Executive Summary:

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

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COMMISSIONED BY TELFORD & WREKIN SAFEGUARDING PARTNERSHIP

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Contents

Glossary

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.Introduction and the Review Process

1.1 This executive summary report of a Domestic Homicide Review (DHR) examines agency responses and support given to Margaret. Margaret was killed by Jack, her son in July 2023 at her home. Margaret died from blunt force trauma after being hit by a claw hammer. Immediately after the killing of his mother, Jack had attempted to kill

his father, who had 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.

1.2 The following pseudonyms were chosen by the family to be used in this review, Margaret for the victim and Jack for the perpetrator to protect their identities and those of their family members. Margaret was 58 years old woman who was married at the time of her death. She identified as White British and did not have any disabilities. 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.

1.3 Following the attack on his parents, Jack was held in a secure unit under the Mental Health Act 1983 to a medium secure unit. He was deemed 'fit for interview' by his treating psychiatrist. Jack was detained under the Mental Health Act until his arrest in October 2023. The Crown Prosecution Service authorised that Jack be charged with the manslaughter of his mother and assault on his father. The following day Jack was remanded in custody by Stafford Crown Court. Jack. In January 2024 a decision was made that he was fit to stand trial and a trial date for July 2024 was agreed. However, the need for a 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 Hospital Order' with a 'Section 41 Restriction Order' under the Mental Health Act later attached in April 2024.

1.5 The Telford and Wrekin Safeguarding Partnership agreed in July 2023 that Margarets death met the criteria for a Domestic Homicide Review. This Review was commissioned to run in parallel with a Mental Health Homicide Review (MHHR). Six of the sixteen agencies contacted confirmed contact with the victim and/or perpetrator and were asked to secure their files. In September 2023 the DHR Panel was convened and a Chair appointed. On the advice of West Mercia Police in November 2023, the DHR was paused to await the outcome of the trial. In May 2024 following the sentencing of Jack, the DHR Panel met. The Individual Management Reviews were requested to tie in with the completion of the draft MHHR report in August 2024.A final draft was shared with the Family in January 2025 and approved by them in May 2025.The DHR was submitted to the Partnership in July 2025 for their approval.

2. Contributors to the DHR

The Panel consisted of seven agencies and was supported by the author of the MHHR who worked jointly with the Chair to avoid any unnecessary duplication for the family, or the agencies involved. Of the seven agencies five were asked to provide Independent Management Reviews (IMRs). In the list below agencies 2-5 IMRs were completed by a member of staff who had not involved with the case and then they were authorised by a responsible officer in each organisation. In the case of the GP Surgery the size of the Practice this independence was not possible as all staff had previous contact over the years with the family.

These five agencies provided an IMR for this DHR.

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

NHS England helpfully shared the Mental Health Homicide Review (MHHR) in draft form throughout the DHR process with the Panel.

The Chair of the DHR and author of the MHHR met jointly with Margaret's husband and daughter who were supported throughout by an advocate from the Victim Support Homicide Team. The Chair of the DHR spoke with Margaret's best friend and confidante of many years who lives a distance away, she and Margaret spoke at length each week. The Chair met with Margarets long standing colleagues at the Nursing Home where she worked. All of the information they provided was helpful as Margaret was a private person and had limited engagement with agencies. The family were supported by an FLO and Victim Support Homicide Team Advocate which they greatly appreciated.

Jack's most recent ex-partner declined to be involved in the DHR.

3. The Review Panel members

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 as the surgery had known the family for many years,

Agency	Role	Name
Independent	Independent Chair and DHR Author	Jan Pickles
Commissioned by NHS England Mental Health	MHH Review lead	Anne Richardson
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
Community Social Work and safeguarding, Telford, and Wrekin Council	Service Delivery Manager	Tracey Holmes
Midlands Partnership Foundation Trust	Safeguarding Named Professional	Sarah Whenmouth
Shropshire Community Health Trust	Nurse Specialist, Safeguarding Adults	Anthony Archambault
GP Medical Practice	Primary Care Practice	GP Partner Safeguarding Lead for Adults and Children.
West Mercia Police	Detective Inspector Statutory and Major Crime Review Team. Police Staff Investigator	Jordan Baker Hannah Clements
Telford & Wrekin Safeguarding Partnership	Safeguarding Adults Board Manager	Lisa Jones
Telford and Wrekin Domestic Abuse Services (from Panel meeting 2)	Service Manager acting as the Panel's independent Domestic Abuse adviser.	Andrea Williams

The Panel opened the review in January 2024 when the Senior Investigating Officer of the case shared an outline of events learned in the police investigation with the Panel. The Panel then met following the sentencing in May 2024, and then in September, October, November and December 2024 to review drafts of this Review.

The DHR Chair spoke with Margarets best friend and close confidant and her employer and long term colleague in order to learn as much was possible about her.

The near final draft was shared with the family in January 2025 for their amendments. The Chair of the DHR and author of the MHHR met with the family together. Once the family were confident the review reflected the life and experiences of Margaret as wife, mother, friend and Nurse the review was completed in May 2025

4.Author of the Overview Report

Jan Pickles was appointed as author of the DHR and author of this report in September 2023. 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 served 17 years as an Independent Board member within the Welsh NHS and was a member of the inaugural National Independent Safeguarding Board for Wales for six 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.

