviour. It could have been challenged by those professionals involved, instead of it being accepted by them. This indicates in the Panel's view the need for an agreed multi-agency risk assessment process.

5.6 This pattern was repeated whilst Jack was an inpatient in hospital. He was uncooperative and unwilling to accept treatment, believing that he was not 'ill' but that he was trying to save his parents from an even worse fate and absconded three times from hospital. There is no sign that these attitudes and behaviours were seen as risks that warranted warning markers being placed on record. On one of the occasions that Jack absconded, there was a gap of four hours before staff on the adult acute inpatient ward alerted the police after he was known to be missing – due it seems to the protocol existing that required a search of hospital premises before alerting the police. Staff at the adult acute inpatient ward did inform Jack's parents, but because they did not see Jack as a threat to them, his parents were not alarmed. Not calling the police on his absconding was a result of the earlier mistake in failing to identify the first incident as one of as domestic abuse. The delay could have provided the time and opportunity for Jack to have carried out his expressed wish to kill his parents. This suggests to the Panel that the process of the identification and assessment of risk did not lead to an effective plan protect the family. Had there been a domestic abuse assessment completed; It is likely that several factors would have been identified possibly triggering a domestic abuse orientated response.

5.5 There was no evidence of services identifying the needs and developing a safety plan for family members after this incident. It is the view of the Panel that had domestic abuse been identified during attendance at the incident, a multi- agency meeting would have been called to discuss measures to protect the family.

5.6 At a team meeting held in in the hospital to discuss Jack in early July 2021 at which his mother was present, it was agreed that due to his history of non-compliance with oral medication whilst in hospital, Jack should be given medication by a nurse by injection. Risk factors were noted concerning Jack's mental health, and it was identified that that his isolation and a risk of violence to others remained current risks.

5.7 Jack was subsequently discharged from the adult acute inpatient ward, despite his evident unwillingness to accept medication and poor compliance whilst in hospital and returned home with easy access to his previously named targets. Jack's mother was alerted to his discharge, but there was not a safety plan developed for her, the family nor any of Jack's previous partners in the event of his relapse. The Panel believe that this was due to domestic abuse not having been first identified, nor the correct risk assessment being undertaken. Jack's sister has stated to the DHR author that "He (Jack) had openly said he would kill all of the family and the dog but would never hurt himself" to her. It seems that this information had not been passed on to those services working with Jack on discharge from the ward.

5.8 The Mental Health Act, and the relevant code of practice also requires a focus upon the concept of the "protection of others" when assessing risk and planning interventions. When the psychiatrist completes a recommendation for either a section 2 or a section 3 MHA part of the assessment requires them to consider whether detention is needed for the protection of others. This is also the case for consideration of a CTO, and the code stresses the need to consider the family's perspective. Significantly the code of practice to the MHA stresses that when

" considering whether detention is necessary for the protection of other people, the factors to consider are the nature of the risk to other people arising from the patient's mental disorder, the likelihood that harm will result and the severity of any potential harm, taking into account:…….. the willingness and ability of those who live with the patient and those who provide care and support to the patient to cope with and manage the risk."

5.9 It is noteworthy that when Jack was discharged, his family, including his mother did not seem to have had any concern for their safety. Again, had the previous event been framed as one of domestic abuse as well as a mental health issue they may have been offered help and advice which could have reframed their normalisation to the threats and behaviour of Jack as being part of a pattern of abuse. In addition, the family would have had a designated domestic abuse worker assigned to them to help identify and manage these risks. The family very quickly became worried about the lack of engagement that they felt that Jack had in his treatment, his suspected return to drug use and previous patterns of behaviour- binges in terms of drugs and alcohol, non-compliance with medication, evading drug testing and erratic behaviour. There appeared to be scant communication between Jack's parents and those working with him which frustrated Jack's mother. Jack's father has stated since Margaret's death that they did