5. Terms of Reference

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

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 Department of Work and Pensions (DWP) are asked to provide briefer information reports to the review

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.

6.Summary chronology

6.1 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 were 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.

6.2 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'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. West Midlands Ambulance Service (WMAS) 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 attending paramedic then contacted the Emergency Duty Team (EDT) advising them of the night's events and that Jack 'did not have capacity' and 'requesting advice and information'. The EDT 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) under the Mental Health Act 1983.

6.3 The CRHT attended that night in June 2021 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 MHAA was undertaken at home the following day and it 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 for Jack could not be offered. The IMR from ASC acknowledges that there was no specific risk assessment or safety plan relating to domestic abuse completed to manage this delay, 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. Jack was later assessed by two mental health practitioners under Section 2 of the MHA[1] whilst on that ward.

6.4 Two weeks after being admitted Jack was discovered in the early evening to be missing from the ward, the staff on duty responded as per the agreed protocol and searched the grounds before contacting West Mercia Police. 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 missing persons 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 immediately 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.

6.5 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) 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 provided by community mental health and related teams put in place on his discharge.

6.6 Jack had worked as a security guard in his father's business, but his use of cocaine, MDMA and cannabis had led to him being unreliable to the point that his

[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

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 another relationship that had ended ten years ago and had been due to see them the child and it's mother 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 after learning he had a child he had becoming more withdrawn and secretive. Jack's sister described him as a "*closed book*" who was shy and introspective but also emotional and warm, often wanting to spend time with her and his mother, wanting to be close to them though not gregarious or noisy. It seems that he had always found large family 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 as domestic abuse or having elements of 'Coercive and Controlling Behaviour' within the meaning of the legislation.

6.7 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 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

6.8 Jack remained in the Adult Acute Inpatient Ward in June 2021 for 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 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.

6.9 Jack's family believed that "*something happened to Jack that week (the 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 now believes that he had hidden it in anticipation, "*knowing he would be arrested*".

6.10 Three months before 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. Jack 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.

6.11 During the family's review of the final draft of the DHR Margaret's 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 possessed four crossbows and many knives stored in his bedroom. A week prior to the manslaughter of Margaret her daughter described the family 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. 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).

7. Key issues arising from the Review

7.1 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 mother and sister were able to remove him from the situation then and disarm him was 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.

7.2 The June 2021 incident at which Jack made serious threats to his family could have alerted appropriate services in the area 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.

7.3 In the June 2021 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. 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 recognises a lack of professional curiosity evidenced in the report and case notes and there was no record of the risks Jack posed whilst on the ward, not taking medication and absconding.

7.4 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. 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. There was no evidence of services identifying the needs and developing a safety plan for family members after this incident in 2021.

7.5 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 indicates in the Panel's view the need for an agreed multi-agency risk assessment process.

7.6 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.

7.7 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.

7.8 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.

7.9 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 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.

7.10 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, 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'. 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[2] 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

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

been a factor in this case, given the proximity of the lockdown events to Jack's sudden deterioration, although it cannot be proven.

7.11 Because a DASH[3] (Domestic Abuse, Stalking and 'Honour'- based abuse, risk checklist helps practitioners identify and understand the risk that victims of domestic abuse are facing) was not used as a risk assessment 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 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 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.

7.12 Jack was assessed using the FACE Risk profile[4] 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 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 Community Treatment Order (CTO)[5] a few months earlier meant that it would be more difficult to return Jack to hospital if there were concerns about his mental health.

7.13 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 Report author 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

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[3] https://safelives.org.uk/resources-for-professionals/dash-resources/

[4] 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

[5] Community Treatment Order-CTO under the S.17A of the MHA1983

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. 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.

7.14 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. 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. Jack did not share their contact details his motivation in doing this appears to be 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. 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.

8. Conclusions

8.1 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 to restrictions preventing children from visiting or staying at the property overnight.

8.2 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.

8.3 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.

8.4 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 Community Treatment Order (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

8.5 The removal of the Community Treatment Order (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.

8.6 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.

8.7 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.

8.8 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.[6] .

9.Lessons to be learned

9.1 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 mental health services. 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.

9.2 The failure of agencies to identify this case as one of domestic abuse, was the Panel believe related to the alleged perpetrator being an adult son with mental health issues and the victim being a parent. Domestic abuse is now routinely

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

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' of the victim.

9.3 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.

9.4 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.

9.5 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, 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.

9.6 To address the issue of the failure to schedule a S117 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.

9.7 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.

9.8 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 is 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. As Jacks weapons were not known to agencies in 2021 these weapons or his interest in them did not factor in any risk assessment seen by the review. Although not used in this tragedy we now know 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.

9.9 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 or 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.

9.10 The MHHR notes in detail the 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[7] reviews are arranged and completed.

9.11 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 when he 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 patients behaviours were then always interpreted as one of mental health and other possibilities were only considered by

[7] 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.

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.

10 Recommendations

10.1 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.

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

10.3 The Right Service First Time Guidance for Call Handlers to identify indicators of domestic abuse is reviewed by West Mercia Police in light of this case.

10.4 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.

10.5 The DHR reinforces the MHHR recommendation

"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.