not understand the purpose of the home visits by mental health services and had little faith in Jack's workers being able to stabilise their son. Had this information at the time been provided to domestic abuse informed workers it may have been reframed in terms of Jack's likely increasing risk to self and family members, rather than of an issue of compliance. Jack's sister stated to the reviewer that she felt that "they were never sat down and told what Jack was suffering from and what his behaviours could be……He was never described as a risk to family members". The Panel do not know at this point whether this lack of information sharing by those working with Jack was a result of applying Jack's statutory rights to privacy or whether it was due to it being customary practice not to involve family members in patient care in any situation. If the former then while Jack was an adult and had statutory rights as an adult to a private life, the family also have a right to a 'life free from unlawful violence' under the Equality and Human Rights Act (1998).[24] In addition, had such behaviours been identified as domestic abuse they would have been interpreted as evidence of non-cooperation and manipulation of those working with him, all factors indicating an increase in risk to Jack and others.

5.10 Jack was described by his sister as a sensitive and self-conscious young man who had been using non- prescribed drugs for several years. Jack had recently returned home some months after the breakup of a relationship- the reasons for that are not known. Jack, according to his family had found out that he had an eleven year old son from a previous relationship. All difficult information to process and consequent emotions for him to manage. In addition, Jack's background as reported by his sister suggests that he was sometimes unsettled and secretive- spending much of his time in 'chat rooms' and websites and using drugs and alcohol - he had worked for his father after leaving school this came to an end due to his being 'unreliable' it was believed by his sister due to his long term substance misuse. Jack described working six days a week as a security guard, but it is evident from the family chronology that he was always short of money. This background of insecurity, instability, failed relationships, erratic behaviour and long term substance misuse seems to have remained either unknown or largely unrecognised by the services both assessing him and working with him research has identified that cases of children abusing their parents did increase over the period of Covid lockdowns and the Panel believe that it is likely that this may have been a factor in this case, given the proximity of the lockdown events to Jack's sudden deterioration, although it cannot be proven.

5.11 Because a DASH[25](Domestic Abuse, Stalking and 'Honour'- based abuse, a risk checklist that helps practitioners identify and understand the risk that victims of domestic abuse are facing) was not used as the risk assessment tool when police officers first attended the incident, an opportunity to identify Jack's behaviour as an ongoing pattern of abusive and controlling behaviour and not solely as a mental health crisis was lost. This first error was in the view of the Panel then compounded by the further assessments completed on Jack, all of which focussed on the patient, his symptoms and needs, and did not seek information from the

[24] https://www.equalityhumanrights.com/human-rights/human-rights-act/article-3-freedom-torture-and-inhuman-or-degrading-treatment
[25] https://safelives.org.uk/resources-for-professionals/dash-resources/

family in terms of a history of their own experiences of his behaviours and their concerns about that, nor following discharge home of their views in terms his progress on discharge, compliance with his medication etc. Jack's sister has confirmed to the reviewer that although victims of his behaviour, none of the family members who had experienced or witnessed those behaviours saw them at the time as potential risks to them, nor as 'domestic abuse'. Jack's behaviours for instance, his known poor compliance during both in-patient and out-patient care with medication, and with his treatment in the community, his known illegal drug use, his obsession with conspiracy theories and weapons and extreme sexual behaviours, are identifiable risk indicators in terms of violent and abusive behaviour. There was no discussion with the family about these elements of Jack's behaviour that were known and of concern to them due the Panel believe to those services working with him not framing Jack as the potential threat to the family that he was.

5.12 The 'FACE' Risk profile is a risk assessment tool used by the MPFT to predict the 'level of risk' presented by patients with whom they worked, it does not provide an overall risk rating (for more detail see the MHHR). Jack was assessed as at 'high risk' from first contact with mental health services and on his discharge to the community in July 2021. He was re-assessed in July 2022 as at 'low risk'. At this point Jack was moved from 'depot' injections administered by workers to Jack himself being responsible for taking this medication orally. The Panel consider it would have been good practice for family members to have been consulted regarding their opinion about these changes to Jack's medication administration method. The Panel believe that had they been consulted they likely would not have agreed, given their existing concerns about Jack's behaviours and mental well-being, however as an independent adult it would not be possible for the family to veto changes to his medication. The family believed that Jack was pretending to cooperate with his treatment and was deliberately misleading the workers. Crucially, this, along with the removal of the CTO a few months earlier meant that it would be more difficult to return Jack to hospital if there were concerns about his mental health. Jack's sister has disclosed to the reviewer that she, following her mother's death has seen Jack's diary in which he had planned for the removal of controls on him, the CTO, drug testing and the depot injections so that he could more safely use drugs. Jack's next assessment was set to be reviewed in March 2023, but this was not done, quite likely due to staffing issues caused by the unplanned absence of Jack's Key Worker and the decision not to replace him with another qualified worker.

5.13 The decision to allow Jack the responsibility for his medication does seem to represent the seminal moment in his management within the community. Jack had historically not complied with the conditions under which he had been discharged according to his family, but that was not known to those working with him due to his being able to avoid any drug testing of him. His sister has told the reviewer that Jack had been drinking and using drugs since his discharge from the adult acute inpatient ward. In addition, the family believed that the behaviours that they witnessed but of which those working with knew nothing about suggested to them a deterioration in his mental health. This key information was never known to those working with Jack. Perhaps had the family been provided with an easier route to share these opinions with those agencies working with Jack this dissonance in how Jack was felt to be progressing could have been avoided. In essence it appears that there was an over-

reliance on one source of information, Jack, and that information was not being triangulated with other sources of information for verification.

5.14 It does seem that the pattern and level of care was maintained despite the Key Worker's absence, from July 2023 onwards. Margaret's daughter stated in interview with the reviewer, albeit in retrospect that she was aware at the time that that those working with Jack in the community assessed him as 'low' risk but that she felt this was due to poor intelligence and their relying on Jack's account of his progress. She stated she was particularly vexed after his discharge from hospital in February 2022, by Jack that there was not any mandatory drug testing of Jack This she felt to have been a key mistake as had a test been taken, she believed it would have revealed evidence of his drug use and "could also have provided an opportunity for family members to have been alerted to any risks associated with him not taking his medication".

5.15 The key errors made in the view of the Panel in managing the potential risks that Jack posed was firstly the failure to recognise the risk of harm that he presented to family members. This was absent from the very first incident in his home in June 2021, when the emergency services response was one of a mental health crisis and not one of a domestic abuse incident and continued through his inpatient stay and discharge and into his care and supervision in the community. Potential indicators of a possible relapse into his previous patterns of behaviour, illicit drug use, disturbed sleep, restlessness, non-compliance with medication were evident to his family members and to a lesser degree those working with him but were framed as reluctance in terms of his cooperation or as medical issues and not as risk factors for which there was some evidence, evasion of treatment, return to drug use and consequent distorted thinking and behaviour.

5.16 Secondly there was scant communication between Jack's family members and those working with him. Family member's report that they did not know whether or how to contact those working with Jack. Home visits undertaken by those working with Jack did not usually seem to involve Jack's parents. In addition, records indicate that arrangements regarding communication with Jack's family, giving the family their contact details, arranging to visit were mostly made through Jack, making communication dependent on his cooperation and compliance, which in the Panel's view should not have been assumed. Family members themselves appeared not to have known how to or whether they could contact those services independently, reducing again the quality of feedback regarding Jack's mental health and behaviour. The Panel believe that the workers involved in Jack's care were unknowingly being manipulated by Jack to prevent them meeting family members and Jack's mother and sister specifically. One can only conclude that his motivation in doing this was to continue to control the information the workers were receiving. He was the single source of their information concerning his behaviour and emotional state, Jack may have feared that hearing information from his family, and of their concerns for him would likely have resulted in a change of approach in his care management by those workers.

5.17 The family members spoken to after the death of Margaret have said that they felt at the time that they were unable to communicate the concerns they had about Jack as they had been given no contact details as to who with or how to contact those that were

working with him. Margaret also shared this view in the nursing home where she worked and with her friend. It is not known at this point whether this was an oversight by services, or is accepted policy, perhaps guided by Data Protection legislation, or whether it indicates an area for improvement to consider for future practice. The MHHR has recommended the strengthening of these arrangements. The Royal College of Psychiatrists' Good Psychiatric Practice -Confidentiality and information sharing (CR209)[26] states the following:

"*The National Confidential Inquiry into Suicide and Homicide has emphasised that talking to family members and carers when preparing clinical and risk assessments can prevent patient suicide and homicide (Appleby et al, 2015[27]). There is nothing to prevent you, or any other healthcare professional, from receiving information provided by any third party about the patient, as receiving information does not equate to disclosure. Indeed, provided the circumstances do not involve disclosure of confidential information, a healthcare professional may actively request information without the patient's consent. This can be an important part of the risk assessment of a patient."*

5.18 In reviewing the experience of Jack's time at the in-patient psychiatric unit and his discharge afterwards it is clear that there was no sense that is evident from the reviews available to the Panel that he was seen as a potential threat to his family. There were indicators suggesting that he did pose a threat, the incident itself and linked risk factors, Jack's poor compliance with conditions set for him, ongoing substance misuse, isolation and loneliness and other entrenched anti-social behaviours. As discussed above there was no safety plan in place for the family should Jack abscond from the adult acute inpatient ward, nor afterwards on his discharge. Standard procedure was followed as with every patient in such an event rather than one tailored to the potential risks that he posed to identified family members. Jack's sister has stated that discussions between family members and staff at the adult acute inpatient ward were always in terms of managing Jack's care and that family members were 'blinded' by their ties and affection to Jack and were not able to identify these risks themselves. Jacks sister has said that she feels in hindsight that this responsibility should have laid with the staff treating Jack and that these responsibilities were not met. Jack's sister felt that overall, there was a lack of inclusion of family members through Jack's time in the adult acute inpatient ward and then into the community. She felt that there was a Care Coordinator in place for Jack but no contact or support for Margaret and the family to help the family. She states that they had tried to contact the mental health charity 'MIND' for

[26] https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/college-reports/2017-college-reports/good-psychiatric-practice-confidentiality-and-information-sharing-2nd-edition-cr209-nov-2017?searchTerms=-Confidentiality%20and%20information%20sharing%20%28CR209

[27] chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://shura.shu.ac.uk/26487/6/Ashmore_EngagementObservationReview%28AM%29.pdf

advice but were unable to. It seems that in essence the lack of a route into the agencies working with Jack for the family, formally or informally, their lack of basic contact details or names both in the community and from the adult acute inpatient ward, and during home visits left them feeling isolated and without a voice in his care. Jack's sister has informed the DHR author that she has written evidence in the form of diary entries made by Jack that he consciously manipulated those working him to enable him to be moved from injection to oral methods of drug administration, and from then to avoid drug testing to enable him to use drugs without detection and so avoid return to inpatient care. This information was never shared by her with those working with Jack as the diary not found until after Margaret's death.

5.19 In summary the Panel acknowledge that Jack was a challenging person to work with and who was non-compliant but would acknowledge this and would often apologise for it to those working with him, the Panel believe that this may have been a strategy to disarm those that worked with him. Importantly, Jack's family members were not involved, or did not feel to be able to contribute during the home visits, which would have been an opportunity to do so. Importantly the family seem to have become alienated from the process of Jack's supervision in the community, despite the obvious investment they had in its success. This, in the Panel's view was a missed opportunity to use the family to gather secondary sources of information about Jack and build the family's ability to support him. The absence of the family member's voice in Jack's assessments is noticeable to the Panel and is compounded by their uncertainty about how or who to contact despite their growing sense of unease concerning him. This led services to rely solely on Jack for information in their assessments of him, this the Panel believe significantly limited their reliability and usefulness. Those working with him did not appear to have considered the possibility that his behaviours, for instance his persistent evasions of drug testing to have been controlling and manipulative of them and was not addressed. This was compounded by the failure to establish a channel of communication with the family, which almost certainly would have led to elevated concerns about Jack and his recovery. The attitudes, beliefs and behaviours that allowed this gap in information gathering should be addressed as a matter of urgency.

5. Conclusions

5.1 Despite Jack's family being identified by services attending as the potential victims of Jack, domestic abuse was not considered by either mental health services or Adult Social Care nor identified by the West Mercia Police during the June 2021 incident. Therefore, the family, who were closely involved in Jack's care, were not fully aware of the nature of the risks that they faced. Had they been informed that they had been the victims of domestic abuse and the risks of that, Margaret's husband and daughter believe they would have acted differently. The family are intelligent and able, and the Panel feel would have sought help and information about domestic abuse and coercive control, so raising their awareness of risk. Had a domestic abuse service been involved with the family, a safety plan would have been developed with them. This would have enabled them to understand and recognise Jack's abusive behaviour and identify the triggers and early warning signs of it- some of which may already have been presenting, for instance Jack not sleeping, his drug and alcohol misuse and seeking to antagonise his father. This failure had also led to the absence of any warning markers on the family home in the event of callouts, and critically in terms of safeguarding, there were no consideration of restrictions preventing children from visiting or staying at the property overnight. That there was no incident during the time of Jack's return to the community should be considered in the Panel's view a 'near miss'.

5.2 In June 2021, when Jack's sister contacted 999, describing the nature of the emergency, the call handler on being told that Jack had been disarmed downgraded the incident to one which did not need police attendance without seeking further information from her. The Panel consider this to have been a premature assessment as the reason for the call was of immediate and serious threat to family members. It is of concern that the call handler felt it right to put aside all other indicators of the seriousness of the harm, the dress, bizarre behaviour, the threatened use of weapons, due to Jack being disarmed. That weapon was still available to him within the home. This appears to the Panel a rather blunt measure in which to judge the imminence or seriousness of a threat, felt by a potential victim. It is likely that the question was asked to identify the potential seriousness of a situation, and is a legitimate one to ask, but in this case, it appears to have led to the mistaken conclusion that risk of harm was no longer present, for which the call handler had no evidence.

5.3 The handover between the crisis response team in the early hours of the morning in June 2021 at the first incident and the MPFT doctors the next day was a critical moment, as domestic abuse had not been identified, and Jack had been left in the care of family members having been only hours earlier his intended targets. Domestic abuse had not been identified despite the known risk factors of the use of threats to identified family members and a pet, a mental health crisis and access to weapons in this case. This continued into the next day with assessments of Jack's mental health only.

5.4 Jack's family do not appear to have been informed of or involved in many of the milestones in Jack's care. For instance, the removal of the CTO in May 2022, was a significant decision with potential impact on the family, but it seems to have been made without any consultation with family members who already had deep concerns about Jack at that time. This was an

opportunity missed. The family were not fully engaged in the rehabilitation nor supervision of Jack by those professionals working with him after his return into the community. This led to an over-reliance on a single source of information, Jack by those workers and their assessment of his wellbeing. This contributed the Panel believe to some key decisions made to be flawed, for instance the removal of the CTO and the move from 'depot' injections to tablet form particularly. This approach also led the family to feel alienated from those agencies supporting Jack, they knew neither what they were doing nor why they were doing it, but they appeared to defer to their judgements despite this.

5.5 The removal of the CTO was a significant decision taken with information from very limited sources, mostly those of professionals working with Jack. The family would have contributed but were not consulted, leading to them feeling alienated from the process and resentful as they would have to live with the consequences, which they believed to be Jack's increase use of drugs and linked behaviours.

5.6 The family believed that Jack had manipulated the services working with him to enable him to return to illicit drugs without detection and his greatest fear, return to hospital under a mental health detention order. This decision had left the family fearful that Jack's drug use would now increase as he no longer had a fear of detection and sanction.

5.7 We cannot know, but it should be considered whether and to what degree the Covid lockdowns and related restrictions played a part in this event. Recent research has identified an increase in violence, abuse of parents by their children during the lockdown periods within the UK. These effects may have been a factor in the manslaughter by Jack of his mother.

5.8 Finally, the side-effects of the anti-psychotic medication that Jack was taking were not known at the time of this case. In retrospect this may help Margaret's family to understand his escalating behaviour. It is now known that the use of this drug can lead to erratic, compulsive and impulsive behaviour or temptation to do something that could harm the individual or others, such as gambling, increased sex drive, uncontrollable shopping and other destructive behaviours[28] .

[28] https://www.nhs.uk/medicines/aripiprazole/side-effects-of-aripiprazole/

6. Lessons to be learnt.

6.1 At no point during Jack's psychotic episode in June 2021 and his assessment and admission to the adult acute inpatient ward were the family advised that they were experiencing domestic abuse. The risks they faced were not assessed from the perspective of risk to them by WMAS, West Mercia Police, ASC or the attending mental health agencies. Once stabilised in the hospital the risks he posed to others in his family that were known to the staff were not reviewed. The adult acute inpatient ward had access to the DASH Risk checklist on the 'RIO' system and the safeguarding advice line but did not despite their understanding that he posed a risk to his family (as demonstrated by their remarks to the police when he absconded) use the accredited checklist.

6.2 The failure of agencies to identify this case as one of domestic abuse, was the Panel believe related to the alleged perpetrator being a sibling with mental health issues and the victim being a parent. Domestic abuse is now routinely identified in intimate partner relationships, that this case involved an adult child on parent threat of violence did not cause the professionals to consider that. Section 2 of the 2021 Domestic Abuse Act provides the definition of "personally connected" and this includes those who would constitute a "relative"[29] of the victim.

6.3 In line with the recent West Mercia Police guidance 'Right Service First Time' the call handler assessed that as Jack had been disarmed a police presence was not required. The incident was assessed as requiring a mental health response only. However, this case presented aggravating factors such as its planned nature, possession of weapons, poor mental health and the likelihood of the perpetrator being under the influence of drugs. These aggravating factors should have led to an escalation of the assessment as they indicated potential significant risk of harm to a known victim.

6.4 As domestic abuse was not identified as an issue the related risks and behaviours associated with domestic abuse such as risks to the children in the wider family or Jack's coercive and controlling behaviour were not considered at the time or explored by services in their ongoing contact with Jack his family or his ex-partners either at hospitalisation or discharge back into the community.

6.5 The AMHP Lead who completed the ASC IMR recognised there were issues with the quality of report writing and recording of AMHP's decision making. The AMHP Lead in response has arranged 'Continuous Professional Development' sessions with the AMHP's workers,

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[29] The definition of "relative" has the meaning given under section 63(1) of the Family Law Act 1996 ('the 1996 Act') which includes immediate biological family, stepfamily and extended family of an individual including such family members of their present or former spouse, civil partner or cohabiting partner.

focussing on completion of AMHP reports, risk assessment and defensible decision making. Following discussions with the Chair the AMHP Lead is seeking to ensure a regular case audit plan is embedded with annual dip sampling to ensure improved standards are maintained and are monitored in their performance data.

6.6 To address the issue of the failure to schedule a S117 review meeting, the ASC IMR author has requested that the current recording system 'LAS' be enhanced. It will now show when a CTO is outstanding and alert staff six weeks before the CTO is due to lapse. The AMHP lead has liaised with the Mental Health team Leader and Business Support to ensure it is implemented.

6.7 The GP noted in this case that the two letters received from mental health services, the discharge letter from Jack's Consultant and the formal letter sent to the GP some three weeks later could have highlighted any potential victims the services were aware of. The GP stated to the Panel that risk information is often within the text of long and complex letters that they receive at the surgery and that it would be useful for this critical information to be highlighted in cases such as this in which named victims have been identified by a patient of the surgery. This would allow the surgery to flag the patient records of the named victims within a family and trigger the GP to ask a broad well-being question with a view to encouraging any disclosure of fear or risk when they attend on their own behalf. Although there are risk indicators that are shared between NHS agencies via 'One Health and Care' records, the author of the MHHR and MPFT member felt that amending these letters would not be workable as they need to read in their entirety by the medical professional .

6.8 The Panel discussed the significance of the possession by Jack of the crossbows. In this case services were not aware of the crossbows until the night of Margaret's death. Crossbows can only be owned by those over 18 years of age and can only be used for target practice and not carried in a public place. There are no on-going control, record or licensing requirements for crossbows, unlike firearms. Because of this, the UK Police have no record of the ownership of crossbows, how they are stored and the number in circulation. There were calls on Government to review the 1987 Crossbows Act and Offensive Weapons Act 2019 with the intention of regulating the sale and possession of crossbows, however it was deemed that existing legislation was sufficient and that incidents involving crossbows were rare.

6.9 The agencies involved should consider how they are currently implementing the Domestic Abuse Act 2021. In this case there was no record of any agency seeking information regarding the welfare of children within the wider family nor those of Jack's ex-partners within the context of Jack's behaviour and potential risks to them. It must be noted that the police following Margaret's manslaughter undertook a welfare check on Jack's son.

6.10 The MHHR notes recent work is being undertaken to ensure better communication between Adult Social Care, MPFT and the Integrated Care Board to look at how provisions for timely, good quality Section 117 reviews are arranged and completed.

6.11 The process of undertaking a DHR and MHHR alongside each other has highlighted the consequences of labelling/identifying an individual as a perpetrator or as a patient never both.

Undoubtedly Jack was seriously ill when he threatened his parents and then two years later attacked them and killed his mother. This case with its complex presentation of intermittent mental illness and domestic abuse once set on a mental health pathway the focus remained on the mental health and wellbeing of the patient. The patient's behaviours were then always interpreted as one of mental health and other possibilities were only considered by those responsible for his care after a significant period when Jack absconded. Once informed the Police immediately acted in response to the perceived risk to his family.

6.12 The Panel discussed the significance of the weapons Jack stored in his bedroom, powerful crossbows and some knives. As the sale and possession of crossbows are not registered or require a licence, agencies knew little of his interest in weapons. Therefore, these weapons or his interest in them did not factor in any risk assessment seen by the review. Although not used in this tragedy the family were fearful of Jack's access to them. All homes contain potential weapons as to whether these crossbows presented as a significant escalation in risk is not known.

7. Recommendations

7.1 West Mercia Police, WMAS, ASC and Mental Health services ensure that their staff are able to identify domestic abuse and coercive control risks using an approved multi-agency risk assessment checklist such as DASH. The use of DASH or the agreed risk identification tool to be audited by the above agencies. These audit outcomes reported to the Community Safety Partnership until all can evidence, they are an embedded process

7.2 The above risk assessments should reflect the Domestic Abuse Act (2021) and include all family members especially children connected to the individuals involved.

7.3 The Right Service First Time Guidance for Call Handlers to identify indicators of domestic abuse and the risk to others even where a psychotic episode is noted is reviewed by West Mercia Police in light of this case.

7.4 The Panel request that the Home Office review the current data on the use of crossbows in domestic manslaughter or 'near misses' to establish if the position adopted in 2019 concerning crossbows remains, that they do not pose a threat.

7.5 The MHHR recommends

" We recommend that existing training for staff should be enhanced to balance the legal and professional responsibilities to assure that two way information is shared appropriately. This is because whilst it is important to respect patients' rights to privacy and confidentiality, assessment and ongoing communication should also usually include some information for the patients family, carers, and other agencies. Information sharing decisions should be taken on a case by case basis, and assured in each case, checked to ensure that decisions are appropriate, evidence based and documented in the electronic patient record."

This DHR reinforces the need for mental health services to demonstrate their duty to listen to families who in many cases are an invaluable source of information. Therefore, we recommend the recording of family members views in terms of welfare and ongoing risks to the patient and others including family members concerning the level of seriousness of the risk posed by the patient and its imminence. This appears in line with Good Psychiatric Practice: Confidentiality and Information Sharing (2nd edition) (CR209 Nov 2017) quoted earlier.

Appendix 1: Methodology for the overview report

Data analysis

The Panel discussed the chronology of events and draft recommendations in an inclusive and collaborative way, which involved all members in reflective learning. It was a generative process which encouraged us to ask the aspirational question – 'what a safe system would look like?' The outcomes from this process have formed the basis of the review recommendations. The recommendations were shared with Margaret's families prior to the review being completed to ensure her family were as involved in the outcomes as possible.

It must be acknowledged that any review opens anxieties, but it was the Panel's intention to create a culture of accountability and learning not of culpability or blame. The Review Panel were unanimous in wanting to value the actions and approaches that worked well, whilst facing the tough issues of what else could or should have been done. The aim was to produce effective recommendations which would make more effective responses to similar situations. R.

The chair wished to adopt a 'no surprises' approach, to encourage meaningful discussion and to air differences of opinion. The draft overview report was circulated to the panel and marked Restricted. Until final comments were received the panel members had the right to share the draft report with those participating professionals and their line managers who have a pre-declared interest in the review.

The Home Office guidelines require the final report in full to remain RESTRICTED and must only be disseminated with the agreement of the Chair of the Domestic Homicide Review Panel.

Appendix 2 Individual Agency recommendations

Recommendations from GP Practice

Nº:	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer	Target date to complete
1.	Include the risk to others as part of risk assessments of patients with mental health-related presentations.	Discussion with clinical staff at practice meetings and review of what structured risk assessment tools are used in patients with mental health-related presentations. Ensure these contain relevant sections on risk to others.		Ensure risk assessments include risk to others when appropriate.	GP1	30/09/2024
2.	Resources for child on parent abuse to be available to staff at Medical Centre.	Identify sources for support in child on parent abuse, such as PEGS; share this information with all staff and ensure resources can be easily accessed when required.		Ensure access to sources of support for child on parent abuse victims and that staff are aware of these and how to access them.	GP1	30/09/2024

3.	Share learning above with other practices in the PCN.	Share learning and actions with safeguarding leads at our PCN practices.		Share learning with other GP practices.	GP1	30/09/2024

HERE ARE THE MHHR RECOMMENDATIONS

Recommendations

As is usual for MHHR reports, the following recommendations have been drafted in partnership with the Trust. The Trust will develop a formal Action Plan which is `SMART' (specific, measurable, attainable, realistic, and timely) when the report of the DHR is completed.

Recommendation 1

1. The Trust will strengthen staff knowledge around safeguarding, particularly in relation to domestic abuse within the family where risk is increased due to mental ill health of a family member.

Recommendation 2

2. The Trust is planning to continue to implement the NHSE inpatient mental health transformation programme. As part of this, the Trust will use its safety module to explore and deliver a project to move away from risk stratification towards formulation and safety planning.

Recommendation 3

3. The Trust will review risk assessment and care planning arrangements. The aim is to ensure that there is clarity of assessments, and communication of risk of violence to others and ensure that information about care and risk are more closely woven together.

Recommendation 4

4. The Trust will complete an audit of the arrangements within the EIP team of engagement with families in relation to the development of the 'Think Family' and Triangle of Care approach to ensure that engagement with families and carers is strengthened, and that continuity of policy across the whole Trust is maintained.

Recommendation 5

5. We recommend that existing training for staff should be enhanced to balance the legal and professional responsibilities to assure that two way information is shared appropriately. This is because whilst it is important to respect patients' rights to privacy and confidentiality, assessment and ongoing communication should also usually include some information for the patients family, carers, and other agencies. Information-sharing decisions should be taken on a case by case basis, and assured in each case, checked to ensure that decisions are appropriate, evidence based and documented in the electronic patient record